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Pelvic Inflammatory Disease – A Case Study.

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ABSTRACT

Pelvic Inflammatory Disease is one of the most common serious infections of non pregnant women of reproductive age, is usually secondary to a sexually transmitted infection. The diagnosis is based on clinical history, examination and clinical symptoms and signs. The goals of therapy include eradication of pathogens from the genital tract and prevention of complication. Despite this, antibiotic treatment based on a clinical assessment is still recommended because failure to treat PID can result in infertility, ectopic pregnancy or chronic pelvic pain up to 40% women.

Keywords: Pelvic Inflammatory Disease, Pelvic Infection, Endometritis, Salpingitis

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Pelvic inflammatory disease or **pelvic inflammatory disorder** (**PID**) is an infection of the upper part of the female reproductive system namely the uterus, fallopian tubes, and ovaries, and inside of the pelvis. Often there may be no symptoms. Signs and symptoms, when present may include lower abdominal pain, vaginal discharge, fever, burning with urination, pain with sex, or irregular menstruation. Untreated PID can result in long term complications, including infertility, ectopic pregnancy, chronic pelvic pain, and cancer.

Case study of Mrs. B

Mrs. B, aged 20 years, came with the complaints of pain in the lower abdomen and back pain for one week, had vaginal white discharge and slight low grade fever. There is no significant family history and past medical history. She attained menarche at the age of 12years, her menstrual cycle is regular. She got married at the age of 19 years. She maintains normal sexual relationship with her husband, no history of using contraceptives.

Pelvic Inflammatory Disease

Pelvic Inflammatory Disease of the upper genital tract. It is a spectrum of infection and inflammation of the upper genital tract organ typically involving the endometrium, fallopian tubes, ovaries, pelvic peritoneum and surrounding structures. The better terminology should be endometritis, salpingitis, pelvic peritonitis or tubo ovarian abcess. The cervivitis is not included in the list

Teenagers have got low hormonal and cell mediated immune defense in response to genital tract infection. Wider area of cervical epithelium allows colonization of Chlamydia trachomatis and N.Gonorrhoea. Multiple sexual partners, Menstruating teenagers, absence of contraceptive pill use, previous history of acute PID, IUD users is at risk of developing PID

Incidence

The incidence varies from 1-2 percent per year among sexually active women. About 85 percent are spontaneous infection in sexually active females of reproductive age. The remaining 15 percent follow procedures which favours the organisms to ascend up such as iatrogenic procedures include endometrial biopsy, uterine curettage, insertion of IUD and hysterosalpingography.

Clinical manifestation

Book picture	Patient picture
➢ Bilateral lower abdominal and pelvic pain which is dull in nature ➢ Fever, lassitude and headache ➢ Irregular and excessive vaginal bleeding ➢ Abnormal vaginal discharge which becomes purulent and copious ➢ Nausea and vomiting ➢ Dyspareunia ➢ Pain and discomfort in right hypochondrium due to concomitant perihepatitis	➢ Lower abdominal and back pain ➢ Had pain in hypochondrium region ➢ Slight low grade fever ➢ White vaginal discharge ➢ Tenderness on abdominal palpation

Complications that may result from delayed treatment. Treatment depends on the infectious agent and generally involves the use of antibiotic therapy. If there is no improvement within two to three days, the patient is typically advised to seek further medical attention. Hospitalization sometimes becomes necessary if there are other complications. Treating sexual partners for possible STIs can help in treatment and prevention.

For women with PID of mild to moderate severity, parenteral and oral therapies appear to be effective. It does not matter to their short- or long-term outcome whether antibiotics are administered to them as inpatients or outpatients. An alternative parenteral regimen is ampicillin/sulbactam plus doxycycline. Another alternative is to use a parenteral regimen with ceftriaxone or cefoxitin plus doxycycline. Clinical

experience guides decisions regarding transition from parenteral to oral therapy, which usually can be initiated within 24–48 hours of clinical improvement [1-4].

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