Royal Cornwall Hospitals
NHS Trust

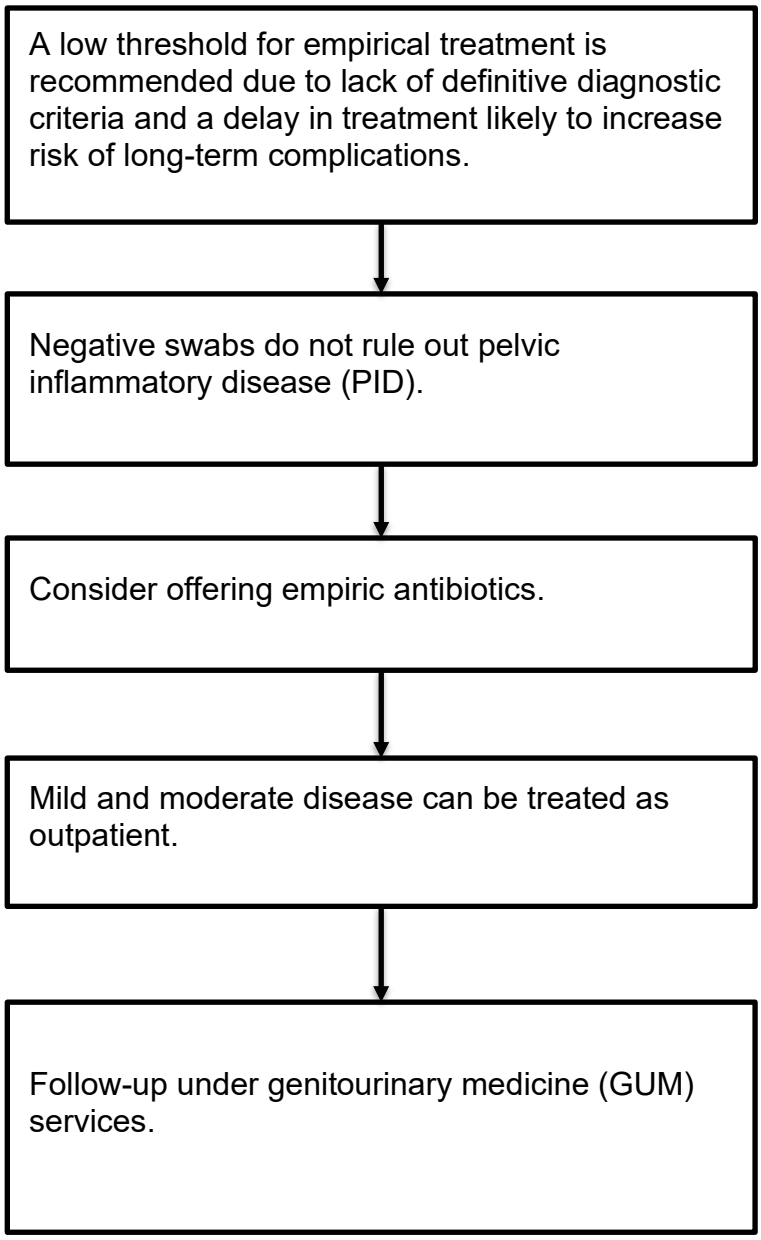
Pelvic Inflammatory Disease Clinical Guideline

V3.0

February 2026

Summary

This guideline will provide evidence-based guidance on the management of pelvic inflammatory disease.



1. Aim/Purpose of this Guideline

1.1. This guideline will provide evidence-based guidance on the management of Pelvic inflammatory disease.

1.2. Pelvic inflammatory disease (PID) is usually the result of an ascending infection from the endocervix resulting in the formation of endometritis, salpingitis, parametritis, oophoritis, tubo-ovarian abscess +/- pelvic peritonitis.

1.3. Chlamydia trachomatis and Neisseria gonorrhoea are only implicated in 25% of PID cases.1 10-45% of endocervical Neisseria gonorrhoea and 10-30% of endocervical Chlamydia trachomatis will develop into PID.

1.4. Organisms commonly found in the vagina such as Gardnerella vaginalis, anaerobes and haemophilus influenza have been implicated. Mycoplasma genitalium has also been associated with PID.

1.5. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Risk factors:

- < 25 years old.
- Early first coitus.
- Multiple sexual partners.
- Recent change in sexual partner (<3 months).
- Personal or partner history of sexual transmitted disease.

- Recent termination of pregnancy.
- Recent insertion of IUCD (<6 weeks).
- HSG (hysterosalpingogram)/ IVF (in vitro fertilisation) /ISCI (intracytoplasmic sperm injection).

2.2. Complications:

- Tubal infertility.
- Risk of ectopic pregnancy.
- Chronic pelvic pain.
- Perihepatitis and pelvic adhesions.

2.3. Symptoms:

- Lower abdominal pain (often bilateral).
- Deep dyspareunia (recent onset).
- Abnormal uterine bleeding (Inter-menstrual/ post-coital).
- Abnormal vaginal discharge (can be slight and transient).
- Right upper quadrant pain (secondary to Fitz-Hugh Curtis syndrome- 10-20%).

2.4. Signs:

- Bilateral lower abdominal pain.
- Cervical motion tenderness.
- Adnexal tenderness.
- Temperature >38°C.

PID may be asymptomatic and clinical symptoms and signs have a poor PPV (65-90%).

2.5. Differential Diagnosis:

- Ectopic pregnancy.
- UTI (urinary tract infection).
- Complications of an ovarian cyst (torsion or rupture).
- Acute appendicitis.
- Endometriosis.

- Functional pain.
- Bowel disorders including inflammatory bowel disease and irritable bowel syndrome.

2.6. Investigations:

- Urinary pregnancy test.
- 'Triple swabs'.
  - Vulvovaginal swab for Chlamydia trachomatis and Neisseria gonorrhoea NAAT (Nucleic Acid Amplification Test). (CTNG (Chlamydia Trachomatis and Neisseria Gonorrhoea) Panther swab).
  - Cervical charcoal swab for Neisseria gonorrhoea culture.
  - High vaginal charcoal swab if vaginitis (and consider HVS (high vaginal swab) for TV culture if vaginitis associated with purulent discharge).
  - Ensure you request the appropriate swabs on Maxims:
    - High vaginal swab.
    - Endo cervical swab.
    - Chlamydia- cervical.
- Bloods.
  - Consider HIV (Human Immunodeficiency Virus) and syphilis serology.
  - Consider FBC (full blood count) and CRP (C-reactive protein) (if raised this supports diagnosis but is nonspecific).

2.7. Management.

2.7.1. A low threshold for empirical treatment is recommended due to lack of definitive diagnostic criteria and a delay in treatment likely to increase risk of long-term complications (as above). Negative swab's do not rule out PID.

2.7.2. Consider offering empiric antibiotics if:

- <25 years old and sexually active and/or recent change in sexual partner.
- **Plus** new onset of bilateral lower abdominal pain with local tenderness on bimanual examination (cervical motion tenderness +/- adnexal tenderness).
- Negative urinary pregnancy test.

2.7.3. Mild and moderate disease can be treated as outpatient.

2.7.4. Inpatient criteria:

- Surgical emergency cannot be excluded.
- Severe disease clinically e.g. clinical signs of tubo-ovarian abscess, pelvic peritonitis, vomiting, or pyrexia (>38°C).
- No clinical response to oral treatment or not tolerated.

2.7.5. N.B., if intra-uterine device (IUD/S) in situ, the Faculty of Sexual and Reproductive Healthcare (FSRH) recommend starting antibiotics and review at 72 hours, with removal of device if no improvement. There is little RCT evidence on treatment of PID with intra-uterine device in situ, but evidence does suggest better short-term clinical outcomes if removed. If sexual intercourse without a barrier method has occurred within the previous seven days, there may be a risk of pregnancy if IUD/S is removed- hormonal emergency contraception and follow-up pregnancy testing may be appropriate.

2.8. Antibiotic Treatment.

2.8.1. Outpatient regimens:

Please see Eolas for prescribing guidance.

2.8.2. Inpatient regimens:

Please see Eolas for prescribing guidance.

2.8.3. If alternative regimes are required due to allergies, please see BASHH guideline or discuss with microbiology and GUM senior doctor.

2.8.4. N.B., IV (intravenous) antibiotics should be continued for 24 hours after clinical improvement then oral switch. IV doxycycline is not licensed in UK but is available from IDIS world medicines.

2.9. Advice for Patients.

2.9.1. Explain condition, treatment (possible side effects) and complications.

2.9.2. Make referral to the sexual health team as per flow chart Appendix 3.

2.9.3. Advise to avoid sexual intercourse until patient and partner have been treated.

2.10. Follow-up under sexual health services (see flow diagram for referral pathway).

2.10.1. Telephone call /e-mail to patient in first 72 hours to initiate partner notification, check is any problems with treatment and education.

2.10.2. Follow up as necessary depending on results/ adherence to treatment and clinical response. Usually will be at 1-2 weeks, either in clinic or by telephone.

2.10.3. Cases of chlamydia, gonorrhoea and other significant STIs (Sexually

Transmitted Infections) detected in the community can be referred by the GP to the GU services run by Brook once the GP has notified the patient of the result.

2.10.4. For those patients who have a positive test result after discharge from the hospital, the results will go to the responsible consultant who will need to notify the patient of the result and refer on to Brook for treatment and partner notification.

2.10.5. Any positive STI results for out-patients will be sent to the responsible consultant to be managed in the same way. Brook is happy to manage all patients diagnosed with an STI AFTER the patient has been informed of the test result from both a treatment and partner notification perspective.

2.10.6. Brook has asked for referrals to be emailed using the attached form (Appendix 4) to cornwallreferrals@brook.org.uk.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Audit the compliance to guideline.
Lead	Sarah Eddy, Advanced Nurse Practitioner, Emergency Gynaecology Unit / Early Pregnancy Unit.
Tool	Ad hoc monitoring of guidance as part of routine audit activity.
Frequency	Annual review at the Audit and Governance meeting.
Reporting arrangements	Audit and Governance meeting.
Acting on recommendations and Lead(s)	Audit and Governance meeting.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within three months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Pelvic Inflammatory Disease Clinical Guideline V3.0
This document replaces (exact title of previous version):	Pelvic Inflammatory Disease Clinical Guideline V2.0
Date Issued/Approved:	February 2026
Date Valid From:	February 2026
Date Valid To:	February 2029
Directorate / Department responsible (author/owner):	Sarah Eddy, Advanced Nurse Practitioner, Emergency Gynaecology Unit/Early Pregnancy Unit.
Contact details:	01872 252686 or rch-tr.egu@nhs.net.
Brief summary of contents:	For all clinical staff working in the division of women, children and HIV to provide evidence based guidance on the management of pelvic inflammatory disease.
Suggested Keywords:	Pelvic, inflammatory, PID, gynaecology, genitourinary medicine.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gynaecology Business and Governance Meeting
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required
Related Documents:	None required
Training Need Identified?	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Gynaecology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
October 2018	V1.0	Initial Issue	Jess Leese; Obs and Gynae Registrar
September 2022	V2.0	Responsibility for genitourinary medicine services and chlamydia screening has been transferred from RCHT to Brook since 1 December 2019. This has therefore changed the referral pathway.	Sarah Eddy, Advanced Nurse Practitioner.
February 2026	V3.0	Section 2.6 updated re. ensuring appropriate swabs are ordered. Inpatient and outpatient antibiotic regimes amended to direct to Eolas prescribing guidance. Referral to HIV for inpatients with STI's removed from follow up criteria.	Sarah Eddy, Advanced Nurse Practitioner.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net.

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Pelvic Inflammatory Disease Clinical Guideline V3.0
Directorate and service area:	Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Sarah Eddy, Advanced Nurse Practitioner
Contact details:	01872 252686 or rch-tr.egu@nhs.net.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Standardised best practice for all clinical staff working in the Care Group of Women, Children and HIV for the management of pelvic inflammatory disease.
2. Policy Objectives	As above.
3. Policy Intended Outcomes	As above.
4. How will you measure each outcome?	See section 3.
5. Who is intended to benefit from the policy?	All obstetrics and gynaecology patients.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Gynaecology Business and Governance meeting.
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those with any identified additional needs will be referred for additional support as appropriate - i.e., to the Liaison Team or for specialised equipment. Written information will be provided in a format to meet the patient and their family's needs e.g. easy read, audio etc.
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	

Protected Characteristic	(Yes or No)	Rationale
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

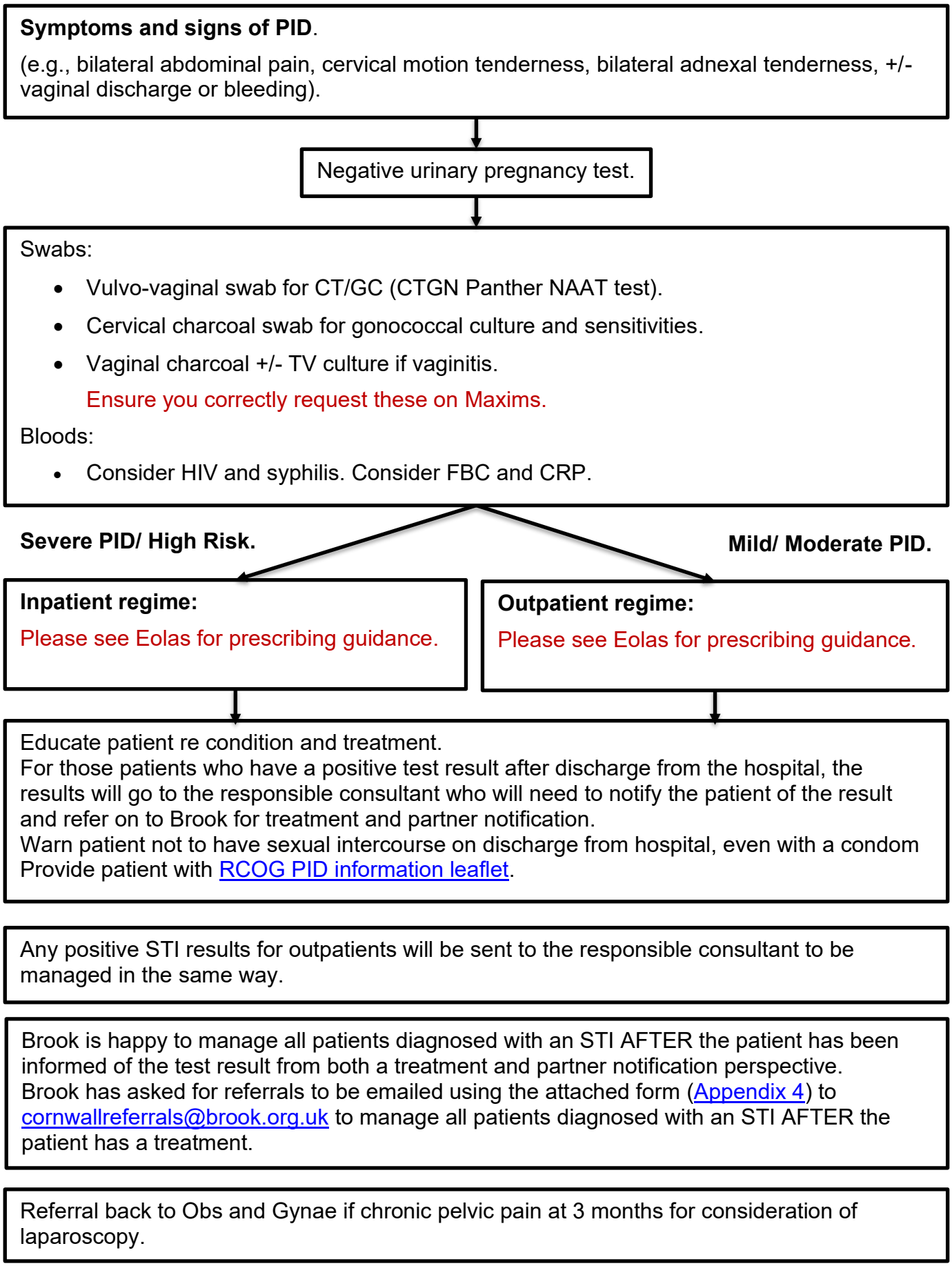
A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Sarah Eddy, Advanced Nurse Practitioner.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis.

Appendix 3. PID Flowchart.



Appendix 4. Brook Referral

Referrer agency address:

Date:

Cornwall Sexual Health and Contraception Service

Dear Referral Team,

Re:

(Client Name) (DOB) (Client Contact Details)

Reason for Referral:

Medical History:

Yours Sincerely,

Brook.org.uk

81 London Road, Liverpool, L3 8JA

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