PIPADOR REVISION

MRCOG Part 1 Revision Notes

Treatment of PID and STIs

CLINICAL MANAGEMENT • LECTURE 494

VISUAL EXAMINATION REVISION NOTES

2026 Edition

494

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Treatment of PID and STIs

Diagnosis and management of PID and common STIs, including pregnancy, partner notification and test of cure (BASHH)

14 days	Ceftriaxone 1 g IM	Doxycycline	Partner notification
PID antibiotics	Gonorrhoea	Chlamydia (non-pregnant)	Always

■ KEY FACTS: Learning objectives

- Define pelvic inflammatory disease (PID) and the common sexually transmitted infections.
- Describe diagnosis and outpatient/inpatient management of PID (BASHH).
- Describe treatment of chlamydia, gonorrhoea, syphilis, herpes, trichomonas, M. genitalium and warts, including pregnancy, partner notification and test of cure.

494.1 Key definitions

Term	Definition
Pelvic inflammatory disease (PID)	Infection of the upper genital tract (endometrium, tubes, ovaries, pelvic peritoneum) — usually ascending from the cervix
Tubo-ovarian abscess (TOA)	Collection involving the tube and ovary — complication of PID
Fitz-Hugh–Curtis syndrome	Perihepatitis (RUQ pain) with PID (chlamydia/gonorrhoea)
Test of cure (TOC)	Repeat test after treatment to confirm eradication (e.g. gonorrhoea, chlamydia in pregnancy, M. genitalium)
Partner notification	Informing and testing/treating sexual partners to prevent reinfection and onward spread
NAAT	Nucleic acid amplification test — first-line for chlamydia/gonorrhoea (vulvovaginal swab)

■ IN PLAIN ENGLISH: PID and STIs

PID is diagnosed **clinically** — treat on suspicion, because delaying treatment risks **infertility, ectopic pregnancy and chronic pelvic pain**. Every STI diagnosis needs partner notification and screening for other infections.

494.2 PID — diagnosis

- Symptoms: lower abdominal pain, deep dyspareunia, abnormal vaginal discharge, intermenstrual/postcoital bleeding, fever (severe).
- Signs: lower abdominal tenderness, **adnexal tenderness and cervical motion tenderness** on bimanual examination, mucopurulent cervicitis.
- Investigations: pregnancy test (exclude ectopic)
  - NAAT for chlamydia and gonorrhoea

  - M. genitalium NAAT
  - Gonorrhoea culture
  - HIV/syphilis serology, FBC/CRP
  - USS if TOA suspected.
- A negative swab does not exclude PID
  - Low threshold for empirical treatment.
  - Differential: ectopic, appendicitis, endometriosis, ovarian torsion/cyst, UTI.

494.3 PID — treatment

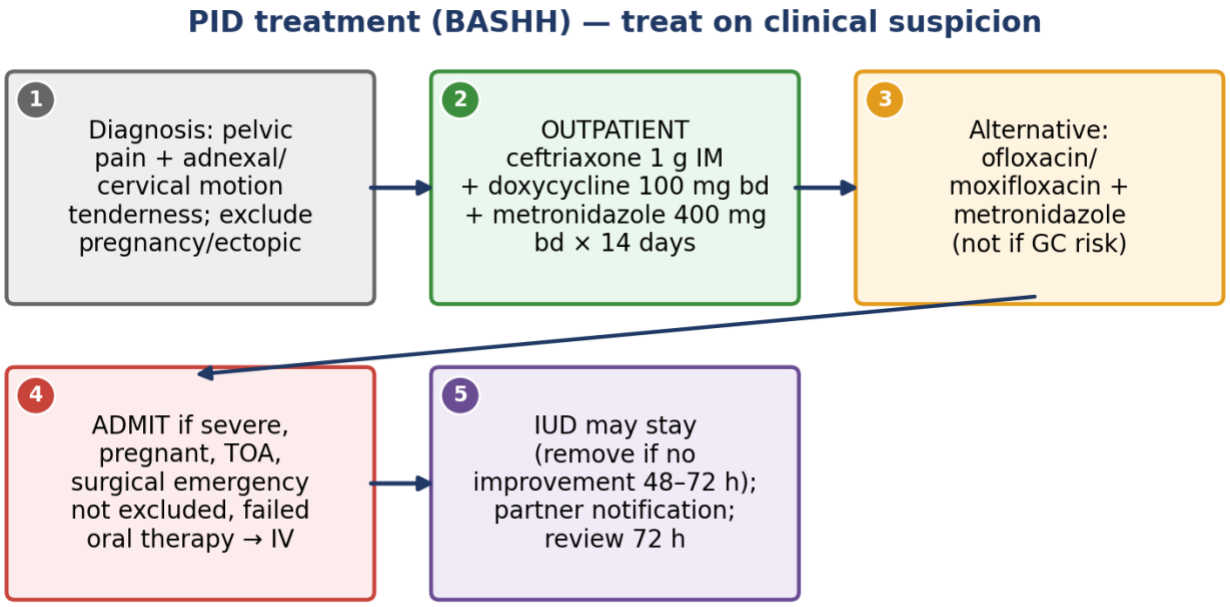


Figure 494.1 — PID treatment (BASHH)

Setting	Regimen (BASHH — check current version)
Outpatient (first line)	Ceftriaxone 1 g IM single dose, PLUS doxycycline 100 mg twice daily AND metronidazole 400 mg twice daily for 14 days
Outpatient alternative	Ofloxacin 400 mg bd + metronidazole 400 mg bd for 14 days (or moxifloxacin 400 mg od 14 days — check LFT/QT) — avoid if gonorrhoea likely
M. genitalium positive	Moxifloxacin 400 mg once daily for 14 days
Inpatient	• IV ceftriaxone 2 g daily + IV/oral doxycycline + metronidazole, then oral to complete 14 days • Admit if surgical emergency not excluded, pregnancy, severe illness, TOA, failed oral therapy
IUD in situ	• Can be left in if mild–moderate • Consider removal if no improvement in 72 h
Pregnancy	• PID rare — consider ectopic • Ceftriaxone + erythromycin + metronidazole (avoid doxycycline, quinolones)
Review	• At 72 h (improvement expected) and 2–4 weeks • Partner notification and treatment • TOC if gonorrhoea/MG
Complications	Infertility (≈ 1 in 10 after an episode), ectopic, chronic pelvic pain, TOA (drainage/laparoscopy)

494.4 Treatment of STIs

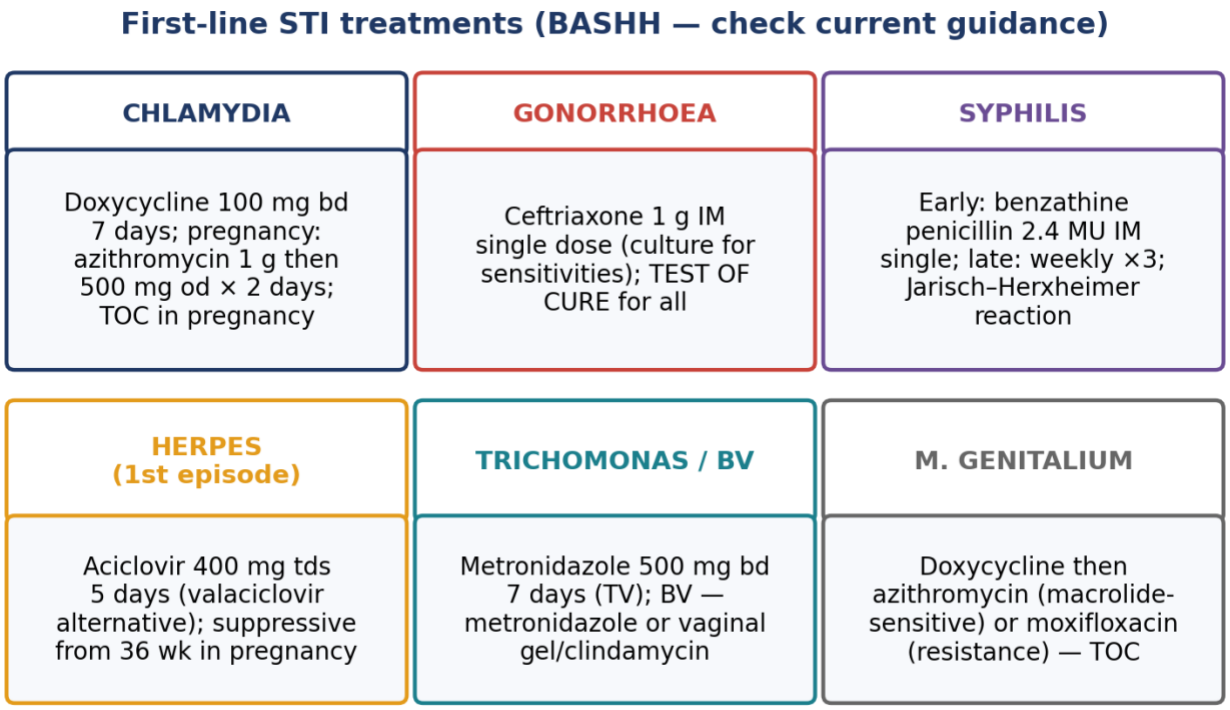


Figure 494.2 — First-line STI treatments

Infection	Key management points
Chlamydia	• Doxycycline 100 mg bd 7 days • Pregnancy/breastfeeding: azithromycin 1 g then 500 mg daily 2 days (or erythromycin/amoxicillin) • TOC in pregnancy (≥ 3 weeks after), retest under-25s at 3–6 months
Gonorrhoea	• Ceftriaxone 1 g IM (culture before treatment for sensitivities) • Ciprofloxacin only if known sensitive • TOC for all (≥ 2 weeks NAAT) • Rising resistance
Syphilis	• Benzathine penicillin G 2.4 MU IM: single dose (early), 3 weekly doses (late latent) • Pregnancy — treat promptly, fetal USS, neonatal follow-up • Serological follow-up
Genital herpes	• First episode: aciclovir 400 mg tds 5 days • Recurrent: episodic or suppressive • Pregnancy: primary in 3rd trimester → CS • Suppression from 36 weeks (RCOG/BASHH)
Trichomonas	• Metronidazole 500 mg bd for 7 days (single dose less effective) • Treat partners
M. genitalium	• Doxycycline 7 days then azithromycin (if macrolide-sensitive) or moxifloxacin (resistance) • TOC ≥ 3 weeks
Anogenital warts	• Podophyllotoxin, imiquimod, cryotherapy, excision • Avoid podophyllotoxin in pregnancy • HPV vaccination prevents

Infection	Key management points
Bacterial vaginosis / candida	• Not STIs — metronidazole for BV • Topical clotrimazole for candida (7 days in pregnancy)

- For every STI: **screen for others** (chlamydia, gonorrhoea, syphilis, HIV ± hepatitis B/C)
  - **Abstain from sex** until treatment complete (7 days after single-dose or completion)
  - **Partner notification**
  - Safeguarding (young people, coercion, exploitation)
  - And consider HIV PrEP/PEP and hepatitis B vaccination where indicated.

■ COMMON PITFALLS

Waiting for swab results before treating suspected PID.

Forgetting to exclude ectopic pregnancy.

Missing test of cure for gonorrhoea or chlamydia in pregnancy.

Using doxycycline in pregnancy.

494.5 Must-know summary

■ EXAM TIP

- PID: clinical diagnosis (adnexal/cervical motion tenderness); exclude ectopic; NAATs; treat empirically.
- Outpatient PID: ceftriaxone 1 g IM + doxycycline + metronidazole 14 days; MG → moxifloxacin; review at 72 h.
- Chlamydia: doxycycline 7 days (azithromycin in pregnancy + TOC); gonorrhoea: ceftriaxone 1 g IM + TOC; syphilis: benzathine penicillin; herpes: aciclovir; TV: metronidazole 7 days.
- Screen for other STIs, partner notification, safeguarding.

■ MNEMONIC / MEMORY AID

PID outpatient — 'Ceftriaxone, Doxy, Metro — 14 days' ('CDM-14').