REPRODUCTIVE / WOMEN'S HEALTH

Pelvic Inflammatory Disease (PID)

An ascending infection of the upper female reproductive tract — a high-yield NCLEX topic linking STI prevention, sepsis recognition, and long-term fertility outcomes.

NGN NCLEX 2026 | Clinical Judgment | STI / Infection | Priority Care

1 Definition & Overview

- **PID** = infection & inflammation of the upper female reproductive tract (uterus, fallopian tubes, ovaries, surrounding pelvic structures).
- Almost always caused by **ascending bacterial infection** — most often from untreated STIs.
- Leading cause of **infertility, ectopic pregnancy, and chronic pelvic pain** in women of reproductive age.

Top culprits: *Chlamydia trachomatis* & *Neisseria gonorrhoeae* — often polymicrobial (anaerobes, mycoplasma).

2 Pathophysiology

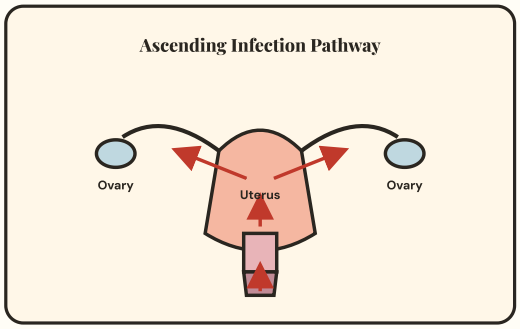
Bacteria enter cervix → Ascend through endometrium →

Salpingitis (tubes)

Oophoritis (ovaries) → Tubo-ovarian abscess →

Peritonitis / sepsis

Long-term result: Scarring & adhesions of fallopian tubes → infertility & ↑↑ ectopic pregnancy risk.



3 Signs & Symptoms

✗ Early / Mild

- Bilateral lower abdominal/pelvic pain
- Abnormal vaginal discharge (purulent, foul-smelling)
- Dyspareunia (painful intercourse)
- Dysuria, urinary frequency
- Intermenstrual or postcoital bleeding
- Low-grade fever, malaise

✓ Late / Severe 🚨

- **High fever > 101°F (38.3°C)**, chills
- Severe pelvic pain, rebound tenderness
- **Cervical motion tenderness** ("chandelier sign")
- Adnexal tenderness/mass (tubo-ovarian abscess)
- N/V, abdominal rigidity → peritonitis
- RUQ pain → **Fitz-Hugh-Curtis** (perihepatitis)
- Sepsis: hypotension, tachycardia, AMS

🚨 **Chandelier Sign = pain on cervical motion exam so severe the patient "jumps to the ceiling." Classic PID finding.**

4 Diagnostics & Risk Factors

Test	Purpose
Pelvic exam	Cervical motion + adnexal tenderness
NAAT (cervical swab)	Detect chlamydia & gonorrhea
CBC w/ diff	↑ WBC (leukocytosis)
ESR & CRP	↑ inflammatory markers
β-hCG (pregnancy test)	**Rule out ectopic before tx**
Transvaginal U/S	Identify abscess, fluid
Laparoscopy	Gold standard (confirmatory)

Risk Factors: Age < 25 · multiple partners · prior STI · douching · unprotected sex · recent IUD insertion (within 3 weeks) · adolescent cervix (more susceptible).

5 Priority Nursing Interventions (ABCs + Safety)

- **Assess** VS, pain, abdominal exam, bowel sounds — monitor for **sepsis** (↓ BP, ↑ HR, ↑ RR, AMS).
- **Position: Semi-Fowler's** — promotes pelvic drainage & prevents ascending spread to upper abdomen.
- **Administer** broad-spectrum IV antibiotics promptly (after cultures drawn, do NOT delay).
- **Pain management:** NSAIDs scheduled + heat (per order).
- **IV fluids** for hydration; strict **I&O**; monitor for ileus.
- **Bed rest** during acute phase; cluster care to allow rest.
- **Sexual abstinence** until completion of treatment AND partner treated.
- **Treat sexual partner(s)** within the past 60 days — even if asymptomatic.
- **Standard precautions**; perineal care; pads NOT tampons.
- **Emotional support** — fertility/STI diagnosis can cause distress, shame.
- **Report** gonorrhea & chlamydia to public health (reportable STIs).

Priority Action: If signs of sepsis or tubo-ovarian abscess rupture (sudden severe pain, rigid abdomen, hypotension) → notify provider STAT, prepare for surgical intervention.

6 Pharmacology

Drug / Class	Mechanism	Side Effects	Nursing Considerations
Ceftriaxone (3rd-gen cephalosporin) IM	Inhibits cell wall synthesis — covers gonorrhea	Injection site pain, diarrhea, hypersensitivity	Assess PCN allergy (cross-reactivity); deep IM Z-track
Doxycycline (Tetracycline) PO ×14 d	Inhibits protein synthesis — covers chlamydia	Photosensitivity, GI upset, tooth staining	Take with full glass of water, upright × 30 min; **avoid dairy/antacids/iron**; sunscreen; **contraindicated in pregnancy**
Metronidazole (Flagyl) PO ×14 d	Anaerobic coverage	Metallic taste, N/V, dark urine	**NO alcohol** during & 72 hr after (disulfiram-like reaction)
Cefoxitin / Cefotetan IV (Inpatient)	Broad anaerobic + Gram-neg coverage	Diarrhea, rash, ↑ INR (cefotetan)	Reserved for severe / inpatient PID; monitor renal function
Clindamycin + Gentamicin	Alternate regimen for severe / abscess	C. diff (clinda); nephro/ototoxicity (gent)	Monitor peak/trough levels; daily renal panel; hearing checks
NSAIDs (ibuprofen)	↓ Prostaglandins — pain & inflammation	GI bleeding, renal impairment	Take with food; assess for melena, edema

Key Pearl: Empiric therapy starts *before* culture results — broad coverage of *N. gonorrhoeae*, *C. trachomatis*, AND anaerobes is required. Single-drug therapy is inadequate.

7 NCLEX Test Traps ⚠

✗ Common Wrong Answer

- Place client **supine** to relieve pelvic pain
- Treat **only the patient** — partner declines, leave alone
- Use **tampons** to control discharge
- Wait for culture results before starting antibiotics
- Tell patient she can stop antibiotics when she feels better
- Reassure that IUDs always cause PID — must be removed
- Confuse PID pain with a simple UTI
- Skip pregnancy test — "she's on birth control"

✓ Correct Priority Action

- Place client in **Semi-Fowler's** — promotes drainage, prevents upward spread
- Notify partners within **60 days**; partner treatment is essential to prevent reinfection
- Use **pads only**; avoid tampons, douching, intercourse
- Start **empiric broad-spectrum antibiotics** immediately after cultures drawn
- Complete **full 14-day course** even if symptoms resolve
- IUD risk is only in the **first 3 weeks** post-insertion; do not auto-remove
- PID = **bilateral pelvic pain + cervical motion tenderness + discharge**; UTI = suprapubic + dysuria
- **Always** rule out pregnancy (ectopic) before treatment

8 Patient & Family Education

- **Finish all antibiotics** — even if symptoms disappear in 2–3 days.
- **Pelvic rest**: no intercourse, tampons, or douching during treatment.
- **Partner(s) must be treated** simultaneously to prevent reinfection.
- Always use **condoms** & limit number of sexual partners.
- **Avoid douching** — disrupts vaginal flora & pushes bacteria upward.
- Follow up in **48–72 hours** to confirm clinical improvement.
- Annual STI screening if at risk; routine chlamydia screen if < 25 & sexually active.
- **Return to ED immediately** if: fever rises, pain worsens, vomiting, fainting, severe abdominal rigidity.
- Discuss **long-term risks:** infertility, ectopic pregnancy, chronic pelvic pain.

9 Memory Boosters

"P.I.D." — The 3 Hallmarks

Pain (bilateral pelvic, cervical motion)
Infection (fever, ↑ WBC, ↑ ESR/CRP)
Discharge (purulent, foul-smelling)

"CHANDELIER Sign" 🎯

Cervical motion = pain so severe she *jumps to the chandelier*. Pathognomonic PID finding on bimanual exam.

"FITZ-HUGH-CURTIS" — RUQ Pain

PID + Fat Hepatic Capsule pain → perihepatitis. "Fitz-Hugh *HURTS* the liver."

"STOP PID" — Patient Teaching

Screen partners · Take all meds · Only condoms (barrier) · Pelvic rest · Pads not tampons · Immediate F/U · Don't douche

10 NCJMM Clinical Judgment — Six-Step Scenario

Scenario: 22-year-old female arrives in ED reporting 4 days of worsening bilateral pelvic pain, fever 101.6°F, foul-smelling yellow-green vaginal discharge, and pain with intercourse. New sexual partner 6 weeks ago; inconsistent condom use. VS: BP 102/64, HR 112, RR 22, T 38.7°C, SpO_2 97%. On exam: **cervical motion tenderness**, bilateral adnexal tenderness, no rebound. β-hCG negative.

1 Recognize Cues

Bilateral pelvic pain · fever 101.6°F · purulent discharge · dyspareunia · cervical motion tenderness · tachycardia · borderline hypotension · new partner · inconsistent condom use.

2 Analyze Cues

Classic triad of pelvic pain + fever + discharge with cervical motion tenderness = ascending STI. Tachycardia & borderline BP suggest **early sepsis**. Negative β-hCG rules out ectopic.

3 Prioritize Hypotheses

#1 PID with early sepsis > tubo-ovarian abscess > ectopic (excluded) > UTI > appendicitis. Greatest risk: hemodynamic collapse, tubal scarring/infertility.

4 Generate Solutions

Obtain cultures (NAAT, blood, urine) · CBC/CMP/ESR/CRP · pelvic U/S · start IV fluids · empiric IV antibiotics (cefoxitin + doxycycline) · pain control · partner notification · admit if septic.

5 Take Action

Place in **Semi-Fowler's** · 2 large-bore IVs, NS bolus · draw cultures BEFORE antibiotics · administer cefoxitin IV + doxycycline · scheduled NSAIDs · strict I&O · monitor VS q15 min until stable.

6 Evaluate Outcomes

Expected: Afebrile in 48–72 hr · ↓ pain & tenderness · stable VS · completed 14-day regimen · partner treated · F/U scheduled · teach-back on prevention & reinfection risk.
