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More than 1 in 10 adults in the United States currently have AIDS (1082), and more women than men are affected. Factors accounting for the disproportionate incidence of AIDS among women include higher incidence in young women (1091,1092), a higher prevalence in women (1094,1095), and a shorter duration of female to male heterosexual partnerships (10911092). Further studies have found that C. trachomatis infection can be asymptomatic and not associated with specific risk factors (1091). N. gonorrhoeae, on the other hand, is closely associated with certain types of HIV-related diseases (1081). Other studies have suggested that N. gonorrhoeae might be more prominent among women with idiopathic or HIV-related CNS disease than among women with meningitis (1083). Women have higher risks for N. gonorrhoeae infection compared with men because of the higher prevalence of infection among women (1094,1095), and women have higher risks for PID (1155,1157). Because diagnosis of PID is sometimes delayed, all sexually active women who are at risk for PID should be evaluated for STIs, including Chlamydia trachomatis, Neisseria gonorrhoeae, Trichomonas vaginalis, and Mycoplasma genitalium. Women with abnormal vaginal discharge, pain with intercourse, abnormal vaginal bleeding, or prolonged menstrual cycle (>4 weeks) or with moderate to severe pelvic pain should be evaluated for uterine abnormalities, ectopic pregnancy, ovarian torsion, or ovarian cysts. In addition, women with severe dyspareunia should be evaluated with a full infertility evaluation and test for endometritis. Initial treatment should consist of empiric treatment with ceftriaxone 500 mg intramuscularly single dose (1159). Because C. trachomatis is the most common STI associated with PID, all women who are sexually active and who are treated empirically for PID should be screened for C. trachomatis and, if positive, treated with erythromycin or azithromycin (1160). Surgical treatment of ectopic pregnancy can result in significant morbidity, including infertility. Because PID also may predispose women to ectopic pregnancy, elective tubal sterilization should be offered to all women who are at risk for PID (1161). Patients with advanced cervical ectopy should undergo in vitro fertilization with intrauterine insemination for conception (1162).

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Initial therapy for PID, which is often prescribed empirically and generally includes a combination of intramuscular or intravenous antibiotics, is directed toward eradication of the presumed pathogen and prevention of recurrent PID. The choice of antimicrobial therapy is based primarily on the causative pathogens and secondarily on patient characteristics, such as age and immune status, adherence to therapy, and preexisting medical conditions (1162,1165,1167,1169). The diagnosis of PID requires demonstration of acute intrauterine infection of the upper genital tract and/or lower genital tract (i.e., salpingitis, tubo-ovarian abscess, or peritonitis); infection of the lower genital tract is often present and reflects the primary pathogenesis in most cases (1162,1165,1169). In a study evaluating the use of intravenous versus oral therapy for PID, women receiving oral therapy had more relapses of PID (76% vs. 20%; 1166). The use of oral antimicrobial therapy is recommended for more severe cases of PID (1167), for women who lack adherence to intramuscular therapy (1166), and for young women (1168). Some experts recommend that amoxicillin (500 mg three times daily for 5 days) be the first choice for initial treatment of PID (1166). However, third-generation cephalosporins with activity against N. gonorrhoeae and C. trachomatis (e.g., cefixime 400 mg twice daily for 3 days or cefpodoxime 100 mg twice daily for 3 days) are recommended to treat women with PID caused by these organisms (1166,1167). Because of the high frequency of resistance among N. gonorrhoeae isolates in the United States, regimens containing expanded-spectrum cephalosporins (ceftriaxone, cefixime, or cefpodoxime) are recommended for initial treatment of PID (1168). A parenteral route of administration is recommended for the treatment of salpingitis, tubo-ovarian abscess, and peritonitis. An oral route of administration is acceptable for treatment of endometritis. Although oral therapy reduces the cost of treatment, an adequate amount of antimicrobial agent must be administered to achieve an adequate concentration at the site of infection. 5ec8ef588b

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