Conservative Management OF PELVIC ABSCESS THROUGH MINIMAL INVASIVE ROUTE

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INTRODUCTION

- Pelvic inflammatory disease is one of the most serious infections women face today.
- Also, it is one of the most common gynecologic reasons for hospitalization and emergency department visits.
- Untreated or unsuccessfully treated women may suffer life-threatening consequences, and even adequately treated women are at much higher risk for potentially serious sequelae.

CASE HISTORY

- A 45-year-old multiparous female P4L3D1, hysterectomy done 4 years back presented to OPD with complaints of –Pain abdomen and Increased frequency of micturition since 7 days, and Fever since 4 days
- The pain was gradual in onset, constant, dull aching pain,confined to the lower abdomen, increased in intensity since 4 days, no aggravating or relieving factors
- Increased frequency of micturition was associated with burning micturition
- Fever was high grade, intermittent in nature, and associated with chills.
- No history of any discharge per vagina, difficulty in passing motion

Previous cycles were regular with average flow .

MENSTRUAL HISTORY

Previous cycles were regular with average flow .

Previous cycles were regular, lasting for 5-6 days with average flow, changing 2-3 pads per day, and no history of dysmenorrhea during menses.

OBSTETRIC HISTORY

- The patient was married for 27 years, P4L3D1, tubectomised.
- G1- FTND / 26 years ago / female child
- G2- FTND / 24 years ago / male child
- G3- FTND / 23 years ago / female child / died at the age of 2 years
- G4 – FTND/22 years ago /male child

PAST HISTORY

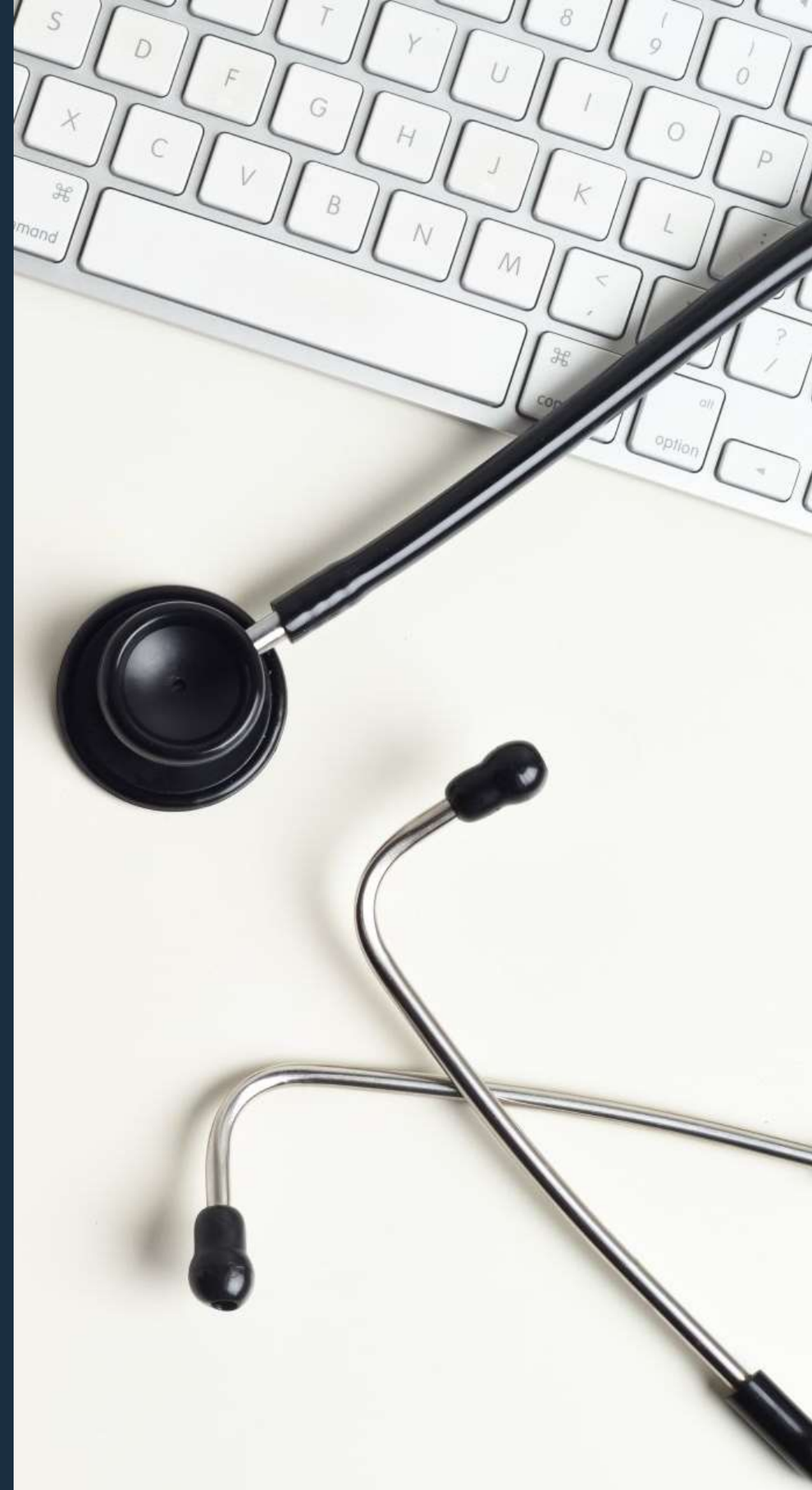
- History of total abdominal hysterectomy in 2019 ivo uterine leiomyoma
- No history of similar complaints in past
- No history of diabetes mellitus, hypertension, thyroid, tuberculosis, asthma, epilepsy, jaundice, blood transfusion, drug allergy, or ICU admission.

PERSONAL HISTORY

- Disturbed sleep since one week due to abdominal discomfort
- Bowel habits were normal
- No history of any addiction

GENERAL EXAMINATION

- The general condition was fair.
- The patient was moderately built, average nourished
- temperature – of 101F
- Pulse was 120 bpm, and blood pressure was 130/86 mm hg.
- Oral cavity, thyroid, breast, skin and nail examination was normal.
- No pallor, icterus, cyanosis, clubbing, lymphadenopathy, or oedema



SYSTEMIC EXAMINATION

- The cardiovascular and respiratory examination was normal.
- Per abdomen examination:
  the abdomen was soft, tenderness in the left iliac fossa

GYNAECOLOGICAL EXAMINATION

- Per speculum examination:
  vault healthy, no discharge present
- Per vaginal examination:
  boggy swelling felt in the left fornix extending to the midline.

  Right fornix free and non-tender.

  Tenderness present in left adnexa.

  cervical motion tenderness was also present

PROVISIONAL DIAGNOSIS: Acute PID with left adnexal mass

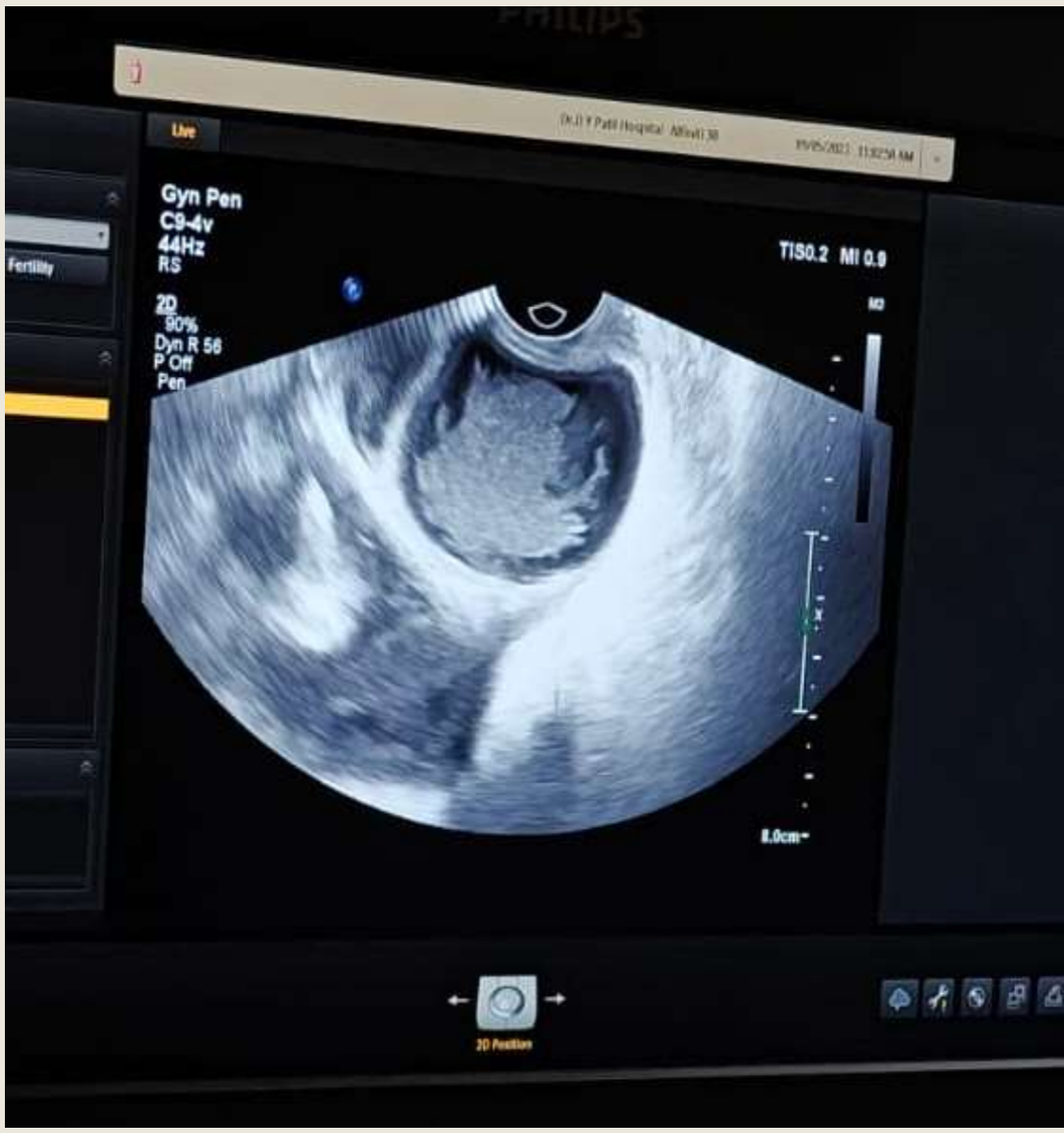
HEMATOLOGICAL EXAMINATION

- On routine investigations -
  - Hb- 10gm/dl, TLC – **21,000,** platelet count – 430,000/MCL
  - CRP - **171 mg/L**
  - Urine routine and microscopy – normal. (pus cells 1-2)
  - Urine and vault swab culture suggestive of no growth.
- µL

RADIOLOGICALEXAMINATION

- USG (TVS) - A lobulated heterogeneous multiloculated, complex tubular multi-cystic lesion, showing thick walls noted in the left adnexal region with maximum dimensions measuring **10*5*8cm** with volume around 229cc with extensive soft tissue oedema with inflammatory changes.
- Inter-bowel and peritoneal adhesions were also seen.
- The lesion extends medially in the midline, posterior to the urinary bladder.
- Inferiorly lesion abuts the vaginal vault
- The left ovary could not seen separately from the lesion

SUGGESTIVE OF – Tubo-ovarian abscess /? Left-sided pyosalpinx



MANAGEMENT

- The patient was started on Inj. Cefotaxime, Metronidazole & Gentamycin along with supportive management – no improvement was seen in symptoms in the next 48 hours
- Inj cefotaxime was withdrawn, and Piperacillin and Tazobactam 4.5gm were substituted,
- 2 days later temperature started settling down with general improvement
- USG Repeated after 48 hours of Inj Piperacillin and Tazobactam, no change in findings.
- Findings were a heterogenous multi-loculated complex lesion showing **thick walls in the left adnexal region having soft tissue oedema and turbid fluid within measuring 10*5*8cm with a volume of 229cc with inter-bowel and peritoneal adhesions.**

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- The decision of therapeutic drainage of Pus was made

(transvaginal aspiration under USG Guidance) Approximately 100cc of foul-smelling pus was aspirated and sent for the following investigations

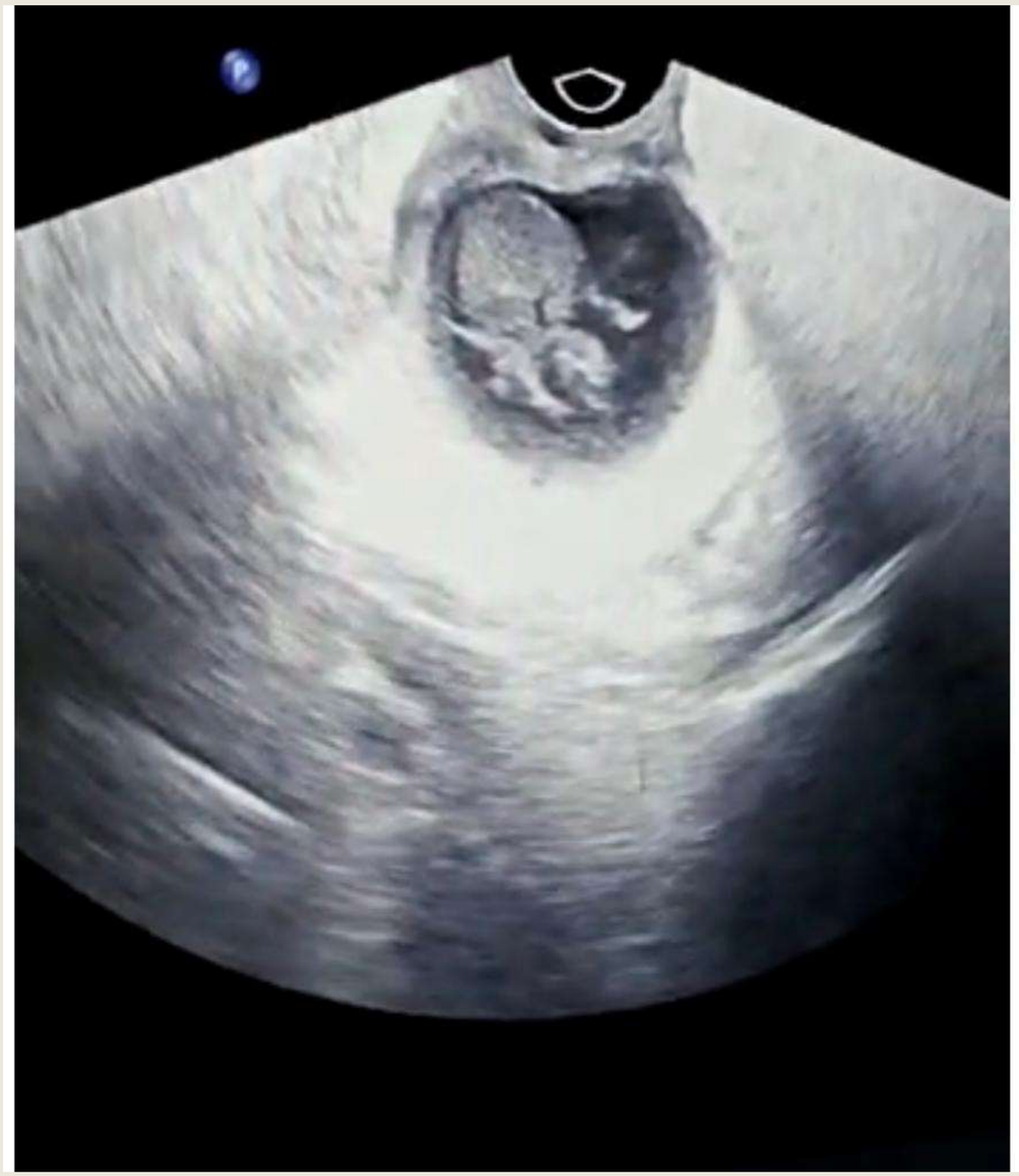
culture and sensitivity ---suggestive of no growth

CB NAAT test --- negative

Post aspiration IRRIGATION WITH 100CC INJ METRONIDAZOLE WAS DONE.

Patient's general condition improved, IV antibiotics were continued

- repeat USG after 10 days of IV antibiotics showed a reduction in the size of the abscess to 4*3*2.5cm
- The patient was discharged and followed on an OPD basis.



- Follow up USG was suggestive of – Anechoic tubular retort shaped structure of 3.4mm *9mm adjacent to left ovary – suggestive of hydrosalpinx .
- Repeat CBC –

Hb- 9.7gm/dl , TLC – 8000/microliter , PLATELET – 466000/microliter .

DISCUSSION

- PELVIC INFLAMMATORY DISEASES: A general term used to refer to infection and inflammation of the upper genital tract in women.

- ETIOLOGY :

Most cases of PID are the result of polymicrobial infections caused by organisms ascending from the vagina and cervix to infect the lining of the endometrium and fallopian tubes.

Causative organisms – N.gonorrhoea, C. trachomatis, endogenous aerobic and anaerobic bacteria , genital mycoplasma species etc

Criteria for diagnosis acute PID

- MINIMUM CRITERIA :
- Cervical motion tenderness or Uterine tenderness or Adnexal tenderness
- ADDITIONAL CRITERIA :
- Oral temperature > 101 F （ 38.3 C ）
- Abnormal cervical or mucopurulent discharge Presence of an abundant number of WBC on saline microscopy of vaginal secretion Elevated ESR and CRP
- Laboratory documentation of cervical infection with N.gonorrhoea or C.trachomatis
- MOST SPECIFIC CRITERIA :
- Endometrial biopsy with histopathologic evidence of endometritis
- TVS or MRI imaging showing – thickened, fluid-filled tubes with or without free pelvic fluid or Tubo-ovarian complex or tubal hyperemia
- Laparoscopic abnormalities consistent with PID

Differential Diagnosis

- Acute appendicitis
- Endometriosis
- Torsion or rupture of adnexal mass
- Ectopic pregnancy
- Cervicitis .

SEQUELE

- Infertility
- Ectopic pregnancy
- Chronic pelvic pain
- Tubo-ovarian abscess

MANAGEMENT

- CDC-recommended treatment regimen for **oral therapy**

Inj.Ceftriaxone 250mg IM single dose

+ Tab.Doxycyclin 100 mg BD for 14 days

With or without – Tab. metronidazole 500 mg BD for 14 days

OR

Inj. cefoxitin 2gm IM single dose and probenecid 1gm orally in a single dose

+ Tab doxycycline 100 mg BD for 14 days with/ without tab metronidazole

Criteria for hospitalization of patient with PID

- Surgical emergencies such as appendicitis can not be ruled out.
- Patient is pregnant.
- The patient does not respond clinically to oral therapy.
- The patient is unable to follow or tolerate an outpatient oral regimen.
- The patient has severe illness, nausea, vomiting, or high fever.
- The patient has a tubo-ovarian abscess.

Parenteral therapy for acute PID

- REGIMEN A

Cefotetan 2 gm IV every 12 hourly OR

Cefoxitin 2gm IV every 6 hourly PLUS

Doxycyclin 100 mg BD every 12 hourly.

- REGIMEN B

Clindamycin 900mg IV every 8 hourly PLUS

Gentamicin loading dose IV Or IM followed by maintenance dose 8 hourly.

SURGICAL MANAGEMENT

- Posterior colpotomy
- Percutaneous drainage
- Exploratory laparotomy

THANKYOU.