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Original Research

To study the clinical profile of patients with pelvic inflammatory disease

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ABSTRACT:
Aim: To study clinical profile of patients with pelvic inflammatory disease. **Methods:** The prospective cross-sectional study which was carried in the Department of Obstetrics and Gynecology. 120 patients in reproductive age group having PID were selected randomly. **Result:** Most common group presenting with PID were between 25to 30 years of age (30.83%) followed by 20 to 25 years of age (25.83%). It was less common in age less than 20years (1.67%) and more than 40 years of age (4.17%).Maximum women with PID were having parity of 2 to 5(64.17%). It was less common in nullipara (5%). PID was commonest in illiterate women (55%) and less common in women who were graduate (1.67%). Maximum number of women presenting with PID did not used contraceptive. (58.33%). 15.83% used barrier method but were irregular and 12.5% used IUCD. Most of the women presented with discharge per vaginum (75.83 %) followed by pain lower abdomen (83.33%) and backache (40%).75.83% women had discharge per vaginum on speculum examination. 90% had cervical motion tenderness and only 5% presented with adenexal mass. **Conclusion:** The worldwide increase in the incidence of PID during the last few decades has led to the secondary epidemics of tubal factor infertility and ectopic pregnancy. The sequelae of PID account for a large proportion of the morbidity associated with sexually transmitted. Infections and the direct and indirect costs associated with PID are enormous. Incidence of PID is increasing especially in developing countries due to lack of awareness and unsafe sexual practices. It is seen to be more in younger age group with morbidity like tubal factor infertility, ectopic pregnancy and chronic pelvic pain.
Key words: Pelvic Inflammatory Disease, Clinical profile

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INTRODUCTION

Pelvic Inflammatory Disease (PID) is defined as the inflammation of the upper genital tract including the uterus, fallopian tubes, the ovaries and the pelvic peritoneum. The incidence of acute PID has decreased in many countries, though its true prevalence is not well known because the majority of cases are subclinical.[1,2] Hospital discharge registries are poor surrogate markers for the true prevalence of PID. In USA, an estimated one million women are treated each year for PID and at least one fourth of these suffer from serious sequelae including infertility, ectopic pregnancy, chronic pelvic pain and requires major abdominal and pelvic surgery.[3] In western countries the origin of pelvic inflammatory disease is due to sexual abuse.[4] On the other hand in third world countries like ours, unsafe delivery and abortion play main role in the development of pelvic inflammatory diseases. Sequelae of PID can sometimes be very pathetic, as it causes subfertility which is a very gloomy event in reproductive health of a woman, as well as for her family life.[5] It can cause pelvic and generalized peritonitis, septic shock; chronic pelvic pain which disturbs day to day activities of a woman. PID can cause dyspareunia which disturbs marital harmony. It may also cause ectopic pregnancy, pelvic abscess and tubo-ovarian mass necessitates major surgeries by which mortality and morbidity is further increased.[6] The most important presenting feature is chronic pelvic pain of varying magnitude.

MATERIAL AND METHODS

The prospective cross-sectional study which was carried in the Department of Obstetrics and Gynecology, after taking the approval of the protocol review committee and institutional ethics committee. 120 Patient presenting with lower abdominal pain with vaginal discharge having either cervical motion

tenderness or uterine tendernessor adnexal tenderness on bimanual examination between 18- 42 years of age were included in this study. Other established causes of lower abdominal pain, before menarche and post menopausal patients After meeting inclusion and exclusion criteria history taken and examination were conducted per speculum and bimanual examination done or variables like age, parity, socioeconomic status, literacy, contraceptive practices and presenting complaints were noted excluded from the study.

STATISTICAL ANALYSIS

Datas were recorded in excel sheet and analysed in tabular form and percentage.

RESULT

Most common group presenting with PID were between 25to 30 years of age (30.83%) followed by 20 to 25 years of age (25.83%). It was less common in age less than 20years (1.67%) and more than 40 years of age (4.17%) (Table 1).

Table 1: Age wise distribution of PID patients

Age	Number of Patients	Percentage
<20	2	1.67
20-25	31	25.83
25-30	37	30.83
30-35	25	20.83
35-40	20	16.67
>40	5	4.17
Total	120	100%

Maximum women with PID were having parity of 2 to 5(64.17%). It was less common in nullipara (5%) (Table 2)

Table 2: Parity wise Distribution of PID patients

Parity	Number of patients	Percentage
0	6	5
1	20	16.67
2-5	77	64.17
>5	17	14.17
Total	120	100

PID was commonest in illiterate women (55%) and less common in women who were graduate (1.67%) (Table 3)

Table 3: Distribution of patients according to literacy

Education	Number of patient	Percentage
Illiterate	66	55
Primary	36	30
SSC	12	10
HSC	4	3.33
Graduate	2	1.67
Total	120	100

PID was more common in women having low socioeconomic status (Table 4)

Table 4: Distribution of patients according to socioeconomic class

Socio-economic status	Number of patients	Percentage
Low	109	90.83
Middle	11	9.17
Total	120	100

Maximum number of women presenting with PID did not used contraceptive. (58.33%). 15.83% used barrier method but were irregular and 12.5% used IUCD (Table 6).

Table 5: Distribution of patients according to age at time of marriage

Age at time marriage(Years)	Number of patients	Percentage
<20	8	6.67
20-30	106	88.33
>30	6	5
Total	120	100

Most of the women presented with discharge per vaginum (75.83 %) followed by pain lower abdomen (83.33%) and backache (40%) (Table 7)

Table 6: Distribution of patients according to use of contraceptive practices

Contraceptive Use	Number of patients	Percentage
Barrier	19	15.83
Oral Contraceptive pills(OCP)	4	3.33
Intra Uterine Contraceptive Device (IUCD)	15	12.5
Tubectomy	12	10
None	70	58.33
Total	120	100

75.83% women had discharge per vaginum on speculum examination. 90% had cervical motion tenderness and only 5% presented with adenexal mass.

Table 7: Distribution of patients according to Presenting Complaints

Presenting Complaints	Number of patients	Percentage
Pain lower Abdomen	100	83.33
Backache	48	40
Per vaginum discharge	91	75.83
Burning micturition	36	30
Itching per vaginum	32	26.67
Fever	18	15
Nausea/ Vomiting	4	3.33
Irregular menstruation	32	26.67
Infertility	18	15

DISCUSSION

The exact incidence of PID is unknown because the disease cannot be diagnosed reliably from clinical symptoms and signs. Moreover women, who have PID, present to the general practitioners, gynaecologist and surgeons. Hospital discharge registries are poor surrogate markers for the true prevalence of PID. However, prevalence of PID is increasing all over the world. In our study Most common group presenting with PID were between 25to 30 years of age (30.83%) followed by 20 to 25 years of age (25.83%). It was less common in age less than 20years (1.67%) and more than 40 years of age (4.17%), Eli Nk Wabong *et al.* also showed maximum incidence in 20 -24 years of age (27.2%) followed by 25 -29 years of age (24.3%).[7] Maximum women with PID were having parity of 2 to 5(64.17%). It was less common in nullipara (5%). Peterson *et al.* also had similar findings.[8] With PID occurring mostly in multipara. But our findings were in contrast to the study done by westrom *et al.* which showed 74.4% cases in nulliparous women.[9] In our study PID was seen most commonly in illiterate women (55%) and less common in women who were graduate (1.67%). Our findings were similar with Eli N K Wabong *et al.* showed maximum PID cases in women who were educated below SSC (54.3%) followed by women having education having below primary level (20%).[7] Less education makes them less aware about prevention of disease.

PID was maximum seen in women of low socioeconomic status (90.83%) It was similar with findings of other studies. S Ahmed *et al.* showed PID cases were more common in low and middle class that is 60% and 30% respectively.[10] Although we cannot draw a conclusion from our study regarding socioeconomic status and PID because majority of patient attending Obstetrics and Gynaecology department of our institute belong to lower or middle socioeconomic status.

Our study showed maximum number of women presenting with PID did not used contraceptive. (58.33%). 15.83% used barrier method but were irregular and 12.5% used IUCD. Patel Sangeeta *et al.* showed 19.33% used IUCD.[11]

Pain lower abdomen was most common presented with discharge per vaginum (75.83 %) followed by pain lower abdomen (83.33%) and backache (40%). These findings were similar to the study by Eli N K Wabong *et al.* which showed pain abdomen in 75.7% and vaginal discharge in 73.27% cases.[7] Fever in our study was less common presentation 15% which is in contrast to Eli N K Wabong *et al.* which showed fever as presenting complaints in 78.85% cases.[7] Maximum patients presented with multiple complains.

On pelvic examination 75.83% women had discharge per vaginum on speculum examination. 90% had cervical motion tenderness and only 5% presented with adenexal mass. our findings corresponds with findings of S Ahmed *et al.* which showed fornicial and cervical motion tenderness in 100% cases, discharge per vaginum without foul smell in 74% and foul smelling vaginal discharge in 16% cases.[10]

CONCLUSION

The worldwide increase in the incidence of PID during the last few decades has led to the secondary epidemics of tubal factor infertility and ectopic pregnancy. The sequelae of PID account for a large proportion of the morbidity associated with sexually transmitted

infections and the direct and indirect costs associated with PID are enormous. Incidence of PID is increasing especially in developing countries due to lack of awareness and unsafe sexual practices. It is seen to be more in younger age group with morbidity like tubal factor infertility, ectopic pregnancy and chronic pelvic pain.

REFERENCE

1. Rohrbeck P. Pelvic inflammatory disease among female recruit trainees, active component, U.S. Armed Forces, 2002-2012. MSMR. 2013; 20(9):15-8.
2. Spencer TH, Umeh PO, Irokanulo E, Baba MM, Spencer BB, Umar AI, et al. Bacterial isolates associated with pelvic inflammatory disease among female patients attending some hospitals in Abuja, Nigeria. Afr J Infect Dis. 2014; 8(1):9-13.
3. Simms I, Warburton F, Weström L. Diagnosis of pelvic inflammatory disease: time for a rethink. Sexually Transmitted Infections. 2003 Dec 1;79(6):491-4.
4. Simms I, Stephenson JM. Pelvic inflammatory disease epidemiology: what do we know and what do we need to know?. Sexually transmitted infections. 2000 Apr 1;76(2):80-7.
5. Wiesenfeld HC, Hillier SL, Krohn MA, Amortegui AJ, Heine RP, Landers DV, Sweet RL. Lower genital tract infection and endometritis: insight into subclinical pelvic inflammatory disease. Obstetrics & Gynecology. 2002 Sep 1;100(3):456-63.
6. Sutton MY, Sternberg M, Zaidi A, Louis ME, Markowitz LE. Trends in pelvic inflammatory disease hospital discharges and ambulatory visits, United States, 1985–2001. Sexually transmitted diseases. 2005 Dec 1;32(12):778-84
7. Elie N kwabong, Madye AN, Dingom Acute Pelvic Inflammatory Disease in Cameroon: A Cross Sectional Descriptive Study. African Journal of Repro-ductive Health. December. 2015; 19(4):87.
8. Peterson HB, Galaid EI, Gater W. Pelvic inflammatory disease Med Clin N AM. 1999; 74:1603-5.
9. Washinton E, Arai SO, Hanssen H, Gnimes DA, Holmes KK. Assessing risk for PID and its sequel, JAMA. 1999; 266:2581-6.
10. Ahmed, Parvin S, Shah DR, Begum P, Sanjowal L, Hassan MK, Arif KM. Clinical Profile of Pelvic In-flammatory Disease (PID). Faridpur Med. Coll. J. 2017; 12(1):25-30.
11. Patel SV, Baxi RK, Kotecha PV, Mazumdar VS, Bakshi HN, Mehta KG. A Case-control study of pelvic in- flammatory disease and its association with multi-parity among patients attending SSG Hospital, Vadodara, Gujarat. Indian Journal of Clinical Prac-tice, 2013, 24(3).