

Pelvic Inflammatory Disease (PID) and Fertility

Understanding Pelvic Infection, Fallopian-Tube Damage, Infertility, Ectopic Pregnancy, Treatment, Fertility Restoration and the Integrative Role of Unani Medicine

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Pelvic Inflammatory Disease—commonly called **PID**—is one of the most important preventable causes of damage to the female reproductive system.

Whenever I explain PID to a patient, I usually begin with one simple message:

Treating the infection early may protect future fertility.

PID is an infection and inflammatory condition affecting the **upper female reproductive tract**. It can involve:

- the uterus,
- endometrium,
- fallopian tubes,
- ovaries and surrounding tissues,
- pelvic peritoneum.

Clinically, the term PID includes a spectrum of conditions such as:

- endometritis,
- salpingitis,
- tubo-ovarian abscess,
- pelvic peritonitis.

Current CDC guidance emphasizes that PID may sometimes produce obvious symptoms, but it can also be mild, vague or even clinically silent. Importantly, even women with mild or unrecognized PID can later develop reproductive complications.

This is precisely why PID deserves serious attention in infertility practice.

A woman may recover from:

- pelvic pain,
- fever,



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- discharge

and believe the entire problem has disappeared.

The active infection may indeed be cured.

However, if inflammation has already injured the fallopian tubes, the woman may later develop:

- tubal blockage,
- peritubal adhesions,
- hydrosalpinx,
- infertility,
- ectopic pregnancy.

ACOG currently states that approximately **1 in 10 women with PID develops infertility**, largely because inflammation can scar and obstruct the fallopian tubes.

The actual individual risk varies considerably according to:

- severity of infection,
- how quickly treatment started,
- whether the tubes were involved,
- whether PID occurred more than once.

Therefore, PID and infertility should be understood as related—but not identical—problems.

What Is Pelvic Inflammatory Disease?

Pelvic inflammatory disease occurs when microorganisms ascend from the lower genital tract into structures higher in the reproductive system.

Normally, the vagina contains many microorganisms.

The cervix provides an important barrier between the vagina and the upper reproductive tract.

When pathogenic organisms move upward through the cervix, they can infect:

- endometrium,
- fallopian tubes,



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- ovaries,
- surrounding pelvic tissues.

The resulting inflammation can cause both:

acute illness

and:

long-term reproductive damage.

CDC defines PID as a spectrum of inflammatory disorders of the upper female genital tract that can include endometritis, salpingitis, tubo-ovarian abscess and pelvic peritonitis.

What Is Salpingitis?

When PID involves the fallopian tubes, it is called:

Salpingitis

This is particularly important for fertility because the fallopian tubes perform several critical reproductive functions.

They:

- receive the ovulated egg from the ovary,
- allow sperm to travel toward the egg,
- provide the normal site where fertilization usually occurs,
- transport the early embryo toward the uterus.

If inflammation damages the delicate inner lining of a tube, fertility can be affected even if the tube does not become completely blocked.

What Is Endometritis?

Endometritis means inflammation or infection of the lining of the uterus.

It can occur as one component of PID.

The endometrium is the tissue into which an embryo must implant.

Acute PID therefore should not be understood only as a “tube infection.”

The inflammatory process may involve several interconnected reproductive structures.

What Is a Tubo-Ovarian Abscess?

One of the more serious complications of PID is:

Tubo-Ovarian Abscess — TOA

This is an infected inflammatory mass involving the fallopian tube, ovary or surrounding pelvic tissues.

The woman may be significantly unwell and may develop:

- severe pelvic pain,
- fever,
- tenderness,
- nausea or vomiting,
- elevated inflammatory markers.

CDC recommends hospitalization or inpatient management when a tubo-ovarian abscess is present, and more than 24 hours of inpatient observation is advised in these cases.

Drainage or surgery may sometimes become necessary when:

- the abscess is large,
- rupture is suspected,
- the patient fails to improve adequately with antibiotics.

A ruptured tubo-ovarian abscess can become life-threatening.

What Causes PID?

PID is usually **polymicrobial**.

That means several different microorganisms may participate.

Two particularly important causes are the sexually transmitted infections:

- **Chlamydia trachomatis**
- **Neisseria gonorrhoeae**

However, these are not the only organisms associated with PID.



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CDC reports that only approximately half of women diagnosed with acute PID test positive for gonorrhea or chlamydia, and vaginal-flora organisms—including anaerobic bacteria and other organisms—may also participate.

Therefore:

PID does not automatically mean that gonorrhea or chlamydia has been proven.

Chlamydia and PID

Chlamydia is particularly important because it frequently produces:

- mild symptoms,
- no symptoms.

A woman can therefore have chlamydial infection without realizing it.

If the organism ascends into the upper reproductive tract, salpingitis and tubal damage may occur.

CDC identifies PID, ectopic pregnancy and infertility among the major reproductive complications of untreated chlamydial infection.

This is one reason screening and prompt treatment of chlamydia can help prevent reproductive complications.

Gonorrhea and PID

Gonorrhea can similarly ascend into the upper genital tract.

Women frequently have:

- mild,
- nonspecific,
- or absent symptoms

from gonococcal cervical infection until complications have developed.

CDC notes that gonorrhea-related PID may lead to tubal scarring and consequently:

- infertility,
 - ectopic pregnancy.
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Is Every Case of PID Sexually Transmitted?

No.

This is important because PID can carry unnecessary social stigma.

Sexually transmitted microorganisms are major causes, but PID is not restricted to STIs.

Organisms associated with:

- bacterial vaginosis,
- vaginal flora,
- anaerobic infections,
- enteric bacteria

may also contribute.

PID or pelvic infection can also occur in certain circumstances related to:

- childbirth,
- miscarriage,
- abortion,
- uterine instrumentation.

WHO's 2025 infertility guidance recognizes untreated STIs, postpartum sepsis and some reproductive-tract infections among important causes of acquired tubal disease.

Therefore, the diagnosis should be handled professionally rather than automatically being treated as evidence about someone's sexual behaviour.

Does PID Mean a Partner Was Unfaithful?

Not necessarily.

This conclusion should never be made simply from a diagnosis of PID.

Some PID is STI-associated.

Other cases involve:

- organisms from vaginal flora,
- postpartum infection,
- post-procedural infection,
- mixed microbial infection.



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If gonorrhea, chlamydia or another STI is identified, appropriate partner evaluation becomes important.

But PID itself should not be used to make assumptions about a relationship.

Can PID Occur After Childbirth?

Yes.

Upper reproductive-tract infection can occur following delivery, particularly when postpartum infection or retained tissue is present.

Postpartum infection is not exactly the same clinical situation as classic STI-associated PID, but infection and inflammation can still damage pelvic reproductive structures.

A detailed obstetric history is therefore important during infertility evaluation.

Can PID Occur After Miscarriage or Abortion?

Yes.

Pelvic infection may occasionally occur following:

- miscarriage,
- uterine evacuation,
- unsafe abortion,
- retained pregnancy tissue.

Appropriate sterile techniques, early recognition of infection and timely treatment reduce complications.

WHO recognizes complications of unsafe abortion and reproductive infections as possible causes of acquired tubal infertility.

Does an IUD Cause PID?

Modern intrauterine contraceptive devices do not produce chronic PID simply because they are present.

CDC states that any increased PID risk related to IUD insertion is mainly concentrated during the first approximately **three weeks after insertion**.



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If PID develops in a woman using an IUD, the device does not automatically need to be removed immediately.

Appropriate antibiotic therapy and clinical follow-up are important.

Can PID Be Silent?

Yes.

This is one of the most important features of the disease.

A woman may have very little pain.

Another may notice only:

- spotting,
- increased vaginal discharge,
- discomfort during intercourse.

Another may have no recognized symptoms.

CDC specifically warns that even **mild or asymptomatic PID can still place a woman at risk for infertility.**

Some women only discover evidence of previous tubal infection years later during an infertility assessment.

Symptoms of Pelvic Inflammatory Disease

Possible symptoms include:

- lower abdominal pain,
- pelvic pain,
- abnormal vaginal discharge,
- unpleasant vaginal discharge,
- fever,
- chills,
- abnormal uterine bleeding,
- bleeding between periods,
- bleeding after intercourse,



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- painful intercourse,
- painful urination,
- nausea,
- vomiting,
- lower back discomfort.

Symptoms may be:

- mild,
- moderate,
- severe.

ACOG emphasizes that symptoms can vary considerably and that PID may resemble other gynecological or abdominal conditions.

Pain During Intercourse

PID can cause:

Dyspareunia

particularly deep pelvic pain during intercourse.

This may occur during active inflammation.

After the acute infection has resolved, persistent pain may sometimes arise from:

- pelvic adhesions,
- chronic inflammation,
- pelvic-floor dysfunction,
- other coexisting disorders.

Persistent dyspareunia should therefore not automatically be treated with repeated antibiotics.

Abnormal Vaginal Discharge

Abnormal discharge can accompany PID.

But vaginal discharge is not specific.

Other causes include:



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- bacterial vaginosis,
- candidiasis,
- trichomoniasis,
- cervicitis.

A proper clinical evaluation is required.

Fever Is Not Always Present

A common misconception is:

“If there is no fever, there is no PID.”

That is incorrect.

PID can be present without fever.

This is one reason early diagnosis is sometimes difficult.

When PID May Be an Emergency

Prompt medical assessment is particularly important for:

- severe abdominal or pelvic pain,
- high fever,
- vomiting,
- fainting,
- marked weakness,
- pregnancy with pelvic pain,
- suspected tubo-ovarian abscess.

These symptoms may indicate:

- severe PID,
- ruptured abscess,
- ectopic pregnancy,
- appendicitis,
- ovarian torsion



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or another urgent condition.

How Is PID Diagnosed?

There is no single simple test that confirms every case of PID.

Diagnosis is usually based upon a combination of:

- symptoms,
- reproductive and sexual history,
- pelvic examination,
- STI testing,
- laboratory tests,
- imaging in selected patients.

CDC deliberately recommends a relatively **low threshold for clinical treatment** because delayed therapy increases the opportunity for reproductive damage.

Pelvic Examination

During examination, findings may include:

- cervical motion tenderness,
- uterine tenderness,
- adnexal tenderness.

CDC recommends considering presumptive PID treatment in an at-risk patient with pelvic or lower abdominal pain when another cause is not evident and one or more of these findings is present.

This approach is designed to avoid delaying treatment while waiting for perfect diagnostic certainty.

STI Testing

Patients with PID should generally be evaluated for sexually transmitted infections.

CDC recommends testing women diagnosed with PID for:

- gonorrhea,



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- chlamydia,
- HIV,
- syphilis.

The precise tests required should be selected by the treating clinician.

Can a Negative Chlamydia or Gonorrhea Test Rule Out PID?

No.

A negative cervical test does not exclude upper reproductive-tract infection.

PID can also involve organisms other than:

- chlamydia,
- gonorrhea.

CDC therefore recommends antimicrobial treatment that covers these major pathogens even when cervical testing is negative if clinical PID is diagnosed.

Ultrasound in PID

Pelvic ultrasound may be particularly useful when clinicians suspect:

- tubo-ovarian abscess,
- hydrosalpinx,
- other adnexal disease.

An ordinary ultrasound can be normal in mild PID.

Therefore:

a normal ultrasound does not automatically exclude acute PID.

Clinical assessment remains important.

Laparoscopy

Laparoscopy allows direct visualization of pelvic organs and can identify:

- salpingitis,
- adhesions,



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- hydrosalpinx,
- other pelvic disease.

However, it is invasive and is not required routinely to diagnose every case of acute PID.

CDC notes that laparoscopy can improve diagnostic specificity for salpingitis but is not practical or necessary for many women with mild disease.

Why Early Treatment Is So Important

Antibiotics can stop active infection.

But once scar tissue has formed, antibiotics cannot reliably make that scar disappear.

This is why early treatment has two goals:

cure the infection,

and:

prevent further structural damage.

ACOG emphasizes that PID is treatable but treatment cannot reverse reproductive scarring that has already occurred.

Delayed Treatment Increases Fertility Risk

Long-term research has demonstrated that delay in seeking care increases the risk of reproductive complications.

A classic cohort study found that women delaying treatment for PID were approximately three times more likely to experience infertility or ectopic pregnancy than women treated promptly.

Although this is older evidence, it remains biologically and clinically important and supports current recommendations for early antimicrobial therapy.

Treatment of Acute PID

Acute PID is fundamentally an **infectious disease requiring appropriate antimicrobial therapy.**

This is one area where I make the treatment hierarchy very clear to patients:



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suspected acute bacterial PID should not be treated with Unani or herbal medicine alone.

The priority is timely antimicrobial treatment according to:

- disease severity,
- pregnancy status,
- local antimicrobial guidelines,
- allergies,
- microbiology when available.

Current Indian Treatment Guidance

India's updated **2024 National AIDS and STD Control Programme—NACO—guidance** includes ceftriaxone-based treatment together with:

- doxycycline for 14 days,
- metronidazole for 14 days

as one recommended approach to lower-abdominal-pain/PID syndrome.

Treatment must be prescribed by an appropriately qualified clinician because management differs in:

- pregnancy,
- breastfeeding,
- severe infection,
- drug allergy,
- tubo-ovarian abscess.

Patients should not self-prescribe antibiotics based upon an internet article.

Current CDC Outpatient Regimen

For mild-to-moderate outpatient PID, current CDC guidance recommends a common regimen consisting of:

ceftriaxone as a single intramuscular dose

plus:



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doxycycline twice daily for 14 days

plus:

metronidazole twice daily for 14 days.

Indian national protocols and individual clinical circumstances may differ, so local prescribing guidance should be followed.

Why Is More Than One Antibiotic Used?

PID is frequently polymicrobial.

Treatment therefore needs to cover organisms including:

- gonorrhea,
- chlamydia,
- anaerobic bacteria,
- other relevant organisms.

CDC notes that adding metronidazole improves anaerobic coverage and also treats bacterial vaginosis, which commonly coexists with PID.

Finish the Full Antibiotic Course

Symptoms may improve within a few days.

That does not necessarily mean infection has been fully eradicated.

Patients should complete the prescribed treatment unless their treating physician changes the regimen.

Stopping early can increase the chance of treatment failure or persistence.

When Is Hospital Treatment Needed?

CDC recommends considering hospitalization when:

- a surgical emergency such as appendicitis cannot be excluded,
- tubo-ovarian abscess is present,
- the woman is pregnant,
- illness is severe,



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- significant nausea or vomiting prevents oral treatment,
 - high fever is present,
 - outpatient therapy cannot be followed,
 - there is no adequate response to outpatient therapy.
-

Pregnancy and PID

Suspected PID during pregnancy requires specialist medical management.

CDC includes pregnancy among the reasons for hospitalization and parenteral treatment.

A pregnant woman with:

- pelvic pain,
- bleeding,
- fever

also requires assessment for other important conditions, especially:

- ectopic pregnancy,
 - miscarriage.
-

Follow-Up After Starting Treatment

Clinical improvement should usually begin within:

approximately 72 hours.

If a woman does not improve within that time after outpatient therapy, CDC recommends:

- reassessing the diagnosis,
 - reconsidering antimicrobial therapy,
 - additional diagnostic investigation,
 - possible hospitalization.
-

Why the Sexual Partner May Need Treatment



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When PID is associated with gonorrhea or chlamydia, treating only the woman can lead to:

reinfection.

CDC recommends evaluation and presumptive treatment for chlamydia and gonorrhea of sexual partners who had contact during the approximately 60 days preceding symptom onset or diagnosis.

This is part of fertility protection.

Preventing recurrent PID matters because repeated episodes increase the risk of tubal damage.

When Can Sexual Intercourse Resume?

CDC advises avoiding intercourse until:

- the patient's treatment is completed,
- symptoms have resolved,
- relevant partners have been treated.

This reduces transmission and reinfection.

Retesting After Chlamydial or Gonococcal PID

When PID was associated with:

- chlamydia,
- gonorrhea,

CDC recommends retesting approximately:

three months after treatment,

even when the partner was also treated.

How Does PID Cause Infertility?

This is the central question in fertility practice.

The main pathway is damage to the:

Fallopian Tubes.



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Inside each fallopian tube is a highly specialized lining containing delicate cells and microscopic structures that help move:

- egg,
- sperm,
- embryo.

Inflammation can damage this tissue.

Healing may then produce:

- fibrosis,
- scar tissue,
- adhesions,
- narrowing,
- complete blockage.

Fertility Does Not Require Only an “Open” Tube

A tube can appear technically open but still function poorly.

For normal fertility, the tube must:

- capture the ovulated egg,
- allow sperm movement,
- support fertilization,
- move the developing embryo toward the uterus.

Severe previous salpingitis can disturb these functions even without complete occlusion.

This is why tubal disease is more complicated than simply:

“open or blocked.”

Peritubal Adhesions

PID may produce adhesions outside the fallopian tubes.

Scar tissue can attach:

- tube to ovary,



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- ovary to pelvic sidewall,
- reproductive organs to surrounding tissues.

These adhesions can alter the normal relationship between:

- ovary,
- fimbrial end of the fallopian tube.

The tube may remain open yet struggle to capture the egg effectively.

Bilateral Tubal Blockage

If both fallopian tubes are completely blocked, sperm cannot normally reach the ovulated egg.

Natural conception then becomes very difficult or impossible depending upon the exact level and severity of obstruction.

Treatment may involve:

- reconstructive tubal surgery in selected women,
 - IVF.
-

Unilateral Tubal Damage

If one tube is damaged but the other is healthy, natural pregnancy can still occur.

However, fertility may be reduced depending upon:

- function of the remaining tube,
- age,
- ovulation,
- male semen quality,
- other infertility factors.

One blocked tube does not automatically mean IVF is required.

What Is Hydrosalpinx?

Hydrosalpinx means a damaged fallopian tube becomes:

- obstructed,



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- dilated,
- filled with fluid.

Previous PID is one of the major causes.

The affected tube may appear elongated or swollen on ultrasound or other imaging.

Hydrosalpinx can impair fertility in two ways:

1. the tube itself may not function normally;
2. hydrosalpingeal fluid may enter the uterine cavity and reduce embryo implantation.

WHO's 2025 infertility guideline recognizes hydrosalpinx as an important form of tubal-factor infertility and recommends treatment before IVF in appropriate patients.

Ectopic Pregnancy After PID

A damaged fallopian tube may allow fertilization but fail to move the embryo normally toward the uterus.

The embryo may then implant inside the tube.

This is called:

Ectopic Pregnancy.

It can become life-threatening if the tube ruptures and causes internal bleeding.

ACOG identifies ectopic pregnancy as one of the important long-term consequences of PID-related tubal scarring.

Women with previous PID should therefore seek prompt medical assessment if they have a positive pregnancy test accompanied by:

- one-sided pelvic pain,
- shoulder-tip pain,
- dizziness,
- fainting,
- abnormal bleeding.

How Often Does PID Cause Infertility?



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The exact risk varies.

ACOG currently gives the useful patient-level estimate that approximately:

1 in 10 women with PID becomes infertile.

A large historic prospective cohort of women with laparoscopically verified PID found confirmed tubal-factor infertility in approximately **10.8%** of those who later attempted conception.

These figures should not be interpreted as a guaranteed individual probability.

The risk depends strongly upon:

- disease severity,
- repeat infections,
- treatment timing.

Repeated PID Is More Dangerous for Fertility

One of the clearest findings from long-term research is that recurrent PID increases reproductive risk.

Historic cohort studies found a strong relationship between:

- number of PID episodes,
- later tubal infertility.

The exact percentages from these older cohorts may not perfectly represent every modern population, but the principle remains highly relevant:

preventing another PID episode is an important fertility treatment.

Severe PID Has Greater Fertility Consequences

Long-term studies have also demonstrated that more severe salpingitis is associated with:

- lower future live-birth probability,
- greater infertility risk.

Therefore, two patients both labelled:

“PID”



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may have very different fertility outcomes.

One woman with early mild infection may recover without detectable tubal damage.

Another woman with:

- bilateral severe salpingitis,
- tubo-ovarian abscess,
- repeated infection

may develop extensive pelvic scarring.

Can a Woman Become Pregnant Normally After PID?

Yes.

Most women who have experienced PID do **not automatically become infertile**.

Many later conceive naturally.

Future fertility depends upon:

- whether the tubes were damaged,
- whether infection recurred,
- age,
- ovulation,
- partner's fertility.

A history of PID is therefore a:

fertility risk factor,

not a diagnosis of permanent infertility.

Does Antibiotic Treatment Restore Fertility?

Antibiotics treat active infection.

They can prevent ongoing damage.

But they do not reliably reverse:

- established fibrosis,
- severe adhesions,



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- completely blocked tubes,
- longstanding hydrosalpinx.

This distinction is extremely important.

A woman may no longer need antibiotics but may still need fertility treatment because of previous structural damage.

ACOG explicitly notes that successful treatment of the infection cannot reverse reproductive scarring that has already occurred.

Persistent Pelvic Pain After PID

Some women develop:

Chronic Pelvic Pain

after PID.

Possible mechanisms include:

- pelvic adhesions,
- persistent sensitization,
- pelvic-floor dysfunction,
- other coexisting gynecological disorders.

Repeated antibiotics should not be prescribed indefinitely when active infection is no longer present.

A new evaluation is required to determine the actual cause of persistent pain.

PID and Painful Intercourse

Persistent deep dyspareunia can develop after:

- pelvic adhesions,
- chronic pelvic pain,
- pelvic-floor muscle guarding.

Treatment may therefore eventually require:

- gynecological evaluation,
- pelvic-floor rehabilitation,



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- pain management,
- sexual-health counselling.

This is particularly relevant to my clinical focus because infertility and sexual pain frequently interact.

When Should Fertility Be Evaluated After PID?

Not every woman requires immediate HSG after one successfully treated episode.

The decision depends upon:

- age,
- reproductive plans,
- severity of previous PID,
- infertility duration.

In general, fertility investigation becomes appropriate when pregnancy does not occur after:

- approximately 12 months in a younger woman without additional major risk factors,
- sooner in older women,
- earlier when significant tubal damage is already suspected.

Previous PID itself may justify earlier tubal assessment in selected infertility patients.

How Are the Fallopian Tubes Evaluated?

The **2025 WHO infertility guideline** recommends either:

Hysterosalpingography — HSG

or:

Hysterosalpingo-Contrast Sonography — HyCoSy

for assessing tubal patency in women with infertility and suspected tubal disease.

The choice depends upon:

- availability,
- expertise,



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- patient preference,
- allergy considerations.

Hysterosalpingography — HSG

HSG uses contrast introduced through the cervix while X-ray images are taken.

If contrast travels through the tubes and spills into the pelvis, this suggests tubal patency.

HSG can identify:

- proximal blockage,
- distal blockage,
- hydrosalpinx,
- some uterine-cavity abnormalities.

It does not directly show every pelvic adhesion.

HyCoSy

HyCoSy evaluates the tubes using:

- ultrasound,
- contrast medium introduced into the uterine cavity.

WHO considers it an alternative to HSG for tubal-patency assessment.

It avoids ionizing radiation but requires appropriate ultrasound expertise.

Can HSG Reopen a Blocked Tube?

Sometimes an HSG that initially appears to show proximal obstruction may demonstrate patency during repeat evaluation because:

- mucus,
- transient tubal spasm

can mimic true obstruction.

But HSG should not be sold as a reliable treatment capable of reversing severe scarred tubal disease.



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Role of Laparoscopy in Tubal Infertility

Laparoscopy may be helpful when there is concern for:

- extensive adhesions,
- endometriosis,
- complex pelvic disease.

It can directly examine:

- tubes,
- ovaries,
- pelvic adhesions.

However, modern infertility evaluation usually begins with less invasive testing rather than routine diagnostic laparoscopy for every patient.

Treatment of Tubal Infertility After PID

Once acute infection has been treated, management changes.

The question is no longer simply:

“Which antibiotic?”

The question becomes:

“How much tubal function remains, and what is the most efficient way to achieve pregnancy?”

The 2025 WHO infertility guideline now provides age- and severity-based recommendations for tubal-factor infertility.

Mild-to-Moderate Tubal Disease in Women Under 35

For women younger than 35 with **mild-to-moderate tubal disease**, WHO conditionally suggests tubal surgery rather than immediate IVF.

When surgery is selected, WHO notes that approximately one year may be a reasonable period to allow natural conception before moving to further treatment such as IVF.

The certainty of evidence is very low, so the recommendation must be individualized.



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Severe Tubal Disease in Women Under 35

For women younger than 35 with **severe tubal disease**, WHO suggests:

IVF rather than reconstructive surgery.

This reflects the lower likelihood that extensively damaged tubes can regain useful physiological function.

Tubal Disease in Women Aged 35 or Older

For women aged **35 or older with tubal-factor infertility**, WHO suggests IVF rather than tubal surgery.

This is an important practical point.

Tubal surgery requires:

- healing,
- time for natural conception attempts.

As female age advances, reproductive time becomes increasingly important.

Hydrosalpinx Before IVF

A hydrosalpinx can reduce IVF implantation success.

The **2025 WHO guideline recommends either salpingectomy or tubal occlusion before IVF in women with hydrosalpinx-related tubal infertility.**

The objective is to prevent harmful hydrosalpingeal fluid from communicating with the uterine cavity.

Salpingectomy

Salpingectomy means surgical removal of the damaged fallopian tube.

It may be considered when:

- severe hydrosalpinx is present,
- IVF is planned.



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However, careful surgery is important because the ovarian blood supply runs close to the tube.

WHO specifically cautions that salpingectomy should be performed in a way that avoids compromising ovarian vascular supply.

Tubal Occlusion

In some women, the hydrosalpinx can be separated from the uterine cavity by tubal occlusion instead of complete tube removal.

WHO considers:

- salpingectomy,
- tubal occlusion

reasonable options before IVF, depending upon surgical feasibility and the presence of adhesions.

IVF Bypasses the Fallopian Tubes

IVF can be particularly effective in tubal infertility because:

- eggs are retrieved directly from the ovaries,
- fertilization occurs in the laboratory,
- embryos are placed directly inside the uterus.

The damaged fallopian tubes therefore do not need to transport:

- sperm,
- egg,
- embryo.

This is why IVF is an important treatment for severe post-PID tubal disease.

IVF Does Not Automatically Require ICSI

A woman with tubal infertility but a male partner with normal sperm does not necessarily require ICSI solely because her tubes are damaged.

The decision between:



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- conventional IVF,
- ICSI

depends largely upon male fertility and previous laboratory outcomes.

Does PID Damage the Ovaries?

Uncomplicated salpingitis primarily affects:

- tubes,
- upper reproductive tract.

Severe PID involving:

- tubo-ovarian abscess,
- ovarian surgery

can sometimes affect ovarian tissue.

But low AMH or diminished ovarian reserve should not automatically be blamed on previous mild PID.

Preventing PID Is Fertility Preservation

The best treatment for post-PID tubal infertility is to prevent tubal damage before it occurs.

Important strategies include:

- appropriate STI screening,
- prompt STI treatment,
- condom use where STI exposure is possible,
- partner treatment,
- avoiding recurrent infection,
- prompt evaluation of pelvic symptoms.

CDC notes that screening and treating sexually active women for chlamydia and gonorrhea reduces their risk of PID.

The Unani Perspective on Pelvic Inflammatory Disease



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Pelvic inflammatory conditions are discussed within the historical Unani framework under concepts related to inflammation of female reproductive organs.

A CCRUM review identifies the contemporary Unani term:

Marz-e-Warm-e-Aana

for pelvic inflammatory disease and notes parallels with the classical concept:

Warm-e-Rahm

describing inflammatory conditions affecting the:

- cervix,
- uterus,
- fallopian tubes,
- ovaries.

CCRUM's standardized Unani terminology also contains terms describing:

- salpingitis,
- fallopian-tube obstruction

and recognizes tubal obstruction as a possible cause of difficulty in conception.

This historical understanding is clinically interesting.

But modern microbiology has added something extremely important:

acute PID is frequently an infection.

Therefore, the presence of an infectious cause must guide treatment.

How Unani Medicine May Be Useful

In appropriately selected patients, Unani treatment may have a role in an **integrative management plan**, particularly for:

- inflammation-related symptoms,
- general reproductive wellbeing,
- nutritional health,
- digestive health,
- convalescence,
- associated menstrual complaints,



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- chronic pelvic discomfort after active infection has been treated,
- sexual and emotional wellbeing.

Traditional Unani treatment also emphasizes:

- Mizaj,
- nutrition,
- digestion,
- lifestyle,
- reproductive health as a whole.

These principles can contribute meaningfully to supportive care.

Recent Clinical Research on Unani Treatment for Uncomplicated PID

Unlike many conditions where direct Unani clinical evidence is minimal, uncomplicated PID has been the subject of some modern randomized research from the **National Institute of Unani Medicine, Bengaluru**.

A 2023 randomized controlled study involving **66 women** compared a vaginal formulation containing:

- *Linum usitatissimum*,
- *Plantago ovata*,
- honey

with a standard-treatment group receiving:

- doxycycline,
- metronidazole.

The study reported improvement in clinical symptoms in both groups.

A further double-blind randomized controlled study involving **60 participants** investigated:

- black sesame (*Sesamum indicum*),
- rose oil (*Rosa damascena*)

as a vaginal intervention compared with a standard doxycycline/metronidazole group in uncomplicated PID and also reported symptom improvement.



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These studies are relevant and justify further investigation of Unani treatment.

But they must be interpreted correctly.

Important Limitations of the Unani Evidence

The existing trials were:

- small,
- single-centre,
- limited to uncomplicated PID,
- relatively short-term.

In the 2023 study, the investigators themselves acknowledged that they did not use some more definitive microbiological or histological measures such as:

- cervical NAAT,
- endometrial biopsy

to establish eradication of upper-tract infection, and recommended larger future trials.

Most importantly, these trials were not designed to show that the Unani interventions prevent:

- tubal scarring,
- ectopic pregnancy,
- infertility,
- tubo-ovarian abscess.

Therefore, I would not extrapolate symptom improvement into a claim that Unani medicine has been proven to prevent PID-related infertility.

Can Unani Medicine Replace Antibiotics in Acute PID?

For suspected active bacterial PID, my answer is:

No—not on the basis of current evidence.

Current international and Indian treatment guidelines recommend prompt antimicrobial treatment because delaying treatment can increase reproductive damage.



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Unani treatment may be considered as complementary care when medically appropriate.

It should not delay or replace necessary antimicrobial treatment in:

- acute PID,
- severe PID,
- pregnancy-associated pelvic infection,
- tubo-ovarian abscess.

Can Unani Medicine Open Scarred Fallopian Tubes?

This also requires careful language.

No oral or topical Unani medicine has been scientifically established as a reliable method for reversing:

- dense tubal fibrosis,
- severe peritubal adhesions,
- advanced hydrosalpinx,
- completely scarred fallopian tubes.

A woman with established structural tubal infertility requires:

- objective tubal evaluation,
- reproductive planning.

Where the structural disease is severe, treatment may require:

- surgery,
- IVF.

What About Unani Treatment for Tubal Infertility?

There are individual reports in the Unani literature.

For example, a published case report from the National Institute of Unani Medicine described conception after Unani treatment in a woman with unilateral tubal blockage.

However, this was:

one case.



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A single successful pregnancy cannot establish that a treatment reliably opens scarred tubes.

In addition, pregnancy can occur naturally when one fallopian tube remains functional.

Therefore, such observations are interesting but cannot replace higher-quality evidence.

My Integrative Approach at Saira Health Care

When a woman comes to me with a history of PID and infertility, I separate the problem into two questions.

First question:

Is active infection still present?

If acute PID is suspected, infection must be diagnosed and treated promptly.

Second question:

Has previous infection already caused reproductive damage?

This may require evaluation for:

- tubal blockage,
- hydrosalpinx,
- adhesions,
- chronic pelvic pain,
- ectopic-pregnancy risk.

These are different treatment problems.

Special Treatment Planning by Dr. Nizamuddin Qasmi

My focused clinical work in **Sexual Disorders & Infertility** means that I assess more than the infection itself.

I ask:

When did the PID occur?

Was it mild or severe?

Was hospitalization necessary?

Was there a tubo-ovarian abscess?

Was treatment completed?

Did infection recur?

Was chlamydia or gonorrhea identified?

How long has the couple been trying for pregnancy?

Has HSG or HyCoSy been performed?

Is there hydrosalpinx?

How old is the woman?

Is ovulation normal?

What is her ovarian reserve where relevant?

What does the male partner's semen analysis show?

These questions determine the fertility plan.

What “Special Treatment” Means at Saira Health Care

Specialized care does not mean giving the same medicine to every woman with PID.

Consider several different patients.

Patient One

A 24-year-old woman with newly diagnosed mild PID.

Her immediate priority is:

prompt antimicrobial treatment and prevention of reinfection.

Patient Two

A 30-year-old woman treated for PID three years ago who is now unable to conceive.

Her problem may no longer be infection.

She may need:

assessment of tubal patency.

Patient Three



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A 28-year-old woman with one blocked tube and one apparently healthy tube.

Natural pregnancy may still be possible.

Treatment depends upon the rest of the fertility evaluation.

Patient Four

A 33-year-old woman with bilateral severe hydrosalpinx.

Repeated herbal or antibiotic courses are unlikely to restore severely scarred tubes.

Her treatment may require:

- tubal surgery,
 - IVF planning.
-

Patient Five

A 38-year-old woman with severe tubal-factor infertility after PID.

Because age matters, spending years attempting low-probability tubal therapies may reduce her reproductive opportunity.

Current WHO guidance would generally favour IVF over reconstructive surgery in women 35 or older with tubal-factor infertility.

These patients require completely different plans.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At **Saira Health Care**, our objective is to prevent women from becoming trapped between two harmful extremes.

One extreme is:

“PID has been treated, so fertility must be normal.”

The other is:

“You had PID once, so natural pregnancy is impossible.”

Neither is correct.

The medically useful approach is to determine whether reproductive damage actually exists.



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Our work in sexual disorders and infertility emphasizes:

- appropriate reproductive history,
- tubal evaluation,
- ovarian assessment,
- male-partner evaluation,
- sexual-function assessment,
- evidence-based fertility planning,
- individualized Unani supportive care.

The Male Partner Must Still Be Evaluated

A history of PID can become such a strong explanation that clinicians sometimes forget to investigate the male partner.

That is a mistake.

A couple may have:

tubal disease in the woman

and:

oligospermia in the man.

Treating only one partner can therefore waste valuable time.

The 2025 WHO infertility guideline emphasizes systematic evaluation of infertility rather than assuming one abnormality always explains the entire problem.

Sexual Health After PID

PID can affect intimacy.

Pain during intercourse can produce:

- fear,
- avoidance,
- pelvic-floor tightening,
- reduced desire.

Infertility can then add:



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- performance pressure,
- relationship stress.

Because my practice is focused on both sexual disorders and infertility, I believe these concerns should be addressed openly.

A couple cannot be expected to maintain effective conception attempts if intercourse itself has become painful or emotionally distressing.

PID Does Not Define a Woman's Character

PID is a medical condition.

It should never become a source of:

- shame,
- blame,
- judgment.

Patients deserve:

- confidentiality,
- factual counselling,
- appropriate partner management where necessary.

Stigma can delay medical care, and delayed care can increase reproductive harm.

Can PID Be Completely Cured?

The active infection can usually be successfully treated.

But “cure” has two meanings.

Infection cure

Antibiotics eradicate the active infectious process.

Structural recovery

Existing scar tissue may remain.

Therefore, a woman can be:

infection-free

while still having:



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post-PID tubal infertility.

This distinction should be explained clearly.

Can Scar Tissue Be Prevented?

The most effective strategy is:

treat PID early before major scarring develops.

Additional prevention includes:

- preventing reinfection,
- appropriate partner treatment,
- STI screening where indicated.

Once extensive fibrosis has developed, treatment becomes more difficult.

Can PID Return?

Yes.

A woman who acquires another infection can develop PID again.

CDC notes that a woman with previous PID also has an increased likelihood of experiencing another episode.

Preventing recurrence is particularly important because reproductive risk rises with repeated episodes.

Can a Woman Have PID More Than Once From the Same Partner?

Yes.

If an STI-associated infection is treated in the woman but not in her partner, reinfection can occur.

This is why partner treatment matters.

PID and Recurrent Vaginal Infection Are Not the Same

Frequent:

- yeast infection,



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- bacterial vaginosis,
- vaginal discharge

does not automatically mean recurrent PID.

PID refers to infection/inflammation of the **upper** female reproductive tract.

A proper diagnosis is required before repeatedly prescribing systemic antibiotics.

Can PID Cause Irregular Periods?

PID may produce:

- abnormal bleeding,
- intermenstrual spotting.

But persistent irregular menstruation may also be due to:

- PCOS,
- thyroid dysfunction,
- perimenopause,
- other hormonal disorders.

The menstrual problem should therefore be investigated separately when appropriate.

Frequently Asked Questions

What is pelvic inflammatory disease?

PID is an inflammatory infectious condition involving the upper female reproductive tract, which may include the uterus, fallopian tubes, ovaries and pelvic tissues.

What is the main cause of PID?

Chlamydia and gonorrhea are important causes, but PID is often polymicrobial and may also involve anaerobes and organisms from vaginal flora.

Is PID always sexually transmitted?

No.



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STIs are major causes, but non-STI-associated organisms and reproductive-tract infections can also be involved.

Does PID prove infidelity?

No.

The diagnosis alone cannot establish how an infection was acquired.

Can PID have no symptoms?

Yes.

PID may be mild or clinically silent.

Even mild or asymptomatic disease can sometimes damage fertility.

What are the common symptoms?

Possible symptoms include:

- lower abdominal pain,
 - pelvic pain,
 - abnormal discharge,
 - fever,
 - abnormal bleeding,
 - painful intercourse,
 - painful urination.
-

Can PID cause infertility?

Yes.

PID can scar or block the fallopian tubes.

ACOG estimates that approximately **one in ten women with PID develops infertility**.

Does one episode of PID always cause infertility?

No.

Most women do not become infertile after a single episode.

Risk depends upon:

- severity,
- delay in treatment,
- recurrent infection.

Does repeated PID increase infertility risk?

Yes.

Long-term cohort studies have consistently demonstrated increasing tubal infertility risk with repeated episodes.

Can PID cause ectopic pregnancy?

Yes.

Scarring can interfere with embryo transport through the fallopian tube, increasing ectopic-pregnancy risk.

Can PID cause chronic pain?

Yes.

PID is associated with chronic pelvic pain in some women.

Can PID cause hydrosalpinx?

Yes.

Severe tubal damage may result in a fluid-filled, obstructed fallopian tube called hydrosalpinx.

Can hydrosalpinx reduce IVF success?

Yes.

Hydrosalpingeal fluid can adversely affect embryo implantation.



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The WHO 2025 infertility guideline recommends salpingectomy or tubal occlusion before IVF in appropriate women with hydrosalpinx.

How is PID diagnosed?

Diagnosis is usually clinical and may involve:

- symptoms,
- pelvic examination,
- STI testing,
- ultrasound,
- additional tests where necessary.

There is no one perfect diagnostic test for every patient.

Can a normal ultrasound rule out PID?

No.

Mild PID may not produce obvious ultrasound changes.

How is PID treated?

Acute PID requires prompt antimicrobial treatment.

Current Indian and CDC guidelines use broad-spectrum combinations directed at likely organisms.

Can I treat PID myself with antibiotics?

No.

Symptoms of PID overlap with potentially urgent conditions such as:

- ectopic pregnancy,
- appendicitis,
- ovarian torsion.

Treatment should be clinician-directed.



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How soon should symptoms improve?

Clinical improvement should generally be apparent within approximately 72 hours.

Lack of improvement requires reassessment.

Does my partner need treatment?

When PID may involve sexually transmitted organisms, recent sexual partners should be evaluated and appropriately treated for chlamydia and gonorrhea.

When can intercourse resume?

Generally after:

- treatment has been completed,
 - symptoms have resolved,
 - relevant partners have been treated.
-

Can antibiotics reopen blocked tubes?

No.

Antibiotics treat active infection.

They do not reliably remove established tubal fibrosis.

How do I know whether PID damaged my tubes?

In an infertility evaluation, tubal patency can be assessed using:

- HSG,
- HyCoSy.

WHO recommends either test for women with suspected tubal-factor infertility.

Can one blocked tube still allow pregnancy?

Yes.

Natural conception may occur when the other fallopian tube is functional and other fertility factors are favourable.

Can bilateral blocked tubes be treated?

Depending upon:

- location,
- severity,
- age,

options may include:

- tubal surgery,
- IVF.

Does WHO recommend surgery or IVF for tubal infertility?

The 2025 WHO guideline suggests:

- **under 35 + mild/moderate disease:** surgery may be considered before IVF;
- **under 35 + severe tubal disease:** IVF is generally favoured;
- **35 or older + tubal disease:** IVF is generally favoured.

These are conditional recommendations with very low certainty of evidence and require individualized counselling.

Can PID-related infertility be cured naturally?

Some women still conceive naturally after PID because the tubes remain sufficiently functional.

But there is no established natural remedy that can reliably reverse severe tubal scar tissue.

Can Unani medicine help PID?

Unani medicine may have a supportive role.

Modern randomized studies from the National Institute of Unani Medicine have reported symptom improvement from selected traditional vaginal formulations in uncomplicated PID.



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However, the studies are small and do not establish prevention of infertility or replacement of guideline-directed antimicrobial therapy.

What is PID called in Unani medicine?

A CCRUM review uses the term:

Marz-e-Warm-e-Aana

and relates it to classical descriptions of:

Warm-e-Rahm.

Can Unani medicine replace antibiotics?

Not for suspected active bacterial PID based upon current evidence.

Appropriate antibiotics should not be delayed.

Can Unani medicines unblock the fallopian tubes?

There is currently insufficient high-quality evidence showing that Unani medicine reliably reverses established severe tubal fibrosis or hydrosalpinx.

Is there Unani research on tubal infertility?

A published case report described conception following Unani treatment in a woman with unilateral tubal blockage, but a single case cannot establish reliable tubal reopening or prove effectiveness for severe tubal infertility.

Can I have IVF if my tubes are blocked?

Yes.

IVF bypasses the fallopian tubes.

If hydrosalpinx is present, treating it before embryo transfer may improve IVF effectiveness.

A Message From Dr. Nizamuddin Qasmi



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When a woman comes to me and says:

“Doctor, I had PID five years ago. Now I am not getting pregnant. Should I take antibiotics again?”

my first answer is:

Not automatically.

If there is no active infection, repeating antibiotics may not solve the fertility problem.

I want to know:

Are the fallopian tubes open?

Is there a hydrosalpinx?

Are there pelvic adhesions?

Is ovulation normal?

How old are you?

What does your husband's semen analysis show?

That is the difference between:

treating the old diagnosis,

and:

investigating the current cause of infertility.

What I Tell Patients With Newly Diagnosed PID

When PID is active, I emphasize urgency.

I explain:

“Do not wait for the pain to become severe.”

Mild symptoms do not guarantee mild internal damage.

Prompt antimicrobial treatment is one of the most important measures we have for protecting the fallopian tubes.

What I Tell Patients After PID Treatment

Once the infection has resolved, I do not create unnecessary fear.

One episode of PID does not mean that a woman will definitely become infertile.



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If she later wants pregnancy, many women conceive normally.

But if conception does not occur within an appropriate period—or if previous PID was severe—tubal evaluation should not be delayed unnecessarily.

What I Tell Patients With Hydrosalpinx

I explain that a hydrosalpinx is not simply:

“water in the tube.”

It usually indicates substantial tubal injury.

If IVF is planned, the affected tube may need:

- removal,
- occlusion

before embryo transfer because hydrosalpingeal fluid can adversely affect implantation.

This is now specifically addressed in the WHO 2025 infertility guideline.

What I Tell Patients About Unani Treatment

I believe Unani medicine has important contributions to make in reproductive health.

Recent clinical trials in uncomplicated PID are encouraging and deserve further research.

However, I also tell patients:

An integrative doctor should know when herbal care can support a patient and when infection requires antibiotics or structural disease requires surgery or IVF.

That is not a weakness of integrative medicine.

It is good medicine.

My Clinical Philosophy

My approach can be summarized as:

Diagnose early → control the infection → prevent recurrence → assess the tubes when fertility is affected → treat structural damage appropriately → support the patient's complete reproductive and sexual health.



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Unani medicine can be integrated responsibly within this pathway.

But it should not delay:

- antibiotics during active bacterial PID,
- drainage of a serious abscess,
- tubal assessment during infertility,
- IVF where severe tubal disease makes natural conception extremely unlikely.

Current Medical Understanding — 2026 Update

Several points are especially important from current evidence.

1. PID is often polymicrobial

Gonorrhea and chlamydia remain major pathogens, but only around half of acute PID cases test positive for either, and anaerobic/vaginal organisms may also participate.

2. Mild PID can still affect fertility

The absence of severe fever or severe pain does not exclude reproductive risk.

3. Early antimicrobial therapy matters

Treatment should begin when clinical PID is reasonably suspected rather than waiting for severe disease or perfect diagnostic certainty.

4. Antibiotics cannot reverse established scarring

Once tubal fibrosis has developed, fertility treatment becomes a separate clinical issue.

5. Repeated episodes increase reproductive risk

Preventing reinfection is therefore an important fertility-preservation strategy.

6. HSG or HyCoSy are recommended for suspected tubal-factor infertility

This is now explicitly included in the 2025 WHO global infertility guideline.

7. Age changes tubal-infertility treatment

WHO now recommends considering both:

- tubal-disease severity,
- female age

when deciding between reconstructive surgery and IVF.

8. Hydrosalpinx should usually be addressed before IVF



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WHO suggests salpingectomy or tubal occlusion before IVF for hydrosalpinx-associated tubal infertility.

9. Unani PID research is developing

Small randomized controlled trials have reported encouraging short-term symptom outcomes with selected traditional formulations in uncomplicated PID.

10. Unani research has not yet demonstrated prevention of tubal infertility

Current studies do not establish that these interventions prevent:

- tubal fibrosis,
- ectopic pregnancy,
- infertility.

Therefore, they should not replace prompt antimicrobial treatment or appropriate fertility intervention.

Conclusion

Pelvic Inflammatory Disease is an infection and inflammatory condition of the upper female reproductive tract that can involve the uterus, fallopian tubes, ovaries and surrounding pelvic tissues.

Its most important reproductive complication is:

Fallopian-Tube Damage.

PID can cause:

- salpingitis,
- tubal fibrosis,
- adhesions,
- tubal blockage,
- hydrosalpinx.

These changes can lead to:

- infertility,
- ectopic pregnancy,
- chronic pelvic pain.



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Chlamydia and gonorrhea remain important causes, but PID is commonly polymicrobial and may also involve organisms from vaginal flora.

PID can be:

- severe,
- mild,
- almost silent.

This is clinically important because even women with mild or unrecognized infection may experience reproductive consequences.

The most important principle of acute management is:

Treat early.

Current Indian 2024 and CDC guidance recommends broad-spectrum antimicrobial treatment for suspected PID, with clinical reassessment when appropriate.

Antibiotics can cure the active infection.

But:

they cannot reliably reverse established fallopian-tube scar tissue.

Therefore, when a woman has a history of PID followed by infertility, the clinical focus needs to shift toward:

- assessing tubal patency,
- identifying hydrosalpinx,
- evaluating the complete fertility status of both partners.

The **2025 WHO infertility guideline** recommends either:

- HSG,
- HyCoSy

for suspected tubal infertility.

For established tubal disease, treatment depends on:

- severity,
- female age.

WHO conditionally suggests:

women under 35 with mild-to-moderate tubal disease: consider surgery;



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women under 35 with severe tubal disease: IVF is generally preferred;

women 35 or older with tubal-factor infertility: IVF is generally preferred.

When hydrosalpinx is present before IVF, WHO suggests:

- salpingectomy,
- tubal occlusion

before IVF in appropriate patients.

From the **Unani perspective**, PID has parallels with descriptions of **Warm-e-Rahm / Marz-e-Warm-e-Aana**, and contemporary Unani research has begun evaluating traditional formulations in uncomplicated PID.

These findings are encouraging.

However, the current studies remain relatively small and do not demonstrate that Unani treatment can reliably prevent:

- tubal scarring,
- hydrosalpinx,
- ectopic pregnancy,
- infertility.

Therefore, at **Saira Health Care**, my approach is integrative but clinically disciplined:

identify active infection early, use appropriate antimicrobial treatment, prevent reinfection, assess tubal function when fertility is affected, evaluate both partners, manage hydrosalpinx or tubal obstruction appropriately, use IVF when clinically indicated, and integrate individualized Unani supportive care for reproductive, menstrual, nutritional, sexual and general wellbeing.

My most important message to patients is:

PID does not automatically mean infertility—but delaying treatment can unnecessarily increase that risk.

And when infertility develops after PID:

do not simply keep treating the infection again and again.

Ask the more important question:

Has the infection already damaged the fallopian tubes?

Once that question is answered, the fertility treatment can become much more precise.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

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Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health (ISRH) — UNFPA

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** has a focused emphasis on sexual disorders, male and female reproductive health and infertility.

His approach to PID-related infertility distinguishes between:

active infection

and:

the reproductive consequences left behind after infection has resolved.

Depending upon the patient, evaluation may include:

- reproductive and infection history,
- pelvic and menstrual assessment,
- review of previous STI investigations,
- ultrasound,
- HSG or HyCoSy for tubal assessment,
- ovarian and ovulatory evaluation,
- male-partner semen analysis,
- sexual-health assessment,
- coordination with gynecologic surgery or IVF services where necessary.

Where clinically appropriate, individualized Unani principles may be incorporated to support the patient's reproductive, nutritional, menstrual, general and sexual wellbeing without replacing necessary antimicrobial treatment or structural fertility management.

Medical Disclaimer

This article is intended for health education and public awareness. It does not establish an individual diagnosis or replace examination and treatment by an appropriately qualified gynecologist, fertility specialist, infectious-disease professional or other healthcare practitioner.

Acute pelvic inflammatory disease can cause permanent reproductive damage if treatment is delayed.

Anyone experiencing:

- significant lower abdominal or pelvic pain,
- fever,
- abnormal vaginal discharge,
- pain during intercourse,
- vomiting,
- pregnancy with pelvic pain or bleeding

should seek appropriate medical assessment.

Antibiotics for PID should be prescribed according to the patient's clinical condition, pregnancy status, allergies and current local or national antimicrobial guidance.

Patients should not self-treat suspected PID with leftover antibiotics, vaginal preparations, Unani medicines, herbs or supplements.

Unani clinical studies in uncomplicated PID are encouraging but do not currently establish that traditional therapy can replace guideline-recommended antibiotics, prevent tubal damage or restore established tubal scarring.

Women with previous PID and difficulty becoming pregnant may require objective evaluation of:

- fallopian-tube patency,
- hydrosalpinx,
- other female fertility factors,

- the male partner.

A history of PID does not prove infertility, and many women subsequently conceive naturally.

Conversely, absence of current infection does not prove that previous tubal damage is absent.

Treatment should always be individualized.



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