

Pelvic Inflammatory Disease (PID)

Understanding Causes, Symptoms, Silent PID, Diagnosis, Antibiotic Treatment, Tubal Damage, Infertility, Ectopic Pregnancy, Sexual Health and the Supportive Role of Unani Medicine

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A Message From Dr. Nizamuddin Qasmi

When a woman comes to me with lower abdominal pain, abnormal vaginal discharge, painful intercourse or difficulty becoming pregnant, one condition I never want to overlook is:

Pelvic Inflammatory Disease — PID.

PID is important because it can sometimes be very obvious, causing severe pain and fever, but in other women it may be so mild that they do not realize an infection has reached the upper reproductive tract.

That is precisely what makes PID clinically important.

A woman may think:

“I only had mild discharge.”

Or:

“I had some pelvic discomfort for a few days and then it improved.”

Months or years later she may present because:

“Doctor, I am unable to conceive.”

In some patients, we then discover:

- damaged fallopian tubes,



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- pelvic adhesions,
- hydrosalpinx,
- a history consistent with previous pelvic infection.

My message to patients is therefore very simple:

PID should be treated early.

But another equally important fact is:

having PID does not automatically mean that a woman will become infertile.

Many women recover and later conceive naturally.

The purpose of modern PID care is to eradicate the active infection as quickly as possible, protect the reproductive organs from further injury, prevent reinfection, evaluate partners appropriately and identify women who may already have developed tubal or pelvic complications.

ACOG's patient guidance, most recently reviewed in **May 2026**, states that PID can cause long-term reproductive problems including infertility, ectopic pregnancy and chronic pelvic pain. ACOG estimates that about **1 in 10 women with PID becomes infertile**, largely because of fallopian-tube scarring.

This risk is serious—but it should be understood accurately rather than used to frighten every woman diagnosed with PID.

What Is Pelvic Inflammatory Disease?

Pelvic inflammatory disease is not a single infection in one organ.

It is a spectrum of infection and inflammation involving the:

upper female reproductive tract.

Depending upon severity and location, PID can include inflammation or infection of the: uterine lining, fallopian tubes, ovaries and surrounding pelvic tissues.

Medical terms that may be used include:

endometritis, meaning inflammation of the endometrium;

salpingitis, meaning inflammation of the fallopian tubes;

tubo-ovarian abscess, meaning an infected collection involving the fallopian tube and ovary;



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and **pelvic peritonitis**, meaning inflammation involving the pelvic lining.

CDC describes PID as this spectrum of upper-genital-tract inflammatory disorders.

In simple language:

PID occurs when infection moves upward from the vagina or cervix into reproductive organs that should normally be relatively protected.

Why PID Matters So Much

PID deserves particular attention because the fallopian tubes are delicate structures.

Their function is much more complicated than simply being “open pipes.”

A healthy tube must:

capture the egg released from the ovary, support sperm transport, provide an appropriate environment for fertilization and move the early embryo toward the uterus.

Inflammation can damage the inner lining of the tube, including the tiny cilia responsible for coordinated transport.

Healing can then lead to:

- fibrosis,
- narrowing,
- adhesions,
- complete blockage,
- hydrosalpinx.

Therefore, a woman can sometimes have a tube that appears technically “open” yet does not function normally.

This is one reason previous PID is important in infertility and ectopic-pregnancy assessment.

What Causes PID?

Two of the best-known causes are sexually transmitted infections:

Chlamydia trachomatis

and:

Neisseria gonorrhoeae.

But PID should not be understood as a disease caused only by these two organisms.

CDC notes that only approximately half of women diagnosed with acute PID test positive for either gonorrhoea or chlamydia. Bacteria associated with vaginal flora—including anaerobic organisms and *Gardnerella vaginalis*—can also be involved. Other organisms, including *Trichomonas vaginalis* and possibly *Mycoplasma genitalium*, may contribute in selected patients.

This means PID is often:

polymicrobial.

Several organisms may participate together.

Does PID Always Mean a Sexually Transmitted Infection?

No.

This point needs to be handled carefully.

Gonorrhoea and chlamydia are important causes of PID, particularly in younger sexually active populations.

But PID may also occur in association with other bacteria from the lower genital tract.

Infection can occasionally be associated with circumstances such as childbirth, miscarriage, abortion or reproductive procedures.

Therefore:

PID should not automatically be interpreted as proof of an STI or recent infidelity.

Clinical evaluation should identify the most likely cause rather than making assumptions about a patient's relationship.

Chlamydia and PID

Chlamydia is particularly important because it frequently causes:

no obvious symptoms.

A woman may therefore have cervical chlamydia without realizing it.

If infection ascends into the upper reproductive tract, salpingitis or other PID manifestations may develop.

Chlamydia is strongly associated with later:

- tubal-factor infertility,
- ectopic pregnancy.

A large cohort study involving more than 850,000 women found that women with a previous positive chlamydia diagnosis had higher subsequent rates of PID, ectopic pregnancy and female infertility than women who had tested negative; risks increased further with repeated positive infections.

This is why:

early diagnosis and treatment of chlamydia is also infertility prevention.

Gonorrhoea and PID

Gonorrhoea can cause:

- cervicitis,
- urethral symptoms,
- pelvic infection.

It can ascend from the cervix into the uterus and tubes.

Because antimicrobial resistance in gonorrhoea is an important public-health concern, treatment should follow current national or international guidance rather than older antibiotic regimens.

PID treatment must usually provide adequate gonococcal coverage even if the initial cervical gonorrhoea test is negative, because a negative lower-genital-tract test does not completely exclude infection higher in the reproductive tract.

Mycoplasma genitalium and PID

M. genitalium has become increasingly important in sexual-health medicine.

Research supports an association between *M. genitalium* and:

- cervicitis,
- endometritis,
- PID.

Its PID presentations may sometimes be comparatively mild.



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However, CDC notes that the precise benefit of routinely testing every woman with PID for *M. genitalium* remains uncertain.

This is an evolving area because:

M. genitalium antibiotic resistance is increasingly common.

Persistent PID or cervicitis symptoms after otherwise appropriate treatment may therefore require specialist reassessment rather than simply repeating the same antibiotics.

Bacterial Vaginosis and PID

Bacterial vaginosis—BV—is an imbalance in the normal vaginal bacterial environment.

BV is associated with PID.

However, the relationship is more complicated than:

“BV automatically causes PID.”

Many women with BV never develop upper reproductive-tract infection.

CDC nevertheless emphasizes the importance of anaerobic organisms in PID and includes metronidazole in recommended outpatient regimens partly to improve anaerobic coverage and simultaneously treat associated BV.

Can PID Develop After Childbirth, Miscarriage or Abortion?

Yes.

Pregnancy-related changes and instrumentation can occasionally allow bacteria to enter the upper genital tract.

A woman with significant pelvic pain, fever or abnormal discharge after:

- childbirth,
- miscarriage,
- abortion,
- uterine procedure

needs prompt assessment.

These situations should not automatically be assumed to be ordinary STI-associated PID because:



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- retained pregnancy tissue,
- endometritis,
- abscess,
- other obstetric complications

may also require investigation.

What About the Copper-T or Other IUDs?

Patients frequently believe:

“An IUD always causes PID.”

That is incorrect.

CDC states that the increased PID risk associated with intrauterine-device insertion is primarily confined to approximately:

the first three weeks after insertion.

If PID develops in a woman who already has an IUD, the device generally does **not** have to be removed immediately. Treatment should begin, with close follow-up. If the woman fails to improve within approximately 48–72 hours, removal may then be considered.

India's current STI/RTI guidance gives similar advice regarding IUD-associated PID.

Therefore:

an IUD is not a reason to withhold PID treatment, nor is automatic immediate removal always required.

Who Is More Likely to Develop PID?

PID can occur in sexually active women of different ages.

Risk is influenced by exposure to sexually transmitted pathogens, untreated cervicitis and previous PID.

A previous PID episode is especially important because:

recurrent episodes increase the probability of tubal damage.

Older long-term cohort data consistently show that reproductive risk rises with both:

- number of PID episodes,



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- severity of salpingitis.

This is why prevention of:

the second episode

can be just as important as treating the first episode.

Symptoms of Pelvic Inflammatory Disease

PID does not have one universal symptom pattern.

The commonest complaint is:

lower abdominal or pelvic pain.

But a woman may also experience abnormal vaginal discharge, bleeding between periods, bleeding after intercourse, painful intercourse, burning while passing urine, fever, nausea or general pelvic discomfort.

Symptoms can range from:

barely noticeable

to:

severe illness.

This variation is one of the reasons PID remains challenging to diagnose.

Can PID Occur Without Fever?

Yes.

A very common misconception is:

“If there is no fever, it cannot be PID.”

This is incorrect.

Fever can occur, particularly in more severe disease.

But mild or moderate PID may occur:

- without fever,
- with nonspecific symptoms.

CDC specifically notes that women with PID often have subtle symptoms and that some are asymptomatic.



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Therefore:

absence of fever does not exclude PID.

Silent or Subclinical PID

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

Some women develop inflammation of the upper reproductive tract without the classic picture of:

- severe pelvic pain,
- high fever,
- marked discharge.

CDC warns that even women with mild or apparently asymptomatic PID may remain at risk of infertility.

A woman may therefore have experienced previous upper genital-tract inflammation and only discover its consequence during:

infertility evaluation.

This is one reason STI prevention and early treatment are so important even when symptoms appear mild.

Pain During Sexual Intercourse

Deep pain during intercourse—deep dyspareunia—can occur with PID.

Inflamed pelvic organs may become tender when moved during penetration.

But dyspareunia has many other causes, including:

- endometriosis,
- pelvic-floor dysfunction,
- ovarian cysts,
- vaginal disorders,
- vulvodynia.

Therefore:

painful intercourse does not automatically diagnose PID.



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Abnormal Bleeding

PID may cause:

- bleeding between periods,
- bleeding after intercourse.

But abnormal bleeding also has other possible causes, including:

- pregnancy,
- cervical disease,
- hormonal disorders,
- polyps.

Persistent post-coital or intermenstrual bleeding deserves proper gynecological evaluation.

When PID May Be an Emergency

Some situations require urgent hospital or gynecological assessment.

Particularly concerning features include severe or rapidly worsening pelvic pain, high fever, persistent vomiting, fainting, abdominal guarding, suspected pregnancy with pain or bleeding, a pelvic mass or concern for tubo-ovarian abscess.

India's 2024 national STI/RTI guideline similarly highlights missed or overdue periods, recent childbirth or abortion, guarding or rebound tenderness, abnormal vaginal bleeding and an abdominal mass as red flags requiring higher-level assessment.

One important reason is that other emergencies can resemble PID.

These include:

ectopic pregnancy

and:

ovarian torsion.

Both can require urgent intervention.

Tubo-Ovarian Abscess



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A tubo-ovarian abscess—TOA—is one of the more serious complications of PID.

It is a collection of infected inflammatory material involving the:

- fallopian tube,
- ovary,
- surrounding tissues.

Women may experience:

- severe pain,
- fever,
- marked pelvic tenderness,
- systemic illness.

CDC includes tubo-ovarian abscess among indications for hospitalization and recommends inpatient observation with intravenous treatment in appropriate cases.

Some abscesses require:

- image-guided drainage,
- surgery

if they do not respond or if rupture is suspected.

A ruptured tubo-ovarian abscess is a medical emergency.

How Is PID Diagnosed?

There is no single perfect blood test or scan that detects every episode of PID.

The diagnosis is often:

clinical.

That means the clinician combines:

- symptoms,
- pelvic examination,
- laboratory testing,
- pregnancy testing,
- imaging when necessary.



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CDC emphasizes that no individual historical, examination or laboratory finding is simultaneously highly sensitive and highly specific for acute PID.

This is why experienced clinicians maintain:

a relatively low threshold for treatment.

Waiting until every possible test becomes abnormal may allow additional tubal damage.

Pelvic Examination

During a pelvic examination, findings that may increase suspicion include:

cervical motion tenderness,

uterine tenderness,

or:

adnexal tenderness.

CDC recommends considering presumptive treatment in an appropriate sexually active woman with pelvic or lower abdominal pain when no better explanation is found and at least one of these minimum examination findings is present.

Requiring all three findings before treatment can miss cases.

Pregnancy Test

A pregnancy test is extremely important.

Why?

Because:

ectopic pregnancy can resemble PID.

A woman with:

- pelvic pain,
- missed period,
- bleeding,
- positive pregnancy test

requires urgent assessment for pregnancy location.



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PID should never be diagnosed casually without considering ectopic pregnancy in a woman who could be pregnant.

Chlamydia and Gonorrhoea Testing

Women diagnosed with PID should be tested for:

gonorrhoea

and:

chlamydia.

NAAT molecular tests are commonly used.

However:

a negative cervical gonorrhoea or chlamydia test does not rule out PID.

CDC specifically notes that upper-genital-tract infection may still be present despite negative lower-tract testing.

Therefore, PID treatment should not be stopped solely because a cervical swab is negative.

HIV and Syphilis Testing

CDC recommends testing women diagnosed with PID for:

- HIV,
- syphilis

as part of comprehensive STI care.

India's National AIDS and STD Control Programme similarly integrates STI management with HIV and syphilis services.

A recommendation for HIV or syphilis testing does not imply that the patient has these infections.

It is part of responsible sexual-health assessment.

Blood Tests

Depending upon the situation, clinicians may request:

- complete blood count,
- CRP,
- ESR.

Elevated inflammatory markers can support the diagnosis but:

normal results do not reliably exclude mild PID.

Laboratory results should therefore be interpreted alongside the clinical picture.

Vaginal Microscopy

A wet preparation may identify:

- increased white blood cells,
- bacterial vaginosis,
- trichomoniasis.

The absence of both:

- cervical inflammation,
- vaginal white blood cells

makes acute PID less likely and should prompt consideration of another explanation.

Ultrasound

Pelvic or transvaginal ultrasonography is useful when clinicians are looking for:

- tubo-ovarian abscess,
- hydrosalpinx,
- thickened fluid-filled tubes,
- ovarian pathology,
- another cause of pelvic pain.

However:

a normal ultrasound does not exclude mild PID.

Early endometritis or mild salpingitis may not be visible.

This distinction is important because patients sometimes say:



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“My ultrasound is normal, therefore I cannot have PID.”

That conclusion is not reliable.

MRI

MRI may occasionally be used when diagnosis is uncertain or complex pelvic pathology needs further characterization.

It is not required for ordinary uncomplicated PID.

Laparoscopy

Laparoscopy allows direct inspection of the pelvis and fallopian tubes.

It can provide strong evidence of:

salpingitis.

But it is invasive and is not routinely necessary for diagnosing every woman with PID.

CDC notes that even laparoscopy may miss:

- endometritis,
- subtle tubal inflammation.

Therefore:

PID remains principally a clinical diagnosis.

Why Treatment Should Begin Early

This is perhaps the most important treatment principle.

CDC emphasizes that treatment should begin as soon as presumptive PID is diagnosed because preventing long-term complications depends upon early antimicrobial therapy.

A classic cohort study found that women who delayed seeking care for symptomatic PID were approximately:

three times more likely

to develop infertility or ectopic pregnancy than women who sought care promptly.

This study is older and modern organisms, diagnostics and treatments have changed, so its exact numerical risk should not automatically be applied to every patient today.



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But the principle remains clinically important:

do not ignore persistent pelvic symptoms when PID is possible.

Is Pelvic Inflammatory Disease Curable?

The active infection usually can be treated successfully with appropriate antibiotics.

But we need to distinguish:

curing active infection

from:

reversing old scar tissue.

ACOG explains this very clearly:

PID can be treated, but treatment **cannot reverse scarring that has already developed.**

Therefore:

antibiotics can stop ongoing bacterial damage.

They cannot guarantee restoration of a tube that has already become permanently scarred or blocked.

This is one of the most important fertility messages in this article.

Why Several Antibiotics Are Used

PID is often polymicrobial.

Treatment must therefore cover several groups of organisms, including:

- gonorrhoea,
- chlamydia,
- anaerobic bacteria.

This is why PID treatment commonly involves:

more than one antimicrobial.

Taking only one antibiotic selected casually from a pharmacy may provide incomplete coverage.



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Current CDC Outpatient Treatment

For mild-to-moderate PID suitable for outpatient treatment, current CDC guidance recommends a regimen built around:

ceftriaxone 500 mg intramuscularly once, plus doxycycline 100 mg orally twice daily for 14 days, with metronidazole 500 mg orally twice daily for 14 days.

Alternative regimens exist for selected circumstances.

This regimen is included here for medical education and should not be treated as a personal prescription.

Individual treatment depends upon factors such as:

- allergy,
- pregnancy,
- severity,
- gonorrhoea resistance,
- drug interactions.

Current Indian NACO Guidance — 2024

India's National Technical Guidelines on STI and RTI updated the management of lower abdominal pain/PID.

The 2024 recommendations use **ceftriaxone 500 mg IM as first-line gonococcal coverage, doxycycline 100 mg twice daily for 14 days and metronidazole 400 mg twice daily for 14 days**; an oral cefixime-based option is also incorporated within the national programme.

The exact regimen used in an individual woman should be selected by her clinician.

Patients should not use this article as a substitute for prescription.

Why Metronidazole Is Important

Metronidazole broadens coverage against:

anaerobic organisms.

It also treats bacterial vaginosis, which frequently coexists with PID.



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CDC notes that adding metronidazole improves eradication of anaerobic organisms from the upper genital tract.

This is why PID therapy cannot always be simplified to:

“Take doxycycline alone.”

Why the Full Course Matters

Symptoms may improve before infection has been fully treated.

Stopping medication early can allow:

- persistent infection,
- treatment failure.

ACOG specifically advises women to complete the prescribed course even when symptoms have disappeared.

When Is Hospital Treatment Needed?

Hospitalization may be appropriate when:

a surgical emergency cannot be excluded, the patient is pregnant, tubo-ovarian abscess is present, illness is severe, vomiting prevents oral treatment, high fever is present, outpatient medication cannot be tolerated or clinical improvement does not occur with outpatient therapy.

CDC provides these as major hospitalization considerations.

Hospitalized patients can receive:

- intravenous antibiotics,
 - closer monitoring,
 - drainage or surgery if required.
-

PID During Pregnancy

Suspected PID in pregnancy deserves particular caution.

Pregnancy itself changes the differential diagnosis of pelvic pain, and serious conditions including:

- ectopic pregnancy,



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- obstetric infection

must be considered.

CDC lists pregnancy among indications for hospitalization when PID is diagnosed.

India's national STI guidance similarly recommends hospital treatment with parenteral therapy for pregnant women diagnosed with PID.

Pregnant women should therefore never self-treat suspected PID.

Follow-Up After Starting Treatment

A woman treated as an outpatient should start showing clinical improvement within approximately:

72 hours.

Improvement includes:

- less fever,
- reduced abdominal/pelvic tenderness,
- reduced cervical-motion or adnexal tenderness.

If meaningful improvement does not occur within three days, CDC recommends:

- reassessment of the diagnosis,
- review of the antimicrobial regimen,
- possible hospitalization,
- additional diagnostic investigation.

This is not a condition where a patient should simply continue ineffective tablets for weeks.

Should the Sexual Partner Be Treated?

Yes, partner management is extremely important when STI-associated PID is possible.

CDC recommends that sexual partners from the:

60 days before symptom onset

be evaluated, tested and presumptively treated for:

- chlamydia,



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- gonorrhoea,

even when the exact organism causing PID has not been isolated.

Why?

Because partners can be:

completely asymptomatic.

Treating only the woman can lead to reinfection.

When Can Sexual Intercourse Resume?

Sexual intercourse should generally be avoided until:

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

This is recommended by CDC to reduce transmission and reinfection.

This temporary abstinence should not be confused with the idea that a woman who once had PID can never again have normal sexual relations.

Retesting After Chlamydial or Gonococcal PID

Women whose PID is associated with:

- chlamydia,
- gonorrhoea

should generally be retested approximately:

three months after treatment,

even when their partner was reportedly treated.

This is because reinfection is common.

Preventing recurrent infection is one of the most important methods of protecting fertility.

Can PID Come Back?

Yes.



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A woman can experience:

recurrent PID.

Each episode matters.

Classic long-term data show that tubal infertility risk rises substantially with:

- repeated episodes,
- greater initial disease severity.

Although these studies are older, the biological principle remains relevant:

repeated tubal inflammation can produce cumulative damage.

This is why partner treatment, STI prevention and retesting are clinically important.

PID and Infertility

This is the question patients ask me most often:

“Doctor, will I still be able to become pregnant?”

My answer is:

many women with a history of PID do become pregnant naturally.

PID does not equal infertility.

But PID does increase the risk of:

tubal-factor infertility.

ACOG estimates that about:

one in ten women with PID

develops infertility.

Individual risk is not identical for every woman.

It depends upon factors such as:

- severity,
- number of episodes,
- time before treatment,
- whether salpingitis occurred,
- presence of abscess or hydrosalpinx.



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What Do Long-Term Studies Show?

One classic Scandinavian cohort followed women with laparoscopically confirmed PID.

Among women attempting pregnancy, approximately **10.8% developed confirmed tubal-factor infertility** after PID. Risk increased markedly with repeated episodes and increasing severity.

These data come from earlier decades and should not be treated as a precise prediction for every woman receiving modern care today.

However, they remain important because they demonstrate clearly that:

the number and severity of PID episodes matter.

One Episode Does Not Mean Permanent Infertility

I want patients to understand this clearly.

A woman may have:

- mild PID,
- prompt treatment,
- preserved tubal function

and later conceive normally.

Therefore:

do not assume infertility before fertility has actually been assessed.

Fear itself can significantly damage sexual relationships and delay attempts at conception unnecessarily.

How Does PID Damage the Fallopian Tubes?

During salpingitis, inflammation can damage:

the tubal epithelium.

The body's healing process may then produce:

- fibrosis,
- adhesions,



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- distortion of the fimbriae,
- narrowing,
- complete occlusion.

Scarring may also develop around the outside of the tube, causing:

peritubal adhesions.

These adhesions can interfere with the normal relationship between the:

- ovary,
- fimbrial end of the tube.

An “Open” Tube May Not Always Be a Normal Tube

This point is extremely important.

A fallopian tube is not simply:

open or closed.

A tube may allow contrast to pass during an HSG yet still have:

- ciliary damage,
- fimbrial damage,
- adhesions,
- impaired transport.

Therefore:

tubal patency does not always equal normal tubal function.

This helps explain why some women conceive with apparently abnormal tubes while others struggle despite technically patent tubes.

What Is Hydrosalpinx?

Hydrosalpinx means:

a fallopian tube that has become blocked and distended with fluid.

Previous PID is an important cause.

Hydrosalpinx matters because it can reduce the likelihood of:



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- natural conception,
- successful embryo implantation during IVF.

When hydrosalpinx is identified in a woman requiring fertility treatment, specialist reproductive management is often necessary.

WHO's first global infertility guideline, published in **November 2025**, includes dedicated recommendations for the treatment of tubal disease and hydrosalpinx.

PID and Ectopic Pregnancy

A fertilized embryo normally travels through the fallopian tube into the uterine cavity.

If the tube has been damaged:

embryo transport may become impaired.

The pregnancy can then implant within the tube.

This is called:

ectopic pregnancy.

ACOG identifies previous PID and fallopian-tube scarring as important mechanisms increasing ectopic-pregnancy risk.

A woman with previous PID who later becomes pregnant should seek urgent medical care if she develops:

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

Ectopic pregnancy can rupture and cause life-threatening internal bleeding.

PID and Chronic Pelvic Pain

Not every consequence of PID is infertility.

Some women develop:

chronic pelvic pain.



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Pain may be related to:

- adhesions,
- previous inflammatory damage,
- pelvic-floor muscle tension,
- associated conditions.

Once active infection is eradicated, repeated antibiotics are not necessarily useful for chronic post-PID pain.

This is where broader sexual-health and pelvic-pain management becomes important.

PID and Painful Intercourse

Deep dyspareunia may persist after PID in some women.

Possible reasons include:

- pelvic adhesions,
- residual tenderness,
- chronic pelvic pain,
- pelvic-floor dysfunction,
- psychological fear after a painful infection.

At Saira Health Care, I believe it is important to ask not only:

“Is the infection gone?”

but also:

“Has comfortable sexual function returned?”

When Should Fertility Be Evaluated After PID?

There is no reason to perform a full infertility work-up on every woman immediately after one successfully treated episode.

However, a history strongly associated with tubal infertility can justify earlier evaluation in appropriate cases.

ASRM recommends beginning infertility investigation without unnecessary delay when a woman has a known medical history associated with infertility, rather than always



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waiting the full routine interval. It also recommends evaluating both partners in parallel when applicable.

Earlier assessment may be particularly reasonable when there is:

- recurrent PID,
- known hydrosalpinx,
- previous ectopic pregnancy,
- significant salpingitis or tubo-ovarian abscess,
- other established infertility factors.

How Are the Fallopian Tubes Checked?

A common test is:

Hysterosalpingography — HSG.

Contrast dye is introduced through the cervix and X-rays are used to evaluate:

- uterine cavity,
- whether contrast passes through the tubes.

Another option is:

hysterosalpingo-contrast sonography — HyCoSy,

which uses ultrasound contrast.

Current ASRM guidance recognizes both HSG and contrast sonographic methods as methods of evaluating tubal patency.

WHO's 2025 infertility guideline similarly provides evidence-based pathways for diagnosing and treating tubal infertility.

Does Every Woman With Previous PID Need Laparoscopy?

No.

Laparoscopy is not recommended routinely merely because a woman has infertility.

ASRM notes that laparoscopy can directly identify:

- peritubal adhesions,
- pelvic pathology



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but should generally be reserved for situations where another clinical indication exists or where additional surgical assessment is justified.

Less invasive tests usually come first.

Infertility After PID Is a Couple's Evaluation

This point is fundamental.

Suppose a woman has previous PID and cannot conceive.

It would be easy to say:

“Your tubes are the problem.”

But her husband or partner may simultaneously have:

- low sperm count,
- poor motility,
- another male factor.

Therefore, infertility assessment should include:

female reproductive evaluation

and:

semen analysis of the male partner.

ASRM specifically recommends parallel evaluation of the male partner when relevant.

At Saira Health Care, this couple-based approach is especially important because my focused clinical practice includes both:

male and female infertility.

What If One Tube Is Blocked?

Pregnancy may still occur naturally if:

- the opposite tube is functional,
- ovulation occurs,
- sperm quality is adequate,
- no other significant infertility factor exists.

Therefore:



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unilateral tubal blockage does not automatically mean IVF is required.

Treatment decisions depend upon:

- age,
- location and severity of tubal disease,
- duration of infertility,
- ovarian reserve,
- semen quality.

What If Both Tubes Are Severely Damaged?

When there is severe bilateral tubal disease, spontaneous conception becomes much less likely.

In selected women:

IVF

can bypass the fallopian tubes because fertilization occurs outside the body and the embryo is transferred directly into the uterus.

WHO's 2025 infertility guideline now provides specific recommendations balancing:

- tubal surgery,
- IVF

according to the woman's age and severity of tubal disease. For women under 35 with mild-to-moderate tubal disease, WHO conditionally suggests tubal surgery before IVF, whereas more severe tubal disease may favour IVF.

These decisions require individualized reproductive counselling.

Does PID Mean I Need ICSI?

No.

ICSI means:

intracytoplasmic sperm injection.

It is primarily a fertilization technique used for:

- important male-factor infertility,



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- selected previous fertilization problems.

Tubal infertility alone does not automatically mean ICSI is necessary.

Standard IVF may be sufficient when sperm quality is appropriate.

Antibiotics Cannot “Open” a Scarred Tube

This is one of the most important misconceptions to correct.

If a tube is blocked because of:

active inflammatory swelling,

the appearance may change after infection is treated.

But when permanent:

- fibrosis,
- dense adhesions,
- structural occlusion

have developed:

antibiotics cannot mechanically reopen the scar.

Likewise, repeatedly prescribing antibiotics months after the active infection is gone does not treat established tubal infertility.

At that stage, the question changes from:

“Which antibiotic?”

to:

“What does the fertility evaluation show?”

Can Unani Medicine Open Blocked Fallopian Tubes?

I approach this question very carefully.

Some women report pregnancy after traditional or integrative treatment.

But pregnancy after treatment does not by itself prove that a previously documented tubal blockage was biologically reversed.

For example, a woman with:

- one blocked tube,



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- one patent tube

can conceive naturally through the patent tube.

Some HSG findings also represent temporary tubal spasm rather than permanent obstruction.

Therefore:

it is not scientifically responsible to promise that an herbal or Unani medicine can reopen every structurally scarred fallopian tube.

Dense post-inflammatory fibrosis may require:

- surgical treatment,
- assisted reproduction.

The Unani Perspective on Pelvic Inflammatory Disease

As a physician trained in **Unani medicine**, I also value the traditional understanding of reproductive-tract inflammation.

Unani literature contains concepts describing inflammatory disease of the uterus and female reproductive organs, including conditions discussed under terms such as:

Warm-e-Rahim

and related inflammatory gynecological conditions.

The traditional approach may consider:

- Mizaj or constitutional temperament,
- inflammation,
- abnormal discharge,
- pelvic discomfort,
- digestive health,
- nutrition,
- general reproductive wellbeing.

These principles can provide a useful whole-person framework.

But modern medicine has added something critically important:



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we can identify specific bacterial pathogens and understand how ascending infection damages the fallopian tubes.

Therefore, modern antimicrobial treatment and traditional supportive medicine should not be confused.

How Unani Medicine May Be Useful in PID

Where clinically appropriate, individualized Unani care may contribute to:

- general recovery,
- nutritional wellbeing,
- digestive health,
- physical strength,
- sexual wellbeing,
- pelvic comfort after acute infection has been appropriately treated.

It may also be valuable in addressing broader problems such as:

- recurrent nonspecific discharge,
- post-infectious discomfort,
- disturbed sleep,
- anxiety,
- sexual avoidance.

The role should be:

integrative and supportive.

Direct Clinical Research on Unani Treatment for PID

Unlike many traditional-medicine topics where direct clinical evidence is almost absent, there have been some randomized studies from India's **National Institute of Unani Medicine** examining traditional formulations in:

uncomplicated PID.

This is scientifically interesting and deserves acknowledgement.



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Linseed, Psyllium and Honey Study

A 2023 randomized controlled study from the National Institute of Unani Medicine evaluated **66 women with uncomplicated PID**.

The intervention involved a vaginal pessary prepared from:

- *Linum usitatissimum* — linseed,
- *Plantago ovata* — psyllium,
- honey.

It was compared with an oral standard-treatment group receiving doxycycline and metronidazole.

The investigators reported improvements in:

- vaginal discharge,
- lower abdominal pain,
- backache,
- pelvic tenderness,
- quality of life.

This is valuable because it represents actual randomized clinical research rather than simply repeating historical claims.

But the Linseed–Psyllium Study Has Important Limitations

The same researchers explicitly acknowledged major limitations.

The study was:

- small,
- single-centre,
- limited to uncomplicated disease,
- short-term.

Most importantly:

NAAT testing, cervical microbiological testing and endometrial biopsy were not used to establish microbiological eradication or histological cure.

The trial also did not determine whether the treatment prevented:



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- fallopian-tube scarring,
- infertility,
- ectopic pregnancy.

Therefore, improvement in:

pain and discharge

cannot automatically be interpreted as proof that sexually transmitted organisms were eradicated from the upper reproductive tract.

Black Sesame and Rose Oil Study

A second randomized, double-blind, double-dummy study from the National Institute of Unani Medicine evaluated **60 women with uncomplicated PID**.

The intervention used:

- black sesame seed preparation,
- rose oil

vaginally and compared it with doxycycline plus metronidazole.

The investigators reported comparable improvement in several clinical symptom scores and vaginal inflammatory-cell findings over the short study period.

Again, this is useful preliminary evidence and supports further study of Unani interventions.

But it should not be overinterpreted.

What These Unani Trials Do Not Prove

These trials do not establish that the studied treatments:

- eradicate gonorrhoea,
- eradicate chlamydia,
- eradicate M. genitalium,
- prevent tubo-ovarian abscess,
- reverse tubal scarring,
- restore fertility,



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- prevent ectopic pregnancy.

The trials were designed primarily around:

short-term uncomplicated PID symptoms.

Current CDC, ACOG and Indian national guidance continues to recommend:

broad-spectrum antimicrobial treatment for active PID.

Therefore:

Unani care should not replace indicated antibiotics in confirmed or clinically suspected acute bacterial PID.

Why I Still Consider the Unani Research Important

Scientific medicine should not dismiss promising research merely because it comes from a traditional system.

The correct approach is:

study it properly.

The existing Unani trials justify larger studies using modern outcomes such as:

- chlamydia NAAT,
- gonorrhoea NAAT,
- Mgen testing,
- endometrial evidence,
- recurrent PID rates,
- tubal patency,
- ectopic pregnancy,
- natural conception,
- live birth.

Until that evidence exists:

symptom improvement should not be called proven infection eradication.

That distinction protects both:

- patients,
- the credibility of Unani medicine.



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Can Unani Treatment Replace Antibiotics in Acute PID?

My answer is:

not on the basis of current evidence.

PID can produce irreversible reproductive damage.

Therefore, a woman with clinically suspected acute bacterial PID should not lose valuable time trying only:

- vaginal herbal preparations,
- decoctions,
- general tonics.

Current antibiotic treatment should begin promptly when clinically indicated.

Unani treatment can then be integrated carefully for:

- supportive care,
- recovery,
- broader reproductive health.

Unani Medicine After the Active Infection Has Been Treated

The role can become different after:

- fever has resolved,
- acute infection has been treated,
- dangerous complications have been excluded.

Some women continue to experience:

- mild pelvic discomfort,
- weakness,
- digestive complaints,
- reduced sexual confidence.

Individualized supportive Unani treatment may be useful within an integrative plan.

If infertility remains, however:

objective fertility testing should proceed.

The patient should not spend months repeatedly treating a presumed “internal infection” when:

- a hydrosalpinx,
- blocked tube,
- male infertility,
- diminished ovarian reserve

may be the actual fertility problem.

Special Treatment Planning by Dr. Nizamuddin Qasmi

When a patient consults me for PID, I do not regard every case as identical.

The first question is:

“Is there active PID now?”

Then I consider:

How severe are the symptoms?

Could she be pregnant?

Could this be an ectopic pregnancy?

Could a tubo-ovarian abscess be present?

Have gonorrhoea and chlamydia been tested?

Is HIV or syphilis testing indicated?

Has the partner been evaluated?

Has she had PID before?

Is she trying to conceive?

Has infertility already been present for months or years?

This distinction is critical.

A woman with:

active acute PID

needs infection treatment.



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A woman with:

infertility five years after PID

does not necessarily need another antibiotic course.

She may need:

- HSG or HyCoSy,
- ultrasound,
- ovarian assessment,
- male semen analysis.

What “Special Treatment” Means at Saira Health Care

At **Saira Health Care**, specialized management does not mean one secret medicine for every woman.

It means:

diagnosis-led, couple-based and fertility-conscious treatment.

The goal is to answer several separate questions:

Is infection active?

Has structural damage developed?

Are the fallopian tubes functional?

Is there a male fertility factor?

Is sexual pain continuing?

Is the woman losing valuable reproductive time through repeated empirical treatment?

This approach is particularly important because of my focused clinical work in:

Sexual Disorders & Infertility.

Patient Example — First Mild Episode of PID

A young woman develops:

- lower abdominal pain,
- cervical-motion tenderness,



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- abnormal discharge.

The priority is:

prompt antibiotic treatment.

Waiting several weeks for every possible investigation could unnecessarily increase reproductive risk.

Patient Example — Severe PID With Fever and Vomiting

This woman may need:

- hospitalization,
- intravenous treatment,
- ultrasound,
- evaluation for abscess or another surgical emergency.

She should not be treated at home with only painkillers or herbal medicines.

Patient Example — Recurrent PID

If PID keeps returning, I ask:

Was the sexual partner treated?

Was chlamydia or gonorrhoea retesting completed?

Did a new infection occur?

Is *M. genitalium* relevant?

Could the diagnosis actually be endometriosis or another pelvic disorder?

Repeated episodes deserve deeper investigation rather than repeated identical prescriptions.

Patient Example — Previous PID but No Current Symptoms

A woman had PID two years ago.

She now feels completely well.

She does **not** need indefinite antibiotics.

If she is not trying for pregnancy, no infertility treatment is automatically necessary.



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If she later develops difficulty conceiving:

evaluate fertility objectively.

Patient Example — Infertility After PID

A woman has been trying to conceive and has a significant previous PID history.

Now the primary question is:

tubal status.

Depending upon age and circumstances, investigations may include:

- HSG,
- HyCoSy.

But I also evaluate:

- ovulation,
- ovarian reserve where appropriate,
- uterus,
- male partner's semen.

This is much more useful than repeatedly treating an old infection.

Patient Example — Hydrosalpinx

A woman with significant hydrosalpinx is not experiencing simply an “infection that needs stronger medicine.”

Hydrosalpinx is:

structural tubal disease.

She requires reproductive-medicine assessment regarding:

- natural-conception prognosis,
- surgical options,
- IVF when appropriate.

Her treatment cannot be reduced to antibiotics or herbal tonics.



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Patient Example — Pelvic Pain After Infection Is Gone

If the infection has been appropriately treated but intercourse remains painful, I consider:

- adhesions,
- endometriosis,
- pelvic-floor dysfunction,
- chronic pelvic pain.

This distinction prevents unnecessary repeated antibiotics.

Supportive Unani care, pelvic-floor management and sexual-health counselling may then become more relevant.

Prevention of PID

Prevention is one of the most effective fertility treatments we have.

PID prevention includes:

preventing and treating sexually transmitted infections before they ascend.

CDC notes that screening and treating sexually active women for:

- chlamydia,
- gonorrhoea

reduces their risk of PID.

Condom use also reduces STI transmission risk.

Early treatment protects not only current health but potentially:

future fertility.

Why Partner Treatment Is Fertility Protection

If the partner remains infected, a woman can be reinfected after completing treatment.

Repeated infection can mean:

repeated inflammation.

Repeated inflammation can mean:

greater probability of tubal damage.



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Partner management is therefore not simply about preventing discharge.

It can be:

long-term reproductive protection.

Can PID Be Prevented After Chlamydia Is Found?

Treating chlamydia before upper-tract infection develops is an important prevention strategy.

This is why screening recommendations for sexually active young women and others at risk exist in many healthcare systems.

Once salpingitis has already produced scarring, however:

treatment cannot undo every structural consequence.

Again:

early treatment matters.

Emotional and Sexual Impact of PID

PID affects more than fallopian tubes.

Some women become afraid that sexual intercourse will:

- trigger pain,
- cause another infection,
- worsen infertility.

Others experience:

- guilt,
- relationship conflict,
- loss of sexual confidence.

This emotional burden should not be ignored.

A woman who has completed treatment should receive accurate counselling about:

- reinfection prevention,
- partner health,
- fertility,



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- resuming sexual activity.

PID Does Not Mean a Woman Is “Unclean”

Because PID is associated with STIs, some patients experience stigma.

This can delay medical care.

The reproductive tract is susceptible to infection for biological reasons.

Medical treatment should be:

confidential, respectful and nonjudgmental.

Fear of social judgement should never prevent a woman from seeking timely PID treatment.

Does PID Prove Infidelity?

No.

The diagnosis alone cannot reliably determine:

- when an infection occurred,
- who acquired it first.

And PID is not always caused by an STI.

Clinical care should focus on:

- diagnosis,
- partner management,
- prevention

rather than accusations.

Can PID Be Caused by Poor Hygiene?

PID is not simply the result of:

- “not being clean enough.”

Overaggressive vaginal cleansing or douching can itself disturb the vaginal environment.

Patients should not use harsh:



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- antiseptics,
- caustic herbal washes,
- chemicals

inside the vagina in an attempt to “sterilize” the reproductive tract.

Vaginal Douching and Self-Treatment

The vagina has a natural microbiological environment.

Repeated use of:

- strong antiseptic washes,
- unstandardized herbal preparations,
- irritant substances

may disturb that environment or cause local inflammation.

No vaginal wash can replace systemic treatment when infection has reached:

- uterus,
- fallopian tubes.

PID is an:

upper reproductive-tract disease.

Frequently Asked Questions

Is pelvic inflammatory disease an STI?

PID itself is an upper reproductive-tract inflammatory syndrome.

Gonorrhoea and chlamydia are major causes, but non-STI vaginal bacteria can also contribute.

Can PID occur with no symptoms?

Yes.

Mild and subclinical disease can occur, and even these women may have reproductive risk.

Does PID always cause fever?

No.



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What is the most common symptom?

Lower abdominal or pelvic pain is the commonest clinical complaint.

Can PID cause abnormal discharge?

Yes.

Can PID cause bleeding after sex?

Yes, particularly when cervicitis accompanies the infection, but other cervical causes must also be considered.

Can PID cause painful intercourse?

Yes.

Deep pelvic pain during intercourse is a recognized symptom.

Can PID cause back pain?

Pelvic inflammation can sometimes be experienced as lower pelvic or low-back discomfort, although back pain is nonspecific.

Can PID cause infertility?

Yes.

Tubal scarring can lead to infertility. ACOG estimates that approximately one in ten women with PID becomes infertile.

Does every woman with PID become infertile?

No.

Most do not automatically become infertile.

Does one mild episode permanently damage the tubes?

Not necessarily.

Risk varies with severity, treatment timing and repeated episodes.

Do repeated PID episodes increase infertility risk?

Yes.

Long-term cohort data demonstrate substantially increasing tubal infertility risk with repeated and more severe disease.

Why is early treatment important?

Delayed care has been associated with greater infertility and ectopic-pregnancy risk, and antibiotics cannot reverse established scar tissue.

Can PID cause ectopic pregnancy?

Yes.

Tubal damage can impair embryo transport and increase ectopic-pregnancy risk.

Can PID cause chronic pelvic pain?

Yes.

What is silent PID?

Upper reproductive-tract inflammation that produces very mild or unrecognized symptoms.

Can normal ultrasound rule out PID?

No.

Mild disease may not produce obvious ultrasound abnormalities.

What does ultrasound help find?

Ultrasound is particularly useful for identifying problems such as tubo-ovarian abscess, hydrosalpinx and alternative pelvic pathology.

What does cervical-motion tenderness mean?

It is pain produced when the cervix is moved during examination and is one of the minimum clinical findings that can support presumptive PID treatment.

If chlamydia and gonorrhoea tests are negative, can I still have PID?

Yes.

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

Do I need an HIV test?

Current PID management generally includes HIV and syphilis testing as part of comprehensive STI care.

What antibiotics treat PID?

Treatment requires broad antimicrobial coverage, commonly including a cephalosporin, doxycycline and metronidazole in outpatient regimens.

What does India's current guideline recommend?



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India's 2024 NACO guideline uses ceftriaxone 500 mg IM once with doxycycline for 14 days and metronidazole for 14 days as updated first-line components for lower-abdominal-pain/PID management, with programme alternatives also described.

Can I treat PID with doxycycline alone?

Not usually.

PID requires broader coverage because it is often polymicrobial.

How soon should symptoms improve?

Clinical improvement should generally begin within about 72 hours after treatment starts. Failure to improve requires reassessment.

Can I stop antibiotics when the pain disappears?

No.

Complete the prescribed course.

Should my husband or sexual partner be treated?

Partners from the preceding 60 days should generally be evaluated and presumptively treated for gonorrhoea and chlamydia when a woman has PID.

Can we have intercourse during treatment?

Sex should generally be avoided until treatment is completed, symptoms have resolved and relevant partners have been treated.

Should I be retested?

Women with chlamydial or gonococcal PID should generally be retested approximately three months after treatment.

Does an IUD need to be removed?

Usually not immediately.

PID can generally be treated while the IUD remains in place, with reassessment in 48–72 hours.

Does an IUD cause long-term PID risk?

The increased PID risk associated with insertion is primarily confined to the first approximately three weeks.

Can PID occur during pregnancy?

Yes, but suspected PID in pregnancy requires specialist/hospital assessment because alternative diagnoses and pregnancy complications must be considered.



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What is a tubo-ovarian abscess?

A serious collection of infection involving the fallopian tube and ovary.

Is a tubo-ovarian abscess dangerous?

It can be.

Hospitalization, IV antibiotics and occasionally drainage or surgery may be required.

Can antibiotics open blocked fallopian tubes?

Antibiotics treat active infection.

They do not reliably reverse permanent fibrosis or dense scar-related blockage.

How do we check the tubes after PID?

HSG and hysterosalpingo-contrast sonographic methods such as HyCoSy can be used to evaluate tubal patency.

Does a patent tube mean the tube is completely normal?

Not necessarily.

A tube can allow contrast to pass yet still have functional ciliary or fimbrial damage.

What is hydrosalpinx?

A blocked, fluid-filled fallopian tube, commonly associated with previous infection or inflammation.

Does hydrosalpinx affect IVF?

Yes.

Hydrosalpinx can negatively influence implantation and often requires specialist management before embryo transfer.

Do I automatically need IVF after PID?

No.

Many women conceive naturally.

Treatment depends upon age, tubal condition, duration of infertility, ovarian factors and male semen findings.

If both tubes are badly damaged, can IVF help?

Yes.



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IVF bypasses the fallopian tubes and is an important option in severe tubal-factor infertility.

Does tubal infertility automatically require ICSI?

No.

ICSI is mainly used for appropriate male-factor or fertilization indications.

Should my husband have a semen analysis?

If the couple has infertility, yes—male and female evaluation should proceed in parallel.

Can Unani medicine help PID?

Unani medicine may have a useful supportive role in carefully selected uncomplicated cases and in recovery, nutrition, pelvic comfort and overall reproductive wellbeing.

Small randomized studies from India's National Institute of Unani Medicine have reported improvement in uncomplicated PID symptoms using formulations involving linseed, psyllium and honey or black sesame with rose oil.

Do these Unani studies prove that antibiotics are unnecessary?

No.

The studies were small and primarily measured short-term symptoms. One explicitly lacked NAAT, microbiological and histological confirmation of eradication. They did not establish prevention of tubal infertility or ectopic pregnancy.

Can Unani medicine permanently reopen scarred fallopian tubes?

There is currently insufficient high-quality evidence to promise that Unani medicines can reverse established dense post-PID tubal fibrosis.

Can Unani medicine be taken with modern PID treatment?

Individualized supportive Unani care may be incorporated where clinically appropriate, provided it does not delay or interfere with necessary antimicrobial, gynecological or fertility treatment.

My Message to a Woman Newly Diagnosed With PID

If you have just been diagnosed with PID, I want you to remember four things.

First:

take the infection seriously.

Second:

do not automatically assume you will become infertile.

Third:

complete treatment and make sure the partner issue is addressed.

Fourth:

seek reassessment if you are not improving within approximately three days.

That approach is far more valuable than living in fear of future infertility.

My Message to a Woman With Infertility After Previous PID

If the infection occurred years ago and you now have difficulty conceiving:

do not keep repeating antibiotics without evidence of active infection.

Now I want to know:

Are the fallopian tubes patent?

Is hydrosalpinx present?

Are you ovulating?

What is your age and ovarian reserve where relevant?

What does your partner's semen analysis show?

This is the stage where:

fertility diagnosis—not repeated infection treatment—is needed.

My Message About Unani Medicine

As a Unani physician, I believe traditional medicine can make a valuable contribution when used responsibly.

I also believe that the credibility of Unani medicine increases when we clearly distinguish:

what is supported by evidence

from:

what still requires research.

The randomized Unani studies in uncomplicated PID are encouraging.

They justify:



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- larger trials,
- modern microbiological testing,
- longer fertility follow-up.

But until such evidence exists, I do not believe a woman with clinically significant acute bacterial PID should be advised to abandon established antibiotic treatment.

My preferred model is:

evidence-based infection treatment + carefully selected Unani supportive care + fertility-focused follow-up.

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, PID is particularly important because it lies directly at the intersection of:

infection, sexual health and fertility.

Our clinical focus is not limited to:

“Did the pelvic pain improve?”

We also consider:

Has the sexual partner been managed?

Is painful intercourse continuing?

Has the woman experienced repeated PID?

Is pregnancy now being planned?

Does she need tubal assessment?

Does the male partner have a semen abnormality?

This is important because fertility belongs to:

the couple.

A history of PID in the woman should never cause clinicians to forget:

the man's fertility evaluation.

Dr. Nizamuddin Qasmi's Specialized Clinical Approach



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In my focused practice in **Sexual Disorders & Infertility**, the management pathway can be summarized as:

active infection must be treated promptly;

severe disease must be recognized early;

sexual partners must be managed appropriately;

recurrent infection should be prevented;

old structural damage should be distinguished from ongoing infection;

infertility should be evaluated objectively and as a couple;

Unani medicine should be integrated responsibly where clinically useful.

This distinction between:

active infection

and:

post-infectious reproductive damage

is one of the most important aspects of good PID care.

Current Medical Understanding — 2026 Update

The medical understanding of PID in 2026 supports several clear conclusions.

PID remains a spectrum of upper female reproductive-tract inflammation rather than one single infection. Approximately half of acute PID patients may test positive for gonorrhoea or chlamydia, meaning other organisms and polymicrobial infection matter.

PID can be mild or clinically silent, and absence of severe symptoms does not guarantee absence of reproductive risk.

Current ACOG guidance, reviewed in **May 2026**, continues to estimate infertility in approximately one in ten women after PID and emphasizes that antibiotic treatment cannot reverse established fallopian-tube scarring.

Early treatment remains essential. Historical cohort evidence showed roughly a threefold increase in infertility or ectopic pregnancy among women who delayed PID care.

Current CDC outpatient management continues to use ceftriaxone with 14 days of doxycycline and metronidazole, providing broad treatment against gonorrhoea, chlamydia and anaerobic organisms.

India's updated **2024 NACO STI/RTI guideline** similarly uses broad treatment for lower-abdominal-pain/PID syndrome and emphasizes follow-up, partner treatment and referral when there is inadequate response.

The **WHO 2025 infertility guideline**, the first global WHO guideline dedicated to infertility, now provides evidence-based pathways for tubal-factor infertility, including choices between tubal surgery and IVF according to disease severity, age and clinical circumstances.

Unani clinical research in uncomplicated PID is growing. Small randomized trials from India's National Institute of Unani Medicine have reported clinically promising symptom improvement using traditional formulations.

But these studies do not yet establish reliable microbiological eradication, prevention of tubal scarring or restoration of fertility.

Therefore:

modern PID care should remain infection-directed during active disease and fertility-directed after permanent reproductive damage is suspected.

Conclusion

Pelvic inflammatory disease is an infection and inflammatory condition of the upper female reproductive tract involving structures such as the uterus, fallopian tubes, ovaries and surrounding pelvic tissues.

It can range from:

mild or almost silent disease

to:

severe pelvic infection with tubo-ovarian abscess.

The most important causes include:

- *Chlamydia trachomatis*,
- *Neisseria gonorrhoeae*,
- anaerobic and other vaginal organisms.

M. genitalium is also an increasingly recognized possible contributor.

Women may experience:

- lower abdominal pain,



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- abnormal discharge,
- painful intercourse,
- abnormal bleeding,
- dysuria,
- fever.

But:

PID can occur without fever and can sometimes be almost asymptomatic.

Because reproductive damage can occur even with comparatively mild disease, clinicians should not require an extreme presentation before considering treatment.

Diagnosis is principally clinical.

A woman with pelvic pain may need:

- pregnancy testing,
- pelvic examination,
- gonorrhoea and chlamydia NAAT,
- HIV/syphilis assessment,
- ultrasound when indicated.

Negative gonorrhoea or chlamydia cervical tests do not completely exclude PID.

Treatment should begin promptly.

Current international and Indian guidance recommends broad antimicrobial coverage rather than one narrow antibiotic.

Patients should improve within approximately:

72 hours.

Failure to improve requires reassessment.

Sexual partners need appropriate evaluation and treatment.

Women with gonococcal or chlamydial PID should generally be retested approximately:
three months later.

The most important long-term concern is:

fallopian-tube damage.

ACOG estimates that roughly one in ten women with PID becomes infertile.



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But this also means:

the majority do not automatically become infertile.

Risk is influenced by:

- severity,
- delay in treatment,
- repeated PID,
- presence of tubal disease.

If infertility occurs after PID, treatment must move beyond repeated antibiotics.

Appropriate evaluation may include:

HSG or HyCoSy for tubal patency,

along with evaluation of:

- ovulation,
- ovarian reserve where indicated,
- uterine factors,
- male semen quality.

A tube that is permanently scarred will not necessarily reopen because infection is treated.

Severe bilateral tubal damage may require:

- reproductive surgery in carefully selected patients,
- IVF.

WHO's 2025 infertility guideline provides a structured approach to these choices.

From the **Unani perspective**, traditional medicine offers a broader reproductive-health framework incorporating:

- Mizaj,
- nutrition,
- digestion,
- pelvic comfort,
- sexual wellbeing,
- recovery.



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Clinical research from the National Institute of Unani Medicine has produced encouraging early findings in uncomplicated PID using formulations such as linseed, psyllium and honey and black sesame with rose oil.

These studies are valuable and should encourage further scientific research.

However:

they should not presently be interpreted as proof that Unani medicines can replace antibiotic therapy during active PID or reverse established fallopian-tube scarring.

At **Saira Health Care**, my preferred approach is therefore:

identify PID early, treat the active infection properly, protect the partner, prevent recurrence, distinguish persistent infection from old tubal damage, investigate infertility as a couple and use individualized Unani medicine responsibly as supportive integrative care.

My final message to every woman is:

PID is treatable, and a diagnosis does not mean that you will become infertile.

But:

treatment should not be delayed.

And if infertility develops afterward:

investigate the fallopian tubes and the complete couple rather than repeatedly treating an infection that may already have resolved.

That distinction can save valuable reproductive time and help us choose the right treatment for the right stage of the disease.

About the Author

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Qualifications & Professional Training

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Dr. Nizamuddin Qasmi is a well-qualified physician with a **specialized clinical focus on Sexual Disorders & Infertility** at Saira Health Care.

His work particularly focuses on the connection between:

sexual health, reproductive infection and fertility.

In women with PID or a previous history of pelvic infection, his clinical approach emphasizes identifying whether there is current active infection or whether the woman's present problem is related to previous reproductive damage.

Depending upon the patient, assessment may include review of STI history and previous treatment, pelvic and reproductive symptoms, partner-management needs, fertility history, tubal evaluation, ovarian and uterine factors and parallel male-partner semen assessment.

Where clinically appropriate, individualized Unani principles may be incorporated to support:

- nutrition,
- digestion,
- general wellbeing,
- sexual health,
- recovery after appropriate infection treatment.

The aim at Saira Health Care is not simply to prescribe medicines for pelvic pain.

The aim is to answer:

Is the infection still active?

Has reproductive damage occurred?

Can natural pregnancy still occur?

Does the couple need fertility treatment?

and:

How can the woman's overall sexual and reproductive health be restored safely?

Medical Disclaimer



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This article is intended for professional education and general public health awareness. It does not establish an individual diagnosis and does not replace examination by an appropriately qualified physician, gynecologist, sexual-health clinician or fertility specialist.

Pelvic or lower-abdominal pain can have causes other than PID, including ectopic pregnancy, appendicitis, ovarian torsion, ovarian cysts, endometriosis and urinary or gastrointestinal disease.

Pregnancy associated with pelvic pain or vaginal bleeding requires urgent medical assessment because ectopic pregnancy can be life-threatening.

Antibiotic regimens and doses mentioned in this article describe published guideline recommendations and should not be interpreted as an individual prescription.

Patients should not start, stop or change antimicrobial treatment without appropriate clinical advice.

Suspected tubo-ovarian abscess, severe illness, high fever, persistent vomiting, severe abdominal tenderness, pregnancy or failure to improve after approximately 72 hours of outpatient PID treatment requires prompt reassessment.

Unani medicine may be used supportively where clinically appropriate, but current evidence is insufficient to recommend replacing established antimicrobial treatment for active PID with Unani or herbal therapy alone.

Similarly, there is insufficient evidence to promise that Unani medicine can permanently reopen a fallopian tube blocked by established post-inflammatory scar tissue.

Women experiencing infertility after PID should receive objective fertility evaluation—including tubal assessment where appropriate—and the male partner should also be evaluated rather than assuming previous PID is the sole cause of the couple's infertility.



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