Pelvic inflammatory disease includes endometritis (including postpartum), chorioamnionitis, intra-amniotic syndrome, salpingitis, tubo-ovarian abscess, and/or pelvic cellulitis and/or pelvic peritonitis.

Pelvic infection in females may be sexually acquired, or may result from ascending infection with endogenous vaginal microbial flora particularly following mechanical disruption of the normal cervical barrier (eg due to postabortal, postpartum or postoperative infection, or associated with an intrauterine contraceptive device [IUCD], for which the risk is highest at time of insertion).

Even with sexually transmitted infections (STIs), the resultant upper tract infection is usually polymicrobial with mixed STI pathogens and endogenous flora, and hence empirical treatment needs to be broad-spectrum and include cover for anaerobic pathogens.

Pelvic actinomycosis is a rare cause of pelvic inflammatory disease, and may mimic pelvic malignancy. It is often associated with prolonged intrauterine contraceptive device (IUCD) use and is often a polymicrobial infection.

Management with a prolonged course of antibiotics (which should be broad-spectrum and needs to continue for at least 6 months to treat coexisting pathogens) and removal of any IUCD can lead to complete resolution.

Surgical intervention (particularly where abscesses are evident) may be necessary in some cases.