Mycoplasma genitalium infection: current treatment options, therapeutic failure, and resistance-associated mutations

Deborah L Couldwell 1,2
David A Lewis 1,2
1 Western Sydney Sexual Health Centre, Parramatta, 2 Centre for Infectious Diseases and Microbiology and Marie Bashir Institute for Infectious Diseases and Biosecurity, Westmead Clinical School, University of Sydney, Sydney, NSW, Australia

Abstract: Mycoplasma genitalium is an important cause of non-gonococcal urethritis, cervicitis, and related upper genital tract infections. The efficacy of doxycycline, used extensively to treat non-gonococcal urethritis in the past, is relatively poor for M. genitalium infection; azithromycin has been the preferred treatment for several years. Research on the efficacy of azithromycin has primarily focused on the 1 g single-dose regimen, but some studies have also evaluated higher doses and longer courses, particularly the extended 1.5 g regimen. This extended regimen is thought to be more efficacious than the 1 g single-dose regimen, although the regimens have not been directly compared in clinical trials. Azithromycin treatment failure was first reported in Australia and has subsequently been documented in several continents. Recent reports indicate an upward trend in the prevalence of macrolide-resistant M. genitalium infections (transmitted resistance), and cases of induced resistance following azithromycin therapy have also been documented. Emergence of antimicrobial-resistant M. genitalium, driven by suboptimal macrolide dosage, now threatens the continued provision of effective and convenient treatments. Advances in techniques to detect resistance mutations in DNA extracts have facilitated correlation of clinical outcomes with genotypic resistance. A strong and consistent association exists between presence of 23S rRNA gene mutations and azithromycin treatment failure. Fluoroquinolones such as moxifloxacin, gatifloxacin, and sitafloxacin remain highly active against most macrolide-resistant M. genitalium. However, the first clinical cases of moxifloxacin treatment failure, due to bacteria with coexistent macrolide-associated and fluoroquinolone-associated resistance mutations, were recently published by Australian investigators. Pristinamycin and solithromycin may be of clinical benefit for such multidrug-resistant infections. Further clinical studies are required to determine the optimal therapeutic dosing schedules for both agents to effect clinical cure and minimize the risk of emergent antimicrobial resistance. Continual inappropriate M. genitalium treatments will likely lead to untreatable infections in the future.

Keywords: Mycoplasma genitalium, non-gonococcal urethritis, macrolide, fluoroquinolone, resistance, treatment failure

Introduction

Mycoplasma genitalium is a cause of acute and chronic non-gonococcal urethritis (NGU) and cervicitis, and is increasingly implicated in upper genital tract infections. This minute genital parasite of the Mollicute class grows slowly as it is lacks the genes required for biosynthesis of amino acids and instead relies on host cells for nutrients. Despite its minute size, M. genitalium displays features in common with other pathogenic bacteria that enable it to cause disease, evade host immune responses through antigenic variability, and readily develop resistance to antimicrobial agents.
Antimicrobial resistance is threatening the provision of effective, safe, and convenient treatment for *M. genitalium*, as well as a number of other bacterial sexually transmitted infections (STIs), such as gonorrhea.\(^3,5\) While the gonococcus has a lengthy and well documented evolutionary history in terms of acquisition of new antimicrobial resistance mechanisms, *M. genitalium* is developing resistance to macrolides and fluoroquinolones at a speed belying its small size and, rather unexpectedly, before the introduction of systematic testing and treatment protocols. Clinical and patient factors promoting antimicrobial resistance in STI pathogens are gathering pace, driving the intrinsic propensity of these organisms to acquire antimicrobial resistance determinants or DNA point mutations at alarming rapidity.\(^4,6-8\)

**Management issues in the treatment of *M. genitalium* infections**

Syndromic treatment of NGU has focused on eradication of *Chlamydia trachomatis*, a well-established cause of reproductive morbidity in women, and is usually instituted at initial presentation before results of investigations to detect specific bacterial causes are made available. In most cases of sexually acquired urethritis and cervicitis, tests are only performed for *Neisseria gonorrhoeae* and *C. trachomatis*.

Few countries offer routine screening for *M. genitalium* and, where this is performed, it typically relies on the use of in-house nucleic acid amplification tests performed on specimens collected at either the initial visit or after failure of first-line therapy. Importantly, there are still no validated and commercially available assays for routine diagnostic testing although these may be available in the near future.\(^9\) While many experts accept current evidence linking *M. genitalium* with upper genital tract infections and infertility, a prospective observational study of morbidity associated with untreated *M. genitalium* infection would not be ethical in the light of current evidence. Doubts about the importance of *M. genitalium* as a reproductive pathogen, along with the lack of an approved diagnostic test, have delayed decisions on testing and treatment protocols.\(^9,10\)

**Overview of natural history and prevalence of *M. genitalium* infection**

The natural history of *M. genitalium* infection in men with NGU has not been studied, but spontaneous clearance of infection occurred in 55% of a cohort of African women within 3 months.\(^11\) In the absence of systematic screening and on the basis of studies conducted where testing is available, *M. genitalium* is most frequently detected in men who present with urethral symptoms.\(^12\) Prevalence rates of 15%–35% are reported in men with symptomatic non-chlamydial NGU, whereas estimates of population prevalence of *M. genitalium* range from 1.1% to 3.3%.\(^13\) Infections in women and anal infections among men-who-have-sex-with-men (MSM) are largely asymptomatic and therefore remain undiagnosed.\(^2,14\) A study among MSM at a London clinic found *M. genitalium* prevalence rates of 2.7% and 4.4% in first-void urine and rectal samples, respectively, with higher rates in human immunodeficiency virus (HIV)-positive versus HIV-negative MSM, suggesting that asymptomatic rectal infection is relatively common in this risk group.\(^15\) Finally, there is evidence that the prevalence of *M. genitalium* is increasing, at least in Scandinavia. A Danish national survey found that the proportion of those tested who tested positive increased significantly between the periods 2006–2008 and 2009–2010.\(^13\)

**Current treatment options**

In common with other mycoplasmas, *M. genitalium* lacks a cell wall, and is therefore not susceptible to antibiotics targeting peptidoglycan assembly. Although tetracyclines, in particular doxycycline, have been used to treat NGU for many years, the efficacy of this antimicrobial class is relatively poor and isolates with reduced susceptibility have been reported.\(^16-18\) Azithromycin, a macrolide, is now preferred for the treatment of NGU and related clinical syndromes on account of its long half-life, excellent tissue penetration, and the fact that it can be administered as a single-dose treatment. Clinical studies in which *M. genitalium* testing and treatment results have been reported include observational studies and several randomized clinical trials; these are summarized in Tables 1 and 2. In most cases, research effort has focused on studying the effectiveness of a single 1 g dose of azithromycin.\(^19-27\) Studies have also reported the efficacy of higher doses and longer courses of azithromycin, particularly the extended 1.5 g course, given as 500 mg on day 1 and then 250 mg daily on days 2–5, or less often, two 1 g doses given 5–7 days apart.\(^17,24,26\)

A controlled but non-randomized clinical trial recruited STI clinic patients with urethritis or cervicitis from Norway and Sweden from 2002 to 2004.\(^20\) Treatment was initiated with either doxycycline (200 mg on day 1, 100 mg daily on days 2–9) or azithromycin 1 g as a single dose. Those who tested positive for *M. genitalium* were followed up, and if initial treatment failed, were treated with the alternative antibiotic, either azithromycin as an extended 1.5 g regimen (500 mg on day 1, 250 mg daily on days 2–5), or doxycycline.
as above. The extended 1.5 g regimen had previously been reported to be very effective as a first-line treatment for *M. genitalium* infection.\(^{17}\) This extended regimen was generally not used to treat individuals at their first clinic visit but rather reserved to treat individuals with a laboratory-confirmed diagnosis of *M. genitalium* infection or sexual contacts of individuals with recently diagnosed *M. genitalium* urethritis or cervicitis. Single-dose azithromycin 1 g was significantly more effective than doxycycline, curing 85% versus 17% of men, and 88% versus 37% of women. This study did not directly compare the efficacy of the single 1 g dose and the extended 1.5 g regimen of azithromycin, but reported that the extended azithromycin regimen, given after doxycycline had failed, was more effective in eradicating *M. genitalium* (45/47, 96%) compared with an initial single 1 g dose (33/39, 85%).\(^{20}\) Although this difference was not statistically significant (\(P=0.133\)), the findings have substantially influenced clinical practice.

In contrast, a retrospective Norwegian study reported no difference in efficacy of three different azithromycin regimens: 1 g stat, 1 g on day 1 and a repeated 1 g dose on days 5–7, or the extended 1.5 g regimen.\(^{24}\) Azithromycin efficacy was lower in this retrospective Norwegian study (72%–79%) compared with the non-randomized controlled trial in Swedish and Norwegian clinics. The authors postulated that routine use of azithromycin 1 g in Norway may select for azithromycin-resistant *M. genitalium* strains.\(^{20,24}\) Additionally, the extended 1.5 g regimen of azithromycin was found to be ineffective once azithromycin 1 g single-dose treatment had failed.\(^{24}\)

The first randomized clinical trial of *M. genitalium* treatment compared azithromycin 1 g with doxycycline 100 mg twice daily for 7 days, and confirmed the results of previous non-randomized trials and observational studies, ie, that a single 1 g dose of azithromycin was more effective than doxycycline for treatment of *M. genitalium* infection in the USA at the time of the study (2002–2004).\(^{23}\) However, before the results of this trial were published, a higher rate of azithromycin 1 g treatment failure was reported among *M. genitalium*-infected patients in Australia.\(^{23}\) In this report, macrolide resistance was identified in strains from patients failing azithromycin treatment. The authors also

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**Table 1** Clinical efficacy studies of tetracycline/doxycycline, alone or versus macrolides, for treatment of *Mycoplasma genitalium* infection

<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Study type</th>
<th>Population</th>
<th><em>M. genitalium</em> cases (n)</th>
<th>Tetracycline regimen(s) and <em>M. genitalium</em> microbiological cure</th>
<th>Macrolide regimen and <em>M. genitalium</em> microbiological cure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horner et al(^{16})</td>
<td>1993</td>
<td>Prospective case–control study</td>
<td>164 men with/without NGU attending an STI clinic, UK</td>
<td>27 men</td>
<td>DOXY 200 mg d 1, 100 mg d 2–d 9; 10/14 cured (71.4%)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Johannsson et al(^{16})</td>
<td>2000</td>
<td>Uncontrolled observational study</td>
<td>233 men and 85 women attending STI clinics, Sweden</td>
<td>18 men</td>
<td>TET 500 mg 12 hourly (\times) 10 d; 5/13 men cured (38.5%)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Gambini et al(^{19})</td>
<td>2000</td>
<td>Prospective study with treatment varying by room</td>
<td>201 men with/without NGU attending an STI clinic, Italy</td>
<td>53 men</td>
<td>DOXY 200 mg/day (\times) 7 d; 33/35 cured (94.3%)</td>
<td>AZM 1 g stat; 14/17 cured (82.4%)</td>
</tr>
<tr>
<td>Falk et al(^{17})</td>
<td>2003</td>
<td>Uncontrolled observational study</td>
<td>519 men and 464 women attending an STI clinic, Sweden</td>
<td>34 men</td>
<td>DOXY 200 mg d 1, 100 mg d 2–d 9 or LYME 300 mg 12 hourly (\times) 10 d; Men: 16/16 cured (100.0%); Women: 20/20 cured (100.0%)</td>
<td></td>
</tr>
<tr>
<td>Björnelius et al(^{20})</td>
<td>2008</td>
<td>Uncontrolled observational study</td>
<td>152 men with NGU and 60 women with cervicitis attending 6 STI clinics, Norway and Sweden</td>
<td>152 men</td>
<td>DOXY 200 mg (d 1), 100 mg (d 2–d 9); Men: 33/39 cured (84.6%); Women: 15/17 cured (88.2%)</td>
<td></td>
</tr>
<tr>
<td>Mena et al(^{21})</td>
<td>2009</td>
<td>Randomized controlled trial</td>
<td>398 men with NGU attending an STI clinic, USA</td>
<td>78 men</td>
<td>DOXY 100 mg 12 hourly (\times) 7 d 14/31 cured (45.2%); Men: 14/23 cured (67.0%)</td>
<td></td>
</tr>
<tr>
<td>Schwebke et al(^{22})</td>
<td>2011</td>
<td>Randomized controlled trial</td>
<td>305 men with NGU attending 4 STI clinics, USA</td>
<td>94 men</td>
<td>DOXY 100 mg 12 hourly (\times) 7 d (+ tinidazole 2 g stat); 12/39 cured (30.8%); Men: 8/27 (29.6%, mITT); 0/23 cured (87.0%)</td>
<td></td>
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<tr>
<td>Manhart et al(^{23})</td>
<td>2013</td>
<td>Randomized controlled trial</td>
<td>606 men with NGU attending an STI clinic, USA</td>
<td>80 men</td>
<td>DOXY 100 mg 12 hourly (\times) 7 d (+ AZM placebo; Men: 27 men; 3/39 cured (14.2%); Women: 3/39 cured (84.6%)</td>
<td></td>
</tr>
</tbody>
</table>

**Abbreviations:** *M. genitalium*, *Mycoplasma genitalium*; NGU, non-gonococcal urethritis; STI, sexually transmitted infection; DOXY, doxycycline; TET, tetracycline; LYME, lymecycline; AZM, azithromycin; d, day/days; mITT, modified intention to treat population.
Table 2: Clinical efficacy studies of fluoroquinolones, alone or versus macrolides, for treatment of *Mycoplasma genitalium* infection

<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Study type</th>
<th>Population</th>
<th>M. genitalium cases (n)</th>
<th>Fluoroquinolone regimen(s) and M. genitalium microbiological cure</th>
<th>Macrolide regimen(s) and M. genitalium microbiological cure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yasuda et al.</td>
<td>2005</td>
<td>Uncontrolled observational study</td>
<td>97 men with NGU attending a urology clinic, Japan</td>
<td>97 men</td>
<td>LVFX 100 mg 8 hourly × 7 d or 14 d&lt;br&gt; TLX 150 mg 8 hourly × 14 d&lt;br&gt; GFLX 200 mg 12 hourly × 7 d or 14 d&lt;br&gt; LVFX (7 d): 5/16 cured (31.3%)&lt;br&gt; LVFX (14 d): 9/18 cured (50.0%)&lt;br&gt; TLX (7 d): 5/7 cured (71.4%)&lt;br&gt; GFLX (7 d): 22/24 cured (91.7%)&lt;br&gt; GFLX (14 d): 6/6 cured (100.0%)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Jernberg et al.</td>
<td>2005</td>
<td>Uncontrolled observational study</td>
<td>5,423 men and 4,683 women attending an STI clinic, Norway</td>
<td>234 men</td>
<td>OFX 200 mg 12 hourly × 10 d&lt;br&gt; MXF 400 mg daily × 7 d&lt;br&gt; OFX: 25/45 cured (55.6%)&lt;br&gt; MXF: 27/27 cured (100.0%)</td>
<td>AZM 1 g stat&lt;br&gt; AZM 1 g on d 1 and d 5–d 7&lt;br&gt; AZM 500 mg daily d 1, 250 mg daily d 2–d 5&lt;br&gt; AZM 1 g stat: 144/183 cured (78.7%)&lt;br&gt; AZM 1 g + 1 g: 28/38 cured (73.7%)&lt;br&gt; AZM 1.5 g (first-line): 76/98 cured (77.6%)&lt;br&gt; AZM 1.5 g (second/third-line): 82/3 cured (37.8%)&lt;br&gt; or&lt;br&gt; AZM 1 g per week × 3 weeks&lt;br&gt; 23/32 cured (71.9%)&lt;br&gt; AZM 1 g stat&lt;br&gt; 101/120 cured (84.2%)</td>
</tr>
<tr>
<td>Bradshaw et al.</td>
<td>2006</td>
<td>Prospective case–control study</td>
<td>636 men with/without NGU attending an STI clinic, Australia</td>
<td>34 men</td>
<td>MXF 400 mg daily × 10 d (following AZM 1 g stat on basis of persistent urethral symptoms)&lt;br&gt; 9/9 cured (100.0%)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Bradshaw et al.</td>
<td>2008</td>
<td>Uncontrolled observational study</td>
<td>1,538 men and 313 women attending an STI clinic, Australia</td>
<td>161 men</td>
<td>MXF 400 mg daily × 10 d (following AZM 1 g stat on basis of persistent urethral symptoms)&lt;br&gt; 11/11 cured (100.0%)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Takahashi et al.</td>
<td>2011</td>
<td>Uncontrolled observational study</td>
<td>87 men with NGU attending a urology clinic, Japan</td>
<td>5 men</td>
<td>LVFX 500 mg daily × 7 d&lt;br&gt; 3/5 cured (60.0%)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Hamasuna et al.</td>
<td>2011</td>
<td>Uncontrolled clinical trial</td>
<td>169 men with NGU attending urology clinics, Japan</td>
<td>18 men</td>
<td>GFLX 200 mg 12 hourly × 7 d&lt;br&gt; 15/18 cured (83.3%)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Ito et al.</td>
<td>2012</td>
<td>Uncontrolled clinical trial</td>
<td>89 men with NGU attending a urology clinic, Japan</td>
<td>14 men</td>
<td>STFX 100 mg 12 hourly × 7 d&lt;br&gt; 11/11 cured (100.0%)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Terada et al.</td>
<td>2012</td>
<td>Uncontrolled retrospective study</td>
<td>257 women with <em>M. genitalium</em> positive cervicitis attending a gynecology clinic, Japan</td>
<td>257 women</td>
<td>MXF 400 mg daily × 7 d&lt;br&gt; MXF 400 mg daily × 14 d&lt;br&gt; LVFX 500 mg daily × 7 d&lt;br&gt; LVFX 500 mg daily × 14 d&lt;br&gt; STFX 200 mg daily × 7 d&lt;br&gt; STFX 200 mg daily × 14 d&lt;br&gt; MXF (7 d): 38/42 cured (90.5%)&lt;br&gt; MXF (14 d): 42/42 cured (100.0%)&lt;br&gt; LVFX (7 d): 12/22 cured (54.5%)</td>
<td>AZM 1 g stat&lt;br&gt; AZM SR 2 g&lt;br&gt; CAM 400 mg daily × 7 d&lt;br&gt; CAM 400 mg daily × 14 d&lt;br&gt; AZM 1 g stat: 36/42 (85.7%)&lt;br&gt; AZM SR 2 g stat: 19/21 (90.5%)&lt;br&gt; CAM (7 d): 13/20 (65.0%)&lt;br&gt; CAM (14 d): 17/20 (85.0%)</td>
</tr>
</tbody>
</table>
reported that moxifloxacin eradicated all cases of persistent infection.²⁸

By 2009, experts had become concerned about the sub-optimal effectiveness of the azithromycin 1 g single-dose regimen, given the premise that treatment should cure at least 95% of uncomplicated STIs.²⁹ The comparative efficacy of the extended 1.5 g azithromycin regimen has never been assessed in a randomized controlled trial and, unfortunately, it was not included in the design of two large NGU treatment trials that were taking place in the USA at the same time.²²,²³

Anagrius et al have shed further light onto the question of choice of azithromycin regimen.³⁰ Consistent with previous observational clinical studies, they did not find a significant difference in treatment efficacy between the single 1 g and extended 1.5 g doses. However, seven patients who had macrolide-susceptible M. genitalium infection prior to treatment with azithromycin 1 g, and who failed initial treatment, had emergent macrolide resistance. In contrast, the single man who failed the extended 1.5 g course of azithromycin was infected with a macrolide-resistant strain of M. genitalium, and 77/77 individuals without pre-existing macrolide resistance were cured by this regimen as either first-line or second-line treatment.³⁰

A strong and consistent association between presence of 23S rRNA gene mutations and failure of azithromycin treatment began to emerge when clinical outcomes and M. genitalium resistance testing results were correlated (Table 3).³⁷,³¹,³² However, it should be noted that epidemiological studies have the potential to overestimate population prevalence of resistance when clinical information about previous antibiotic treatment is unavailable.³³ In addition, patients with macrolide resistance mutations may still test negative after treatment with single-dose azithromycin.³⁴ This outcome may reflect failure to detect persistent infection due to low bacterial loads associated with M. genitalium infection or to natural resolution of infection.³¹,³⁵,³⁶

An alarming trend is now apparent, with macrolide-resistant M. genitalium being widely reported as the underlying cause for the increasing rates of treatment failure with the azithromycin 1 g single-dose regimen. Although suboptimal macrolide dosage appears to be the main driver of the observed trend, the role of socioepidemiological factors, for example importation of antimicrobial-resistant M. genitalium strains or transmission of these within defined sexual networks, remains uncertain and requires more research.²⁸,³¹,³⁷

The presence of macrolide resistance-associated mutations has been highly associated with failure to eradicate M. genitalium in several Australian clinical studies.²⁸,³¹,³⁶
Table 3 Laboratory studies of *Mycoplasma genitalium* antimicrobial susceptibility and genotypic resistance testing

<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Study type</th>
<th>Population</th>
<th>M. genitalium DNA extracts or isolates examined (n)</th>
<th>Macrolide resistance (MIC data/resistance mutations)</th>
<th>Fluoroquinolone resistance (MIC data/resistance mutations)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradshaw</td>
<td>2006</td>
<td>Prospective case–control study</td>
<td>9 men with NGU attending an STI clinic, Australia</td>
<td>4 isolates</td>
<td>All 4 isolates had raised MICs to macrolides (AZM &gt;8 mg/L, ERY &gt;32 mg/L, CAM &gt;32 mg/L)</td>
<td>Not applicable</td>
<td>8/9 men experienced improvement/resolution of symptoms before NGU recurrence; one was persistently asymptomatic</td>
</tr>
<tr>
<td>Jensen</td>
<td>2008</td>
<td>Laboratory analysis</td>
<td><em>M. genitalium</em> DNA extracts and isolates from 12 men with NGU who failed AZM therapy in Australia, Norway, and Sweden 7 AZM-resistant genetically distinct control strains, Sweden</td>
<td>12 AZM-resistant DNA extracts 7 clinical isolates 7 control strains</td>
<td>7/7 isolates persisting after azithromycin therapy had raised MICs to macrolides (AZM ≥8 mg/L, ERY ≥16 mg/L, CAM ≥16 mg/L) 12 23S rRNA gene mutations reported: 5 at position 2059 (all A2059G); 5 at position 2058 (4 A2058G, one A2058C)</td>
<td>Not applicable</td>
<td>None</td>
</tr>
<tr>
<td>Chrisment</td>
<td>2012</td>
<td>Uncontrolled retrospective study</td>
<td>136 patients with <em>M. genitalium</em> infection attending STI clinics, general practice clinics, and hospitals, France</td>
<td>115 DNA extracts</td>
<td>Single substitutions reported in the gyrA gene at position 321 (T321A) in 2 specimens Single substitutions reported in the parC gene of 4 specimens: G248A, G259T, A260T, A290G</td>
<td>Not applicable</td>
<td>None</td>
</tr>
<tr>
<td>Shimada</td>
<td>2010</td>
<td>Uncontrolled retrospective study</td>
<td>308 men with NGU attending a urology clinic, Japan</td>
<td>28 DNA extracts</td>
<td>4 23S rRNA gene mutations reported: 1 at position 2059 (A2059G); 3 at position 2185 (T2185G)</td>
<td>Not applicable</td>
<td>The A2158G mutation is not associated with macrolide resistance in other bacteria. Amino acid substitutions reported in the L4 and L22 ribosomal proteins of unknown significance. The strain with the A2059G mutation was cured with AZM 1 g All 7 men had no AZM-resistant mutations in pretreatment <em>M. genitalium</em> DNA extracts. One of the <em>M. genitalium</em> strains with the A2058G mutation also had a L4 protein mutation</td>
</tr>
<tr>
<td>Shimada</td>
<td>2011</td>
<td>Uncontrolled retrospective study</td>
<td>308 men with NGU attending a urology clinic, Japan</td>
<td>25 DNA extracts</td>
<td>4 23S rRNA gene mutations reported: 2 at position 2059 (A2059G); 2 at position 2058 (A2058G)</td>
<td>Not applicable</td>
<td>None</td>
</tr>
<tr>
<td>Ito et al</td>
<td>2011</td>
<td>Laboratory analysis</td>
<td>7 men with <em>M. genitalium</em> related NGU which failed AZM therapy at a urology clinic, Japan</td>
<td>7 DNA extracts</td>
<td>4 23S rRNA gene mutations reported: 2 at position 2059 (A2059G); 2 at position 2058 (A2058G)</td>
<td>Not applicable</td>
<td>None</td>
</tr>
<tr>
<td>Study Authors</td>
<td>Year</td>
<td>Study Design</td>
<td>Setting</td>
<td>Participants</td>
<td>Samples</td>
<td>DNA Extracts</td>
<td>23S rRNA Mutations</td>
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<tr>
<td>Walker et al</td>
<td>2013</td>
<td>Longitudinal study</td>
<td>1,100 women attending 29 primary care clinics, Australia</td>
<td>33 DNA</td>
<td></td>
<td></td>
<td>2/27 pretreatment samples from patients cured with AZM</td>
</tr>
<tr>
<td>Twin et al</td>
<td>2012</td>
<td>Laboratory analysis</td>
<td>82 pretreatment and 20 post-treatment samples from patients with clinical treatment failure attending an STI clinic, Australia</td>
<td>102 DNA</td>
<td></td>
<td></td>
<td>16/82 pretreatment samples had 23S rRNA gene mutations (A2058G, A2059G, A2059C)</td>
</tr>
<tr>
<td>Gesink et al</td>
<td>2012</td>
<td>Uncontrolled observational study</td>
<td>314 participants recruited through telephone and community initiatives, Greenland</td>
<td>26 DNA</td>
<td></td>
<td></td>
<td>Single 23S rRNA gene mutations reported in 26/26 M. genitalium cases tested: 17 at position 2058 (A2058G); 9 at position 2059 (A2059G)</td>
</tr>
<tr>
<td>Tagg et al</td>
<td>2013</td>
<td>Laboratory analysis</td>
<td>143 initial and 43 follow-up M. genitalium-positive samples from 167 patients attending STI clinics, Australia</td>
<td>186 DNA</td>
<td></td>
<td></td>
<td>62/143 (43.4%) initial DNA extracts had 23S rRNA gene mutations at either position 2058 (21 A2058G, 2 A2058T, 1 A2058C), or 2059 (38 A2059G)</td>
</tr>
<tr>
<td>Couldwell et al</td>
<td>2013</td>
<td>Uncontrolled observational study</td>
<td>33 patients attending a STI clinic with M. genitalium infections, either as NGU cases (30 men) or their sexual partners (2 women, 1 man), Australia</td>
<td>32 DNA</td>
<td></td>
<td></td>
<td>15/32 (46.9%) had 23S rRNA gene mutations at position 2058 (A2058G, A2058T) or position 2059 (A2059G)</td>
</tr>
<tr>
<td>Yew et al</td>
<td>2011</td>
<td>Laboratory analysis</td>
<td>11 M. genitalium DNA extracts from men with recurrent NGU, New Zealand</td>
<td>9 DNA</td>
<td></td>
<td></td>
<td>4/9 (44.4%) had A2059G mutations in the 23S rRNA gene</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Study type</th>
<th>Population</th>
<th>M. genitalium DNA extracts or isolates examined (n)</th>
<th>Macrolide resistance (MIC data/resistance mutations(^a))</th>
<th>Fluoroquinolone resistance (MIC data/resistance mutations(^b))</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anagrius et al(^{30}) 2013</td>
<td>Uncontrolled retrospective study</td>
<td>11 patients testing positive for M. genitalium after treatment with azithromycin 1 g single-dose (n=10) or extended azithromycin 1.5 g (n=1) therapy, Sweden</td>
<td>8 DNA extracts</td>
<td>1/8 (12.5%) pretreatment and 8/8 (100.0%) post-treatment samples had non-specified macrolide-associated 23S rRNA gene mutations</td>
<td>Not applicable</td>
<td>2/10 pretreatment samples were missing and 1/10 pretreatment samples had insufficient DNA for amplification. The patient failing the extended azithromycin had macrolide mutations in the pretreatment DNA extract</td>
<td></td>
</tr>
<tr>
<td>Pond et al(^{41}) 2014</td>
<td>Uncontrolled observational study</td>
<td>217 men with urethritis-related symptoms, UK</td>
<td>22 DNA extracts</td>
<td>23S rRNA gene mutations reported in 9/22 (40.9%) samples: 5 at position 2058 (A2058G); 9 at position 2059 (3 A2059G, 1 A2059C)</td>
<td>1/22 (4.5%) had a parC mutation (A247C)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Kikuchi et al(^{38}) 2014</td>
<td>Laboratory analysis</td>
<td>90 M. genitalium DNA extracts from men with NGU, Japan</td>
<td>68 DNA extracts (macrolide resistance testing) 51 DNA extracts (fluoroquinolone resistance testing)</td>
<td>5/68 (7.4%) samples: 4 at position 2058 (A2058G); 1 at position 2059 (A2059G)</td>
<td>5/51 (9.8%) had gyrA mutations (4 C267T, 1 C270T); 18/51 (35.3%) had parC mutations (12 G248A, 3 G248T, 2 G259A, 1 C356A)</td>
<td>The significance of the reported C356A mutation is unclear as it is outside the fluoroquinolone resistance-determining region</td>
<td></td>
</tr>
<tr>
<td>Salado-Rasmussen and Jensen(^{13}) 2014</td>
<td>Uncontrolled retrospective survey</td>
<td>1,008 patients from general practice, private specialists and hospitals with M. genitalium infection, Denmark</td>
<td>1,085 DNA extracts</td>
<td>385/1,008 (35.5%) patients had macrolide resistance; A2058G (61%) and A2059G (35%) were the most common mutations</td>
<td>Not applicable</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Hay et al(^{42}) 2015</td>
<td>Laboratory analysis</td>
<td>601 women attending primary health care clinics, South Africa</td>
<td>41 DNA extracts</td>
<td>A2058G mutations reported in the 23S rRNA gene of 4/41 (9.8%) DNA extracts tested</td>
<td>Not applicable</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Notes: \(^a\)Mutation positions are according to *Escherichia coli* numbering; \(^b\)mutation positions are according to *M. genitalium* G37 genome (GenBank accession number NC000908.2).

Abbreviations: M. genitalium, Mycoplasma genitalium; NGU, non-gonococcal urethritis; STI, sexually transmitted infection; AZM, azithromycin; CAM, clarithromycin; ERY, erythromycin; AZM\(^s\), azithromycin-susceptible; AZM\(^r\), azithromycin-resistant; SNP, single nucleotide polymorphism; MIC, minimum inhibitory concentration.
In Melbourne, Australia, azithromycin efficacy has declined from 84% between 2005 and 2007, and to 69% from 2007 to 2009 ($P<0.001$). Elsewhere in the Pacific region, macrolide resistance mutations were not detected in a small number of *M. genitalium*-positive urethral samples from Japanese men tested in 2011–2012, whereas five (29.4%) of 17 screened *M. genitalium* DNA extracts had 23S rRNA gene mutations in 2013. A similar trend has been observed in the USA where, by 2011, only 40% of infections were cured by single-dose azithromycin 1 g, compared with 87% in 2002–2004.21

In Scandinavia, a retrospective case study in Sweden tracked the trajectory of macrolide resistance from 2006 to 2007, when no macrolide resistance was detected, through to 2011, when 21% of *M. genitalium*-positive samples harbored 23S rRNA gene mutations associated with macrolide resistance. A Danish national survey reported a 38% prevalence of macrolide resistance-associated mutations in first *M. genitalium* test samples from 2007 to 2010. The lowest rate of resistance was found in samples from private specialists, mostly gynecologists who were conducting screening for STIs including *M. genitalium*. The highest rate occurred among STI clinic patients where *M. genitalium* testing was generally restricted to persistently symptomatic patients with negative results for other pathogens; these patients were likely to have received azithromycin treatment prior to their first *M. genitalium* test. In an alarming report from Greenland, 100% of *M. genitalium* strains detected in 2008–2009 carried macrolide resistance mutations, resulting in replacement of azithromycin with tetracyclines in the recommended syndromic treatment guideline for urethritis and cervicitis.

Elsewhere in Europe, the rate of macrolide resistance varied in France from 10% to 15% each year from 2006 to 2010, whereas no resistance mutations were detected in the small number of available samples from 2003 to 2005. There was, however, no significant trend observed between 2003 and 2006 or between 2007 and 2010. In the UK, *M. genitalium* was detected in five asymptomatic and 17 symptomatic men with and without urethritis in a London clinic. Among these 22 initial samples, nine harbored macrolide-associated resistance mutations, and phylogenetic analysis of 18 samples revealed two main clusters within which strain types were not closely related. None of the men with urethritis and with macrolide-resistant strains of *M. genitalium* returned for follow-up, despite having received treatment with either doxycycline or azithromycin 1 g that would have been unlikely to cure their infections.

There is a lack of data on the prevalence of macrolide resistance-associated mutations among the *M. genitalium* strains circulating in African, Asian, and Latin American countries. Many countries within these continental regions rely on syndromic management for STI control, and laboratory diagnostic capability is generally absent or very minimal. In addition, tetracyclines are preferred to macrolides for syndromic management of genital discharges due to the differential cost and limited budget for STI control. Accordingly, it remains very unclear as to what role *M. genitalium* plays in reproductive tract morbidity in resource-poor settings and to what extent *M. genitalium* strains have acquired resistance mutations. The only reported macrolide resistance data from Africa has been laboratory-based using remnant specimens collected over 4 months in 2011–2012 in a limited geographic area in rural South Africa. The authors reported a prevalence of 23S rRNA gene mutations in four (9.8%) of 41 DNA extracts screened. We were unable to find any studies reporting macrolide-associated mutations in *M. genitalium* strains from Latin America or resource-poor countries in Asia.

The most recent data on macrolide resistance is from a prospective cohort of *M. genitalium*-infected patients with NGU, cervicitis, or pelvic inflammatory disease, as well as their sexual contacts, enrolled in Melbourne, Australia, between June 2012 and July 2013. Only 3% of patients were lost to follow-up; 95 (61%) of 155 were microbiologically cured by single-dose azithromycin 1 g. Baseline macrolide resistance was detected in 56 (36%) patients (transmitted resistance) and most (87%) of these failed azithromycin therapy. In addition, eleven (11%) of the 99 patients without baseline macrolide resistance also developed signature 23S rRNA gene mutations (induced resistance) and failed therapy. Overall, a high azithromycin 1 g treatment failure rate (39%) was reported in this study. This study provided the first definitive evidence for timing of test of cure; all patients who tested negative for *M. genitalium* at day 28 by polymerase chain reaction (PCR) assay also tested negative by day 14.

Fluoroquinolones such as moxifloxacin, gatifloxacin, and sitafloxacin remain highly active against most macrolide-resistant *M. genitalium* isolates. Although demonstrated to have high activity against *M. genitalium* in vitro, the newer fluoroquinolones, including gemifloxacin, sparfloxacin, grepafloxacin, trovafloxacin, and garenoxacin, have yet to be evaluated in clinical trials. In contrast, ciprofloxacin has poor activity, and both ofloxacin and levofloxacin are less active against *M. genitalium* than moxifloxacin and the newer fluoroquinolones mentioned above.

Ofloxacin and levofloxacin have been used to treat NGU in the past, particularly in Japan, although neither are ideal
drugs to treat *M. genitalium* infection.\textsuperscript{43,44} Levofloxacin, given as 100 mg 8-hourly for 7 days or 14 days has been shown to produce low *M. genitalium* eradication rate of 31\% or 50\%, respectively, and has been associated with a high prevalence of recurrence of urethral discharge.\textsuperscript{45,46} In a small study with nine evaluable patients, a 10-day course of ofloxacin 200 mg 12 hourly failed to clear *M. genitalium* in 56\% of cases.\textsuperscript{24}

Moxifloxacin 400 mg once daily for 7–10 days generally cures *M. genitalium* infections that have failed azithromycin therapy.\textsuperscript{25,32} As a result, moxifloxacin is currently the treatment of choice for macrolide-resistant *M. genitalium* infections. Based on the results of in vitro susceptibility testing, sitafloxacin appears to be as active as moxifloxacin. Two recent small clinical studies in Japan, where moxifloxacin is not available, reported that a 100 mg 12-hourly regimen of sitafloxacin for 1 week eradicated *M. genitalium* in 11/11 and 15/16 patients, respectively, including five patients with persistent or recurrent NGU.\textsuperscript{47,48} Although no longer available, gatifloxacin, given at a dosage of 200 mg 12-hourly for 1 or 2 weeks, also resulted in high eradication rates for *M. genitalium* in men with NGU.\textsuperscript{55,49}

The first clinical report of moxifloxacin treatment failure associated with fluoroquinolone-associated resistance mutations in *M. genitalium* strains emerged in 2013 from Sydney, Australia.\textsuperscript{36} A recent study from Melbourne found that moxifloxacin cured only 53 (88\%) of 60 macrolide-resistant *M. genitalium* infections; the seven that failed moxifloxacin had fluoroquinolone-associated resistance mutations in *gyrA* and *parC*.\textsuperscript{27} Accordingly, it is strongly recommended that clinicians avoid low-ef\-ficacy fluoroquinolones, such as levofloxacin or ofloxacin, to treat NGU cases for fear of driving a rise in the prevalence of fluoroquinolone resistance among *M. genitalium* strains. While most *M. genitalium* strains remain susceptible to moxifloxacin and sitafloxacin, there is increasing concern about how best to treat dual macrolide-resistant and fluoroquinolone-resistant *M. genitalium* infections.

A new fluoroketolide antibiotic, solithromycin, has shown superior in vitro activity against *M. genitalium* compared with macrolides, fluoroquinolones, and tetracyclines.\textsuperscript{50} When tested against macrolide-resistant strains, solithromycin was more active in vitro than azithromycin, although there was evidence of some cross-resistance.\textsuperscript{50} Mutations in the *M. genitalium* 23S rRNA gene at position 2058 (*Escherichia coli* numbering) led to higher solithromycin minimum inhibitory concentrations (MICs) than those in position 2059 and were the only changes explaining solithromycin resistance. In Denmark, where 40\% of *M. genitalium* strains are azithromycin-resistant, the authors postulate that 85\% of these resistant strains, or 94\% of all *M. genitalium* strains, would be susceptible to solithromycin. Superior activity is thought to be due to solithromycin having three ribosomal binding sites, compared with only one in the case of azithromycin. Solithromycin also showed good activity against five strains from patients who had failed both azithromycin and moxifloxacin treatment.\textsuperscript{30} This antimicrobial agent was recently shown to be highly effective against *C. trachomatis* and *N. gonorrhoeae* in vitro and against uncomplicated urogenital gonorrhea in a Phase II clinical trial, suggesting it could treat several STIs simultaneously.\textsuperscript{51–53} Should the efficacy of solithromycin be demonstrated in further clinical trials, it may be an option for the syndromic management of urethritis and related clinical syndromes in the future.

Pristinamycin, a streptogramin antimicrobial generally used to treat vancomycin-resistant *Enterococcus faecium* bacteremia and complicated skin infections caused by methicillin-resistant *Staphylococcus aureus*, has also been used to treat *M. genitalium* infections. Bissessor et al administered pristinamycin in a regimen of 1 g hourly for 10 days to six patients who failed both azithromycin (1 g as a single dose) and moxifloxacin (400 mg daily for 10 days).\textsuperscript{27} All six patients remained PCR-negative for *M. genitalium* 28 days after receiving the pristinamycin. As this study represents the first reported use of pristinamycin among a small group of patients infected with multi-drug resistant *M. genitalium*, further clinical evaluations are required in order to better evaluate the effectiveness, optimal dosage, and potential for acquisition of antimicrobial resistance determinants. Even if pristinamycin continues to prove effective, its currently limited availability and high cost do not support wider use, particularly in resource-poor settings.

**Antimicrobial resistance testing in *M. genitalium***

*M. genitalium* was first cultured by direct inoculation of urethral swab material onto SP4 Mycoplasma medium and subsequently by coculture of urethral specimens with Vero cell cultures grown in supplemented serum-free medium.\textsuperscript{54,55} *M. genitalium* has now been successfully isolated from urethral swabs, urinary sediments, and cervical swabs.\textsuperscript{56} In vitro antimicrobial susceptibility testing traditionally requires isolation of a single strain through multiple passages in culture (axenic culture). This has proven difficult due to the fastidious nutritional and environmental requirements of *M. genitalium* as well as its slow growth; indeed, it can take up to 6 months to isolate a single colony. This propensity of *M. genitalium* culture to fail has impeded studies reliant
on observations of bacterial growth following addition of serial dilutions of antimicrobial agents to SP4 medium-based axenic cultures.56

In an attempt to overcome the challenges of strain loss with subsequent subcultures, the growth of _M. genitalium_ in inoculated Vero cell cultures has been monitored by use of a quantitative TaqMan S’ nuclease real-time PCR, which in turn relies on detection of the single-copy _mgpB_ adhesion gene.57 In this assay, growth inhibition due to the presence of antimicrobial agents can be expressed as a proportion of the DNA load of _M. genitalium_ controls grown in the same culture system. Whichever method is used, phenotypic resistance testing for _M. genitalium_ remains a laborious and time-consuming process. Consequently, there are relatively few antimicrobial susceptibility studies reported in the literature. The data that do exist may not be representative of the larger number of untested _M. genitalium_ strains circulating on a global level.

Advances in techniques to detect putative resistance mutations in initial culture specimens without the need for axenic culture, and more recently, directly from clinical samples, have facilitated epidemiological studies of _M. genitalium_ resistance, as well as correlation of clinical outcomes with results of genotypic resistance testing.31,33,56,58 Rapid high resolution melt analysis (HRMA) now allows detection of macrolide resistance-associated mutations at the time of initial detection of _M. genitalium_. This dramatically reduces the time needed to perform resistance testing, which may be as long as 2–3 months for previously described in vitro MIC determination based on the Vero cell culture system and quantitative TaqMan S’ nuclease real-time PCR determination of growth inhibition.32,57 However, the rapid HRMA assay was unable to detect type IV single nucleotide polymorphisms within the 23S rRNA gene at position 2058 (ie, A2058T, _E. coli_ numbering).31 This is an important limitation of the HRMA assay as A2058T mutations do comprise a small proportion of macrolide resistance-associated mutations in some reports.13,33,38 A real-time PCR assay based on fluorescence resonance energy transfer coupled with melting curve analysis was reported to be more discriminatory and reproducible in clinical specimens when compared with the rapid HRMA assay.59 Use of such rapid assays on specimens collected prior to treatment avoids the wait for a test-of-cure result before instituting second-line treatment for patients with persistent NGU. However, treatment would not be expedited for those azithromycin-treated men who developed emergent macrolide resistance following therapy.

**Overview of mutations associated with resistance and treatment failure**

**Tetracyclines**

In vitro antimicrobial susceptibility testing of recent clinical isolates has demonstrated the emergence of some strains with decreased susceptibility to doxycycline (1 µg/mL) and tetracycline (4 µg/mL).16 Although tetracycline resistance-associated mutations have not so far been identified in _M. genitalium_, _tetM_ gene mutations conferring tetracycline resistance have been identified in _M. hominis_ and _Ureaplasma urealyticum_ isolated from genital specimens.43

**Macrolides**

Macrolide antibiotics, including azithromycin, prevent bacterial replication by binding to the 50S ribosomal subunit, inhibiting translation of mRNA and thus interfering with protein synthesis. Mutations at positions 2058 and 2059 (_E. coli_ numbering) in region V of the 23S rRNA gene alter ribosomal structure, thereby preventing macrolide binding, and have been associated with macrolide resistance in a number of pathogenic bacteria, including _M. genitalium_ and two other sexually acquired pathogens, _N. gonorrhoeae_ and _Treponema pallidum_.59 While the latter two sexually transmitted pathogens have multiple copies of 23S rRNA genes, _M. genitalium_ has only a single rRNA gene operon encoding for the 23S, 16S, and 5S rRNA subunits. It has been hypothesized that this relative deficiency in the number of 23S rRNA gene copies may increase the susceptibility of _M. genitalium_ to develop high-level macrolide resistance.59 In addition, the ability of _M. genitalium_ to exist intracellularly, together with its very slow growth, could favor selection of macrolide-resistant strains, given that azithromycin has a much longer intracellular than extracellular half-life.3

The first study to demonstrate macrolide resistance in azithromycin treatment failure in _M. genitalium_ urethritis was reported in 2006.28 The authors performed phenotypic antimicrobial drug susceptibility testing on four specimens, collected after azithromycin 1 g single-dose treatment had failed, and reported increased MICs to azithromycin (>8 mg/L), erythromycin (>32 mg/L), and clarithromycin (>32 mg/L). All four isolates were sensitive to moxifloxacin, with MICs in the range of 0.031–0.125 mg/L, and retained in vitro susceptibility to doxycycline (MICs 0.125–0.25 mg/L).28

In an attempt to determine the genetic mechanism underlying the observed macrolide resistance, these four isolates and three macrolide-resistant _M. genitalium_ isolates from
Scandinavian patients, who had also failed azithromycin, were further studied along with several distinct azithromycin-susceptible M. genitalium strains.32 The genetic basis for drug resistance was determined by sequencing the 23S rRNA gene, as well as genes encoding L4 and L22 proteins, as mutations with these genes were already associated with macrolide resistance in other Mollicutes.

The authors identified three different mutations at positions 2058 and 2059 (E. coli numbering) in region V of the 23S rRNA gene which were deemed responsible for the macrolide resistance phenotype.32 Although some point mutations were found in the L4 and L22 genes, most of them did not result in amino acid changes, and their effect was thought to be minor or non-existent in terms of the expression of the macrolide-resistant phenotype. Only one strain possessed an amino acid substitution, i.e., the H69R mutation in L4, known to be associated with macrolide resistance in Mollicutes. The authors subsequently developed and validated a PCR assay to detect macrolide resistance-associated mutations.33 Nine paired pretreatment and post-treatment samples from patients who failed a single dose 1 g dose of azithromycin were further analyzed with this assay. Macrolide resistance-associated 23S rRNA gene mutations were present in two of the pretreatment DNA extracts and all of the nine post-treatment DNA extracts, suggesting that azithromycin resistance had emerged during treatment. Induced macrolide resistance has subsequently been reported by others.7,8

Researchers in Melbourne, Australia, reported that rapid HRMA detected sexually transmitted macrolide resistance mutations in 16 (20%) of 82 pretreatment samples, while selection of macrolide resistance-associated mutations occurred in eleven (55%) of 20 of those with initial wild-type infections who failed initial treatment.31 Elsewhere in Australia, macrolide resistance-associated mutations were detected by sequencing of PCR amplicons in 62 (43%) of 143 initial M. genitalium-positive samples collected in Sydney from 2008 to 2011.34 Sexually transmitted macrolide resistance was present in four (20%) of a small subset of 20 samples collected from patients who had never received azithromycin prior to their first test.36

**Fluoroquinolones**

Fluoroquinolone antibiotics bind to the DNA gyrase and topoisomerase IV enzymes, blocking DNA replication. Mutations in defined regions of the DNA gyrase genes, gyrA and gyrB, and the topoisomerase IV genes, parC and parE, have been linked to high-level fluoroquinolone resistance in various bacteria, including N. gonorrhoeae and M. genitalium.5,33

As mentioned above, the first clinical reports of M. genitalium infection failing therapy with moxifloxacin as a result of fluoroquinolone-associated resistance mutations emerged in 2013.36 Fluoroquinolone resistance-associated mutations in the parC and/or gyrA genes were detected in eleven (15%) of 143 initial M. genitalium PCR-positive samples from Sydney and in six (19%) of 32 of these samples from patients at one clinic.35,36 In this population, fluoroquinolone antibiotics are not used for treatment of any STIs or widely in the community for the treatment of other infectious diseases. Despite this, fluoroquinolone resistance-associated mutations were significantly associated with failure of moxifloxacin treatment (P=0.005).36 Patients infected with M. genitalium strains containing both macrolide and fluoroquinolone resistance-associated mutations failed therapy with both azithromycin and moxifloxacin, raising concerns about untreatable M. genitalium infection in the future.

Subsequently, fluoroquinolone resistance was also reported from a London clinic.41 In addition, approximately one-third of 51 Japanese men with NGU were infected with M. genitalium and had fluoroquinolone resistance-associated mutations in parC, but 9/9 were cured by sitafloxacin 100 mg prescribed twice daily for 7 days.38 The relatively high prevalence of fluoroquinolone resistance in this patient group may be a consequence of the common use of fluoroquinolones in STI treatment in Japan.60

**Future directions**

Despite mounting evidence of increasing failure of azithromycin 1 g as a single-dose treatment for M. genitalium-associated NGU, this regimen continues to be used as first-line treatment for NGU in many parts of the world. This is in part because NGU treatment remains focused on treating chlamydial infections, which are deemed to have more serious sequelae. While C. trachomatis is universally accepted as an STI, the pathogen status of M. genitalium is not so prominent, which has in turn led to recent calls for M. genitalium to be regarded more seriously and to be recognized as a significant STI with associated morbidity.2,10 Once this happens, there will be enhanced efforts to introduce commercial assays for M. genitalium detection, ideally multiplexed with C. trachomatis and N. gonorrhoeae. In resource-poor settings, more effort is required to validate genital discharge syndromic management protocols that could adequately treat both C. trachomatis and M. genitalium infections.
STI treatments are devised according to the local epidemiology of antimicrobial susceptibility, but generating such data for \textit{M. genitalium} strains would be a major and ongoing challenge for laboratories. Diagnostic testing for \textit{M. genitalium} has not been widely available, and antimicrobial susceptibility testing remains available in only a few laboratories worldwide.\textsuperscript{9} Consequently, the issue of macrolide treatment failure in \textit{M. genitalium} infection was unrecognized until relatively recently. It is clear, in retrospect, that the choice of treatment for \textit{M. genitalium} infections within the context of NGU has always been inadequate. By the time that randomized trials were designed to investigate \textit{M. genitalium} treatment, macrolide resistance among \textit{M. genitalium} strains was entrenched and rising. Evidence of increasing failure of azithromycin in the treatment of NGU re-emphasizes the ease with which antibiotic resistance can accelerate where suboptimal treatment is provided for a common infection or syndrome.

There are now calls to abandon single-dose azithromycin 1 g treatment for \textit{M. genitalium} and related clinical syndromes.\textsuperscript{10} One suggested strategy is to revert to use of doxycycline for treatment of NGU, and to then use the extended regimen of azithromycin 1.5 g for those who fail initial therapy, with a 10-day course of moxifloxacin as third-line therapy, and to treat contacts with the same regimen(s).\textsuperscript{10} This approach could be used in settings with or without availability of \textit{M. genitalium} testing, and would potentially slow the rate of resistance development. Its success relies on three premises: firstly, that the extended 1.5 g azithromycin regimen is sufficiently effective, for which there is limited evidence to date; secondly, that patients who fail therapy will continue to return for follow-up, and lastly that macrolide resistance is not already present.\textsuperscript{24,30} Epidemiological studies have detected circulating macrolide resistance in up to 100\% of local strains in some populations.\textsuperscript{39} In addition, there may be consequences for treatment of other pathogens. For example, suboptimal adherence to doxycycline occurred in 28\% of men in a prospective randomized controlled trial of NGU treatment, and was associated with 9-fold higher risk of microbiological failure among men infected with \textit{C. trachomatis}.\textsuperscript{61}

The current practices of performing \textit{M. genitalium} testing primarily in men with NGU and failure to provide systematic screening recommendations for asymptomatic individuals contribute to the selection pressure generating macrolide resistance, especially among groups with high rates of partner change. Given published prevalence data, it is likely that many MSM who receive the single-dose azithromycin 1 g treatment, either for chlamydial infection or as dual therapy with ceftriaxone for treatment of gonorrhea, are also asymptptomatically infected with rectal \textit{M. genitalium}.\textsuperscript{15} Some infections may be cured, but macrolide resistance probably emerges with high frequency in this scenario, leading to pathogen persistence and onward transmission to sexual partners. In the case of \textit{M. genitalium} infection in women, more than one-third of a cohort of African female sex workers received syndromic treatment for other STIs during follow-up, without any effect on clearance of \textit{M. genitalium}, even though some of these infections would have been expected to respond to fluoroquinolones and doxycycline given as syndromic management for vaginal discharge and lower abdominal pain syndromes.\textsuperscript{11} This finding has led to speculation of widespread \textit{M. genitalium} antimicrobial resistance in sub-Saharan Africa, where in some cohorts and particularly among HIV-infected patients, the prevalence of \textit{M. genitalium} infection exceeds that of gonorrhea and chlamydial infection.\textsuperscript{62,63}

Antimicrobial susceptibility surveillance should be instituted more widely, particularly in resource-limited settings where data are either very few or non-existent, to inform treatment guidelines. New molecular technologies have shortened the many months formerly required for antimicrobial susceptibility testing through use of axenic culture systems. It is now possible to test patients’ specimens directly for the presence of signature resistance mutations for macrolide and fluoroquinolone resistance.\textsuperscript{31,57,58} Ideally, future \textit{M. genitalium} detection assays would incorporate detection of macrolide resistance mutations, which could improve treatment effectiveness and help limit the spread of resistance.\textsuperscript{9,13}

**Conclusion**

In conclusion, the minimalist nature of \textit{M. genitalium}, encompassing its error-prone genome, parasitic lifestyle, and slow replication, has ironically proved to be its greatest strength, giving this organism the ability to evade detection and readily develop treatment resistance. Effective management of \textit{M. genitalium} infection, within the context of broader STI control, will ideally require a number of new interventions including: the development and validation of a commercial multiplex assay to detect \textit{N. gonorrhoeae}, \textit{C. trachomatis}, and \textit{M. genitalium} incorporating detection of key resistance mutations; systematic screening of high-risk groups, including screening among MSM for rectal infection; establishment of local and regional surveillance networks to monitor prevalence of infection and antimicrobial resistance; and development and clinical evaluation of new treatments.
Solithromycin is a promising option, offering a higher barrier to resistance and potential efficacy in syndromic STI treatment in *M. genitalium*-associated clinical syndromes such as NGU, as well as in resource-limited settings.

**Disclosure**

The authors report no conflicts of interest in this work.

**References**


