

# Testing for and managing Mycoplasma Genitalium in women attending a GUM clinic 2016-2017

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## Introduction

There is mounting evidence to suggesting Mycoplasma Genitalium (MG) causes cervicitis and pelvic Inflammatory disease (PID) in women . Within our clinic, we currently test all women with suspected PID/cervicitis and contacts of men with MG urethritis.

## Aim

To determine effectiveness of testing and managing MG in women attending a level 3 GUM clinic.

## Method

Women coded for MG infection between November 2016 and October 2017 were identified. Their clinic records were reviewed for clinical presentation, antibiotic usage and time to microbiological cure.

## Results

Over the 12 month period, 790 women were tested for MG and 66 (8.4%) were positive. The median age was 22 (17-45) years, and 54/66 (81.8%) were of white ethnicity. 15/66 (22.7%) presented as sexual contacts of MG. 42/66 (63.6%) had symptoms at presentation (fig.1), with 42% having ≥2 or more (fig.2). Co-infections were seen with Chlamydia Trachomatis 6/66(9.1%) and Neisseria Gonorrhoea 3/66 (4.5.%) and concomitant bacterial vaginosis was found in 15/66 (22.7%). During the same time period, 241 women were diagnosed with PID and MG was detected in 22/241 (9.1%) of these.

Of the 66 positive cases , all were offered either first line treatment with a five day course of extended azithromycin (500mg stat and 250mg od for four days), or second line 10-14 days of moxifloxacin (400mg od).

All were asked to return for test of cure (TOC) at four weeks post treatment. 51/66 (77.3%) attended and 16/51 (31.3%) had a positive TOC despite documented treatment adherence but 10/16 (62.5%) did claim a re-infection risk. All positive TOCs had been treated with extended azithromycin and 10/16 (62.5%) were asymptomatic at presentation. Following re-treatment, 11/16 (68.8%) attended for a second TOC, with 6/11(54.5%) remaining positive, despite complying with treatment adherence and abstinence. Of these, four had been incorrectly retreated with azithromycin, one with moxifloxacin and one refused initial re-treatment. All six were retreated a third time with moxifloxacin and subsequently cleared. Median time to microbiological cure following one treatment regimen was 35 days (14-85) and for ≥2 regimens was 168 days (fig.3).

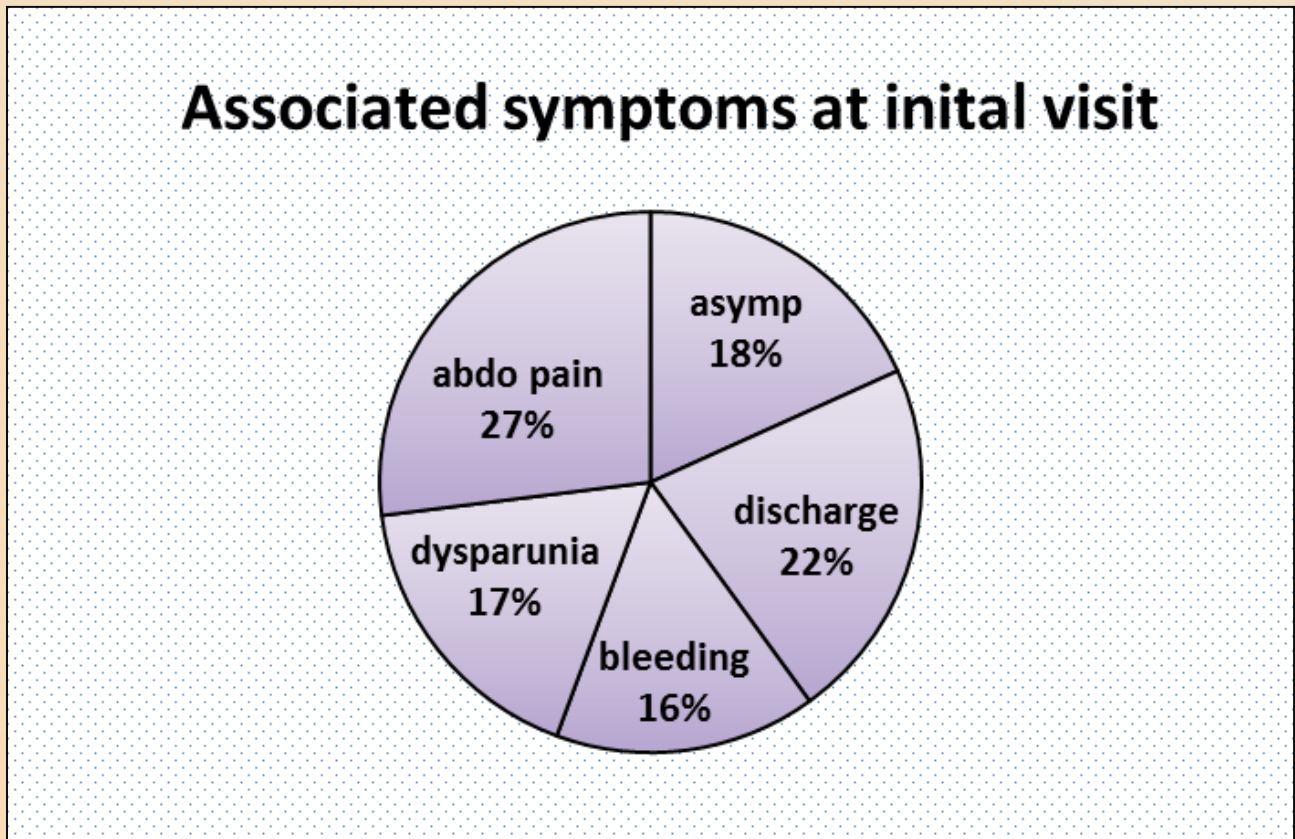


Figure 1 Presenting symptoms at initial visit to the GUM clinic

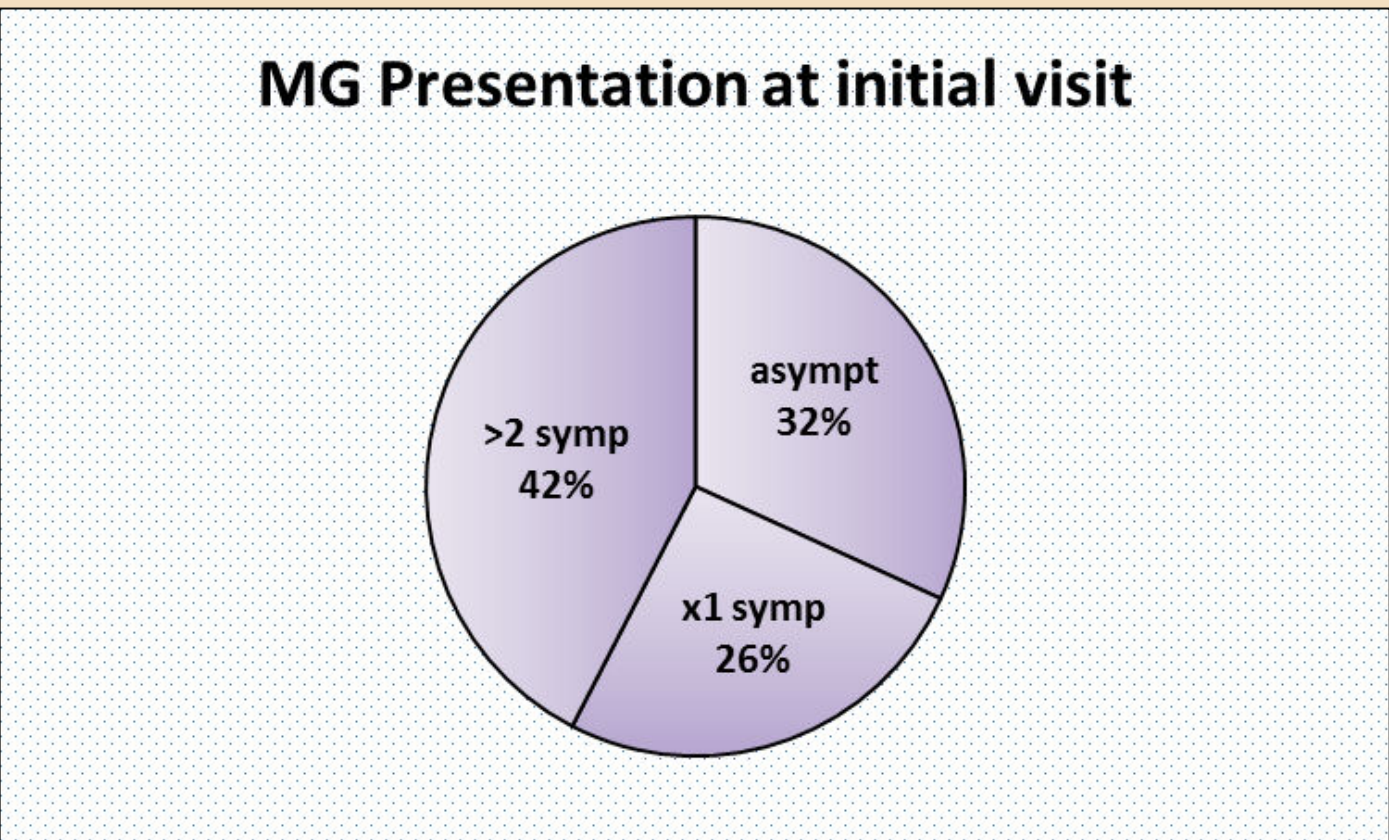


Figure 2 proportion of symptomatic/asymptomatic patients at initial visit.

## Discussion

- Good rates of clinical cure suggest infection clearance, but treatment failure with azithromycin is common (31.3%) inferring high rates of macrolide resistance once poor adherence and re-infection risk have been excluded.
- Azithromycin use is associated with much longer time to achieving microbiological cure.
- Moxifloxacin remains effective with no treatment failures.
- Attendance for TOC is poor and may be partially explained by asymptomatic nature of presentation.
- Managing Mycoplasma Genitalium without macrolide resistance testing is laborious, expensive and time consuming.
- Macrolide resistance testing alongside detection is strongly recommended where a MG testing service is being implemented.

| Treatment                   | Days Cleared |
|-----------------------------|--------------|
| Azithromycin 5 day course   | 35 days      |
| Moxifloxacin 10-14/7 course | 41 days      |
| Azithromycin/Moxifloxacin   | 143 days     |
| >3 Treatments               | 168 days     |

Figure 3 Days to microbiological cure, using 1,2 or ≥ 2 treatment regimens