CLINICAL GUIDELINES PROGRAM
NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV • HCV • STIs • SUBSTANCE USE • LGBTQ+ HEALTH

Mycoplasma genitalium Management in Adults

Updates, Authorship, and Related Resources

Date of current publication	June 10, 2026
Highlights of changes, additions, and updates in the June 10, 2026 edition	• Global: Discussion and references updated throughout • Laboratory Testing and Diagnosis section: Pelvic inflammatory disease (PID) added to the following recommendation: Clinicians should test for *M. genitalium* in individuals with persistent or recurrent urethritis or cervicitis, or with PID. (B2) • Treatment section: – New recommendation: When managing *M. genitalium* treatment failure, clinicians should obtain macrolide resistance testing to guide antimicrobial selection. (A2) – New recommendation: For ongoing sex partners of individuals with symptomatic *M. genitalium* infection, clinicians should offer testing and treat those with positive M. genitalium test results. (B3) – Recommendation removed: When *M. genitalium* testing is unavailable, clinicians should treat patients when there is a high clinical index of suspicion for *M. genitalium* infection and other STIs have been reasonably excluded from the differential diagnosis. (B3) – Table 1 updated: Section removed on what to do if *M. genitalium* nucleic acid amplification testing is unavailable, as testing is now widely available
Intended users	Clinicians who manage sexually transmitted infections in adults aged 18 years and older
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Contents

Purpose of This Guideline

The New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program developed this guideline to address the care of adults with and without HIV who have acquired sexually transmitted *Mycoplasma genitalium* infection, with the goals of:

- Assisting clinicians in recognizing common clinical manifestations of *M. genitalium* infection
- Providing clinicians with evidence-based recommendations on screening, diagnostic testing, and treatment of *M. genitalium* infection
- Ensuring New York State recommendations for *M. genitalium* screening, diagnosis, and treatment reflect the rapidly evolving evidence on the organism, infection, potential complications, and implications of drug resistance

M. genitalium is a well-recognized cause of sexually transmitted infections (STIs) worldwide and is linked to urethritis, cervicitis, and pelvic inflammatory disease, yet much is still unknown about the organism, infection, and potential complications. Treatment of *M. genitalium* infection is challenging in an era of increasing antimicrobial resistance across multiple drug classes. Emerging antimicrobial resistance worldwide has become a concern, and specific testing strategies and treatment recommendations in the United States and elsewhere have been implemented to address this issue.

Prevalence of *M. genitalium* infection: The prevalence of *M. genitalium* infection varies depending on the clinical setting and population being tested. In a large U.S. cohort of participants with and without STI symptoms in varied clinical settings, overall *M. genitalium* prevalence was approximately 10% [Gaydos, et al. 2019]. In the MyGeniUS study, which examined *M. genitalium* prevalence and resistance mutations in STI clinics across the United States, overall prevalence was slightly higher at 16.6% [Manhart, et al. 2023]. Prevalence has consistently been higher among individuals younger than 21 years [Manhart, et al. 2023; Menezes, et al. 2023]. *M. genitalium* prevalence among people with HIV in North America is estimated to be 20% [Zhang, et al. 2025]. Data from multiple countries and populations that include a mix of symptomatic and asymptomatic individuals suggest that asymptomatic *M. genitalium* infection is common [Calas, et al. 2021; Gesink, et al. 2016; Huppert, et al. 2008; Manhart, et al. 2007].

Clinical Manifestations

Although asymptomatic infection is common, *Mycoplasma genitalium* infection has been associated with the clinical syndromes of urethritis, cervicitis, and pelvic inflammatory disease (PID). The relationships between *M. genitalium* and cervicitis and urethritis have been established, with the strongest association seen with urethritis [CDC 2021; Dehon, et al. 2016; Lis, et al. 2015; Lusk, et al. 2011; Gaydos, et al. 2009; Wikström and Jensen 2006; Mena, et al. 2002; Totten, et al. 2001]. Symptoms are typically similar to those seen with chlamydial urethritis (nonpurulent urethral discharge) as opposed to gonococcal urethritis (frankly purulent discharge).

A 2023 systematic review and meta-analysis found that *M. genitalium*, detected by nucleic acid amplification testing, was associated with 67% greater odds of PID [Htaik, et al. 2024]. A randomized trial comparing the addition of metronidazole or placebo to standard PID treatment (ceftriaxone plus doxycycline) noted a statistically significant reduction in detection of *M. genitalium* 30 days after treatment in the metronidazole arm [Wiesenfeld, et al. 2021]. More recently, in a study conducted in sexually transmitted infection clinics in the United States, infection with *M. genitalium* was associated with bacterial vaginosis (odds ratio, 3.08; 95% confidence interval, 1.58–5.99, *P*=.0113), although control for other factors associated with BV was limited [Schwebke, et al. 2024]. Some experts suggest these findings implicate the influence of the vaginal microbiome on *M. genitalium*, but further investigation is needed [Mitchell, et al. 2021].

M. genitalium has been identified at various anatomic sites [Baiers, et al. 2024; Yazdy, et al. 2023]. Currently there is no evidence that *M. genitalium* is a cause of pharyngitis and insufficient evidence that it is a cause of vaginitis, proctitis, or epididymo-orchitis [Baiers, et al. 2024; Yazdy, et al. 2023; Manhart, et al. 2022; Read, et al. 2019; Horner and Martin 2017].

Laboratory Testing and Diagnosis

☑ RECOMMENDATIONS

Laboratory Testing and Diagnosis

- Clinicians should *not* routinely screen for *Mycoplasma genitalium* in asymptomatic individuals. (A3)
- Clinicians should test for *M. genitalium* in individuals with persistent or recurrent urethritis or cervicitis, or with PID. (B2)
- When testing is indicated, clinicians should use NAAT to diagnose *M. genitalium* infection, with reflex to resistance testing when available. (A1)

Abbreviations: NAAT, nucleic acid amplification testing; PID, pelvic inflammatory disease.

M. genitalium has no cell wall and can take months to grow in culture; thus, traditional methods of diagnosis with gram stain or culture are not useful. Diagnosis was difficult until NAAT became available. NAAT is the preferred U.S. Food and Drug Administration (FDA)-approved diagnostic method for *M. genitalium* infection. FDA-approved tests currently cleared for use on urine, vaginal, endocervical, urethra, and penile meatus specimens are the Aptima Mycoplasma Genitalium Assay (Hologic Inc) and Cobas TV/MG Assay (Roche Molecular Systems, Inc.). The latter detects both *M. genitalium* and *Trichomonas vaginalis* from a single specimen. For both assays, FDA labeling indicates vaginal specimens are preferred for females and urine specimens are preferred for males. Specimens may be self-collected or clinician collected. The Alinity m STI assay (Abbott Molecular, Inc.) detects *M. genitalium*, *T. vaginalis*, *Neisseria gonorrhoeae*, and *Chlamydia trachomatis* from a single specimen and is validated for self-collected or clinician-collected vaginal swabs or urine specimens. The cobas® liat CT/NG/MG (Roche Molecular Systems, Inc.) assay, a point-of-care Clinical Laboratory Improvement Amendments of 1988 (CLIA)-waived assay for use by nonlaboratory personnel, was approved in 2025 and detects *C. trachomatis*, *N. gonorrhoeae*, and *M. genitalium* from a clinician- or self-collected vaginal swab or urine specimen.

The specimen and site of optimal sensitivity for testing in transgender individuals with a neopenis or neovagina have not been evaluated.

Screening: Available evidence *does not* support routine screening for *M. genitalium* in asymptomatic individuals or in any specific population [ASHM 2025; Soni, et al. 2025; Baiers, et al. 2024; Manhart, et al. 2023; Yazdy, et al. 2023; Brehony, et al. 2022; Jensen, et al. 2022; Manhart, et al. 2022; CDC 2021; Golden, et al. 2017; Horner and Martin 2017], and the Centers for

Disease Control and Prevention (CDC) recommends against routine screening of asymptomatic individuals [CDC 2021]. Prevalence estimates of *M. genitalium* in the general population are low, antimicrobial resistance is increasing, the implications of asymptomatic infection are unknown, and treatment options are limited [CDC 2021; Fernández-Huerta, et al. 2020; Baumann, et al. 2018; Golden, et al. 2017; Horner and Martin 2017]. Spontaneous clearance of asymptomatic *M. genitalium* has been described in both men and women and is often cleared with standard treatment for sexually transmitted infection (STI) syndromes when either azithromycin or doxycycline are included in the regimen [Berdoyes, et al. 2026; Roy, et al. 2026; Ring, et al. 2022].

At present, there is insufficient evidence regarding pregnancy complications and treatment benefits to recommend for or against screening in asymptomatic pregnant individuals [Chen, et al. 2023; Frenzer, et al. 2022; Wiesenfeld and Manhart 2017].

Diagnostic testing: The 2021 CDC STI treatment guidelines specify that *M. genitalium* testing not be performed in initial testing for presenting STI syndromes of cervicitis or urethritis, and to consider testing in individuals with PID [CDC 2021]. The recommended use of diagnostic testing for *M. genitalium* in the United States has been limited to individuals with persistent or recurrent symptoms, because of low rates of detection and because many empiric treatment regimens for STIs include drugs that have activity against *M. genitalium* and have been demonstrated to clear infection in approximately 56% to 86% of cases [Roy, et al. 2026]. The standard of care for PID (as recommended by the CDC) includes metronidazole, which has activity against *M. genitalium,* and its inclusion in PID treatment was demonstrated to reduce *M. genitalium* in follow-up [Wood, et al. 2023; CDC 2021; Wiesenfeld, et al. 2021].

Vaginal symptoms have not been strongly associated with detection of *M. genitalium*, different from the diagnoses of cervicitis or urethritis, specifically [Manhart, et al. 2023; Yazdy, et al. 2023; Brehony, et al. 2022; Latimer, et al. 2022]. Diagnoses of persistent, recurrent urethritis in STI clinics have been increasing since 2015, and it is suspected that *M. genitalium* and other pathogens not identified by routine testing may play a role [Llata, et al. 2024]. San Francisco City Clinic implemented doxycycline as initial therapy for nongonococcal urethritis (NGU) along with *M. genitalium* testing at initial visits, and found that this strategy reduced visits for persistent or recurrent NGU from 8% to 3% (P<.0001) [Johnson, et al. 2023]; however, it is unclear which intervention led to this change, as more than half of infections may be cured by doxycycline alone, and 69% of patients had no microbiologic diagnosis, compared with 82% before intervention.

International guidelines recommend that *M. genitalium* testing be reserved for symptomatic individuals and ongoing sex partners of individuals who test positive; however, recommendations for timing of testing (e.g., initial for acute symptoms or STI syndromes vs. second-line for persistent/recurrent symptoms) differ [ASHM 2025; Soni, et al. 2025; Jensen, et al. 2022; Public Health Agency of Canada 2022].

This evolving body of evidence demonstrates that the optimal timing for diagnostic testing for *M. genitalium* remains uncertain. This committee suggests limiting *M. genitalium* testing to circumstances in which STI signs or symptoms persist despite empiric treatment for gonorrhea and chlamydia.

Testing of sex partners: There is little evidence to date to guide the management for sex partners of individuals diagnosed with *M. genitalium* infection. The CDC and most international guidelines suggest limiting *M. genitalium* testing and treatment to ongoing sex partners of individuals diagnosed and treated for symptomatic *M. genitalium* infection (see guideline section Treatment > Partner Treatment for more detail).

→ KEY POINT

- Routine screening is not recommended, and diagnostic testing is reserved for individuals who:
  - Have persistent symptoms of urethritis, cervicitis, or PID despite therapy for gonorrhea and chlamydia
  - Are current sex partners of individuals treated for symptomatic *M. genitalium* infection

Resistance testing: Molecular tests that detect both *M. genitalium* and antibiotic-associated resistance mutations are available. ARUP Laboratories and LabCorp offer macrolide reflex testing approved for use in New York State for NAAT-positive specimens. The association of certain resistance mutations with clinical treatment failure is inconsistent for quinolone antibiotics [Yuan, et al. 2025; Conway, et al. 2020], and quinolone resistance assays are not currently available commercially in the United States. However, resistance testing has been demonstrated to be a clinically useful tool to guide treatment, resulting in high cure rates, as evidenced by the resistance-guided antimicrobial therapy model (see guideline section Treatment) [Durukan, et al. 2020]. To optimally deliver 2-step resistance-guided therapy, diagnostic testing should include reflex to macrolide resistance testing when available.

Treatment

☑ RECOMMENDATIONS

Treatment

- Clinicians should treat patients with urethritis (A2), cervicitis (A2), and PID (B2) caused by *Mycoplasma genitalium* infection as recommended in Table 1: Recommended Antimicrobial Regimens for *Mycoplasma genitalium* Treatment.
- When managing *M. genitalium* treatment failure, clinicians should obtain macrolide resistance testing to guide antimicrobial regimen selection. (A2)
- For ongoing sex partners of individuals with symptomatic *M. genitalium* infection, clinicians should offer testing and treat those with positive *M. genitalium* test results. (B3)

Abbreviation: PID, pelvic inflammatory disease.

Azithromycin, doxycycline, and moxifloxacin are the most frequently used antibacterial agents for treatment of *M. genitalium* infection (see Table 1, below). There is geographic variability in cure rates and prevalence of antimicrobial resistance with respect to these antibiotics. Rates of microbiologic cure with use of single-antibiotic regimens in a New York City population, excluding sequential therapy, were 82% with moxifloxacin, 43% with single-dose azithromycin, 31% with a multiday course of azithromycin, and 60% with doxycycline [Mullis, et al. 2024]. In France, however, the cure rate with single-dose azithromycin was relatively high at 86% (18/21) of cases, and doxycycline cured 55.6% (10/18) [Roy, et al. 2026].

Antimicrobial Resistance

In the MyGeniUS study, the prevalence of macrolide resistance-associated mutations among included sexually transmitted infection (STI) clinics across 4 regions in the United States was 59.1%, with values ranging from 51.3% to 70.6% [Manhart, et al. 2023]. Although not statistically significant, a systematic review examining resistance mutations in *M. genitalium* globally through 2023 noted an overall downward trend in macrolide resistance mutations to 33.3%, and stable overall prevalence of the primary mutation conferring fluoroquinolone resistance at 14% [Chua, et al. 2025]. Factors associated with macrolide resistance mutations include male-to-male sexual contact, use of HIV pre-exposure prophylaxis, a recent STI, recurrent bacterial STIs, STI coinfection, and use of antibiotics within the previous 30 days [Chua, et al. 2025; Sokoll, et al. 2023; De Baetselier, et al. 2022; Bercot, et al. 2021; Broad, et al. 2021; De Baetselier, et al. 2021; de Salazar, et al. 2021; Latimer, et al. 2020; Li, et al. 2020; Anagrius, et al. 2013].

Several medications have been studied for *M. genitalium* treatment after initial treatment failure. Minocycline cured 67% to 71% of *M. genitalium* infections in small observational studies [Clarke, et al. 2023; Bachmann, et al. 2020; Doyle, et al. 2020]. Metronidazole and tinidazole have activity against *M. genitalium*, and when metronidazole has been combined with minocycline or doxycycline, cure rates are 80% or higher [Htaik, et al. 2025; Wood, et al. 2023; Wiesenfeld, et al. 2021]. Monotherapy with nitroimidazoles may also be effective, but evidence is limited to case reports and in vitro data [Liscynesky, et al. 2025; Wood, et al. 2023]. Newer agents such as omadacycline, zoliflodacin, and gepotidacin have demonstrated activity against *M. genitalium* in vitro [Waites, et al. 2022; Jensen, et al. 2020; Damiao Gouveia, et al. 2018], but no in vivo efficacy data are available. A 2023 case report from the United Kingdom describes successful treatment with chloramphenicol for persistent urethritis with macrolide resistance [Goodfellow, et al. 2023]. Pristinamycin (of varying dosing strategies) has demonstrated cure rates of approximately 75%, and case reports describe its use in combination with other medications discussed above, but pristinamycin is not available in the United States [Raccagni, et al. 2023; Doyle, et al. 2020].

Two-Step Treatment Approach

Updates to treatment recommendations in the United States and elsewhere address the emerging concern of antimicrobial resistance across multiple drug classes. With evidence of increasing macrolide resistance and treatment failures associated with a single dose of azithromycin 1 g, in 2021, the Centers for Disease Control and Prevention (CDC) recommended against use of this regimen in favor of 2-step antibiotic therapy [Horner, et al. 2018; Gesink, et al. 2016; Manhart, et al. 2013]. Pretreatment with doxycycline has been shown to decrease the overall bacterial burden, making treatment with a second follow-up drug more efficacious [Durukan, et al. 2020; Anagrius, et al. 2013; Björnelius, et al. 2008].

Table 1, below, outlines recommended antimicrobial regimens for *M. genitalium* treatment.

Table 1: Recommended Antimicrobial Regimens for *Mycoplasma genitalium* Treatment [a]		
Selected Conditions	**Oral Regimens**	**Considerations**
Resistance testing unavailable *or* Macrolide resistant	Doxycycline 100 mg twice daily for 7 days *followed by* moxifloxacin 400 mg once daily for 7 days	• **Pregnancy:** Doxycycline and moxifloxacin are generally not recommended [b]. • **Preferred for PID:** 14-day moxifloxacin-containing regimen [c]
Macrolide susceptible *or* Moxifloxacin unavailable	Doxycycline 100 mg twice daily for 7 days *followed by* azithromycin 1 g on day 1 *followed by* azithromycin 500 mg once daily for 3 days	• **Persistent symptoms:** If regimen is used in the absence of macrolide-susceptibility testing, perform test of cure 21 days after treatment completion [CDC 2021]. • **Pregnancy:** Doxycycline is generally not recommended [b].

Abbreviations: FDA, U.S. Food and Drug Administration; NAAT, nucleic acid amplification testing; PID, pelvic inflammatory disease; STI, sexually transmitted infection.

Notes:

a. *M. genitalium* detected by FDA-approved NAAT.
b. See guideline section Treatment > Pregnancy.
c. A 14-day regimen containing moxifloxacin (400 mg per day) is effective for PID treatment [Ovens, et al. 2020; Latimer, et al. 2019; Judlin, et al. 2010; Ross, et al. 2006], in addition to an empiric 14-day regimen for PID that contains doxycycline [CDC 2021]. The evaluation and treatment of PID are not limited to the management discussed here.

The CDC 2021 sexually transmitted infection (STI) Treatment guidelines include treatment recommendations for uncomplicated chlamydial infections, nongonococcal urethritis, and cervicitis with oral doxycycline 100 mg twice daily for 7 days [CDC 2021]. This facilitates use of a 2-step doxycycline-containing regimen for individuals with persistent or recurrent urethritis or cervicitis who return for follow-up. Standard empiric therapy for PID also includes doxycycline as a component. The CDC recommends that when testing results become available after treatment initiation in cases of PID attributed to *M. genitalium*, moxifloxacin should be added to the empiric PID regimen rather than given sequentially [CDC 2021]. For PID related to *M. genitalium* or the PID clinical syndrome in general, a 14-day course of moxifloxacin was found to be effective [Ovens, et al. 2020; Latimer, et al. 2019; Judlin, et al. 2010; Ross, et al. 2006]. Because of emerging resistance overall and a lack of treatment alternatives, Australian, Canadian, and European STI guidelines do not recommend moxifloxacin for initial empiric treatment of *M. genitalium* infection [ASHM 2025; Soni, et al. 2025; Jensen, et al. 2022; Public Health Agency of Canada 2022], although, notably, access to antimicrobial resistance testing outside the United States is more widely accessible to guide treatment selection.

Australian and British treatment guidelines also recommend a 2-step treatment approach [ASHM 2025; Soni, et al. 2025]. In Australia, cure rates reached more than 90% with the implementation of resistance-guided therapy (RGT) [Vodstrcil, et al. 2022; Durukan, et al. 2020]: Individuals with an STI syndrome received 7 days of oral doxycycline 100 mg twice daily empirically and then, if found to have *M. genitalium* infection without macrolide resistance, received 2.5 g oral azithromycin over 4 days (1 g on day 1 and 500 mg once daily on days 2 through 4). After initial treatment with doxycycline, individuals with macrolide-resistant *M. genitalium* infection received oral moxifloxacin 400 mg once daily for 7 days. A test of cure was performed 2 to 4 weeks after treatment. The cure rate with the RGT approach was 92%, even in regions with reported quinolone resistance of 15% to 20% [Durukan, et al. 2020]. Use of doxycycline followed by moxifloxacin or sitafloxacin (not available in the United States) continued to result in high cure rates [Yuan, et al. 2025; Vodstrcil, et al. 2022].

Treating asymptomatic *M. genitalium* infection: Asymptomatic *M. genitalium* infection is common, and the benefit of treating asymptomatic individuals has not been clearly demonstrated. There is a theoretical benefit to treating asymptomatic ongoing partners of individuals with symptomatic infection (see Partner Treatment, below); treatment of asymptomatic *M. genitalium* is otherwise not recommended.

Test of cure: The timeframe used for test of cure in the published literature is highly variable. Testing too soon after treatment carries the risk of detecting residual noninfectious particles. The CDC recommends a test of cure at 21 days for those treated with the 2-step doxycycline plus azithromycin regimen (see Table 1, above) who did not complete macrolide

resistance testing [CDC 2021]. This committee prefers that test of cure be reserved for patients who remain symptomatic and obtained no sooner than 21 days after treatment.

STI coinfection: When coinfection with another STI is present, it remains unclear based on available evidence whether *M. genitalium* is a true pathogen requiring treatment. If *M. genitalium* is detected in a patient with another STI, this committee recommends reserving treatment for *M. genitalium* for those with persistent symptoms despite appropriate treatment of the other infection (e.g., gonorrhea, chlamydia, trichomoniasis).

Managing Treatment Failure

It is important to distinguish between reinfection and treatment failure; see Partner Treatment, below. To aid in management of *M. genitalium* infection, macrolide resistance testing (if not already performed at diagnosis) should be obtained to help guide antimicrobial regimen selection going forward. For individuals with persistent infection despite treatment with recommended 2-step therapy, minocycline 100 mg orally twice daily for 14 days is an option supported by observational data [Clarke, et al. 2023; Doyle, et al. 2020]. If this regimen is unsuccessful, nitroimidazoles may be considered, although optimal drug choice and dosing vary. In cases of treatment failure across multiple drug classes and detected macrolide resistance, treatment options with case reports of success include the following: 1) minocycline 100 mg orally twice daily combined with metronidazole 500 mg orally twice daily for 14 days (tinidazole 2 g orally once daily may be substituted for the twice daily metronidazole), and 2) tinidazole 2 g orally once daily for 7 days [Htaik, et al. 2025; Liscynesky, et al. 2025; Wood, et al. 2023].

→ KEY POINT

- Consult an infectious disease or STI expert for individuals who have persistent infection despite salvage therapy, for consideration of alternative therapies and drug combinations (see Antimicrobial Resistance, above).

Pregnancy

Moxifloxacin and doxycycline are generally *not recommended* for pregnant individuals. An azithromycin-only course of treatment (e.g., azithromycin 1 g on day 1 followed by 500 mg once daily on days 2, 3, and 4) can be considered with acknowledgment of the risk of treatment failure (see discussion above). Given the high rates of azithromycin resistance, shared decision-making is warranted after considering the potential risks of untreated *M. genitalium* infection during pregnancy and the potential risk of adverse drug events associated with antibiotics not generally used during pregnancy. Some individuals may elect to postpone treatment until after delivery, depending on individual circumstances [Jensen, et al. 2022]. International guidelines advise caution when selecting treatment for pregnant individuals, generally proposing initial treatment with azithromycin monotherapy (with varying dosing strategies), with some suggesting pristinamycin (not available in the United States) as an alternative and acknowledging its limited safety data [Drew and Eogan 2024].

Some studies have raised concerns about associations between *M. genitalium* infection and infertility and pregnancy complications, although the evidence is limited and insufficient to demonstrate causation. A meta-analysis of available studies suggested significant associations with preterm birth and spontaneous abortion [Lis, et al. 2015]. In this same analysis, the risk of infertility was described as elevated but was not statistically significant [Lis, et al. 2015]. A systematic review that examined multiple mycoplasma species and spontaneous abortion, specifically, found that the presence of *M. genitalium* (as detected by polymerase chain reaction [PCR] test) was not associated with spontaneous abortion [Chen, et al. 2023]. Some studies have reported associations between *M. genitalium* infection and preterm birth and low birth weight, but the lack of control for confounding within these studies limit the strength of the analyses [Scoullar, et al. 2024; Frenzer, et al. 2022]. Much of the existing data are from observational studies and are further limited by confounding and use of serology before 2019 [Frenzer, et al. 2022].

Partner Treatment

There is insufficient evidence to determine whether sex partners of individuals with symptomatic *M. genitalium* infection should receive treatment only if infection is detected through a laboratory test [ASHM 2025; Soni, et al. 2025; Jensen, et al. 2022; Public Health Agency of Canada 2022] or regardless of test results. In alignment with CDC guidelines, to prevent potential reinfection of the index patient, this committee recommends offering testing to ongoing sex partners and limiting treatment to those with positive test results. Partners can be treated with the same regimen as the index patient [CDC 2021].

All Recommendations

☑ ALL RECOMMENDATIONS: MYCOPLASMA GENITALIUM MANAGEMENT IN ADULTS

Laboratory Testing and Diagnosis

- Clinicians should *not* routinely screen for *Mycoplasma genitalium* in asymptomatic individuals. (A3)
- Clinicians should test for *M. genitalium* in individuals with persistent or recurrent urethritis or cervicitis, or with PID. (B2)
- When testing is indicated, clinicians should use NAAT to diagnose *M. genitalium* infection, with reflex to resistance testing when available. (A1)

Treatment

- Clinicians should treat patients with urethritis (A2), cervicitis (A2), and PID (B2) caused by *Mycoplasma genitalium* infection as recommended in Table 1: Recommended Antimicrobial Regimens for *Mycoplasma genitalium* Treatment.
- When managing *M. genitalium* treatment failure, clinicians should obtain macrolide resistance testing to guide antimicrobial regimen selection. (A2)
- For ongoing sex partners of individuals with symptomatic *M. genitalium* infection, clinicians should offer testing and treat those with positive *M. genitalium* test results. (B3)

Abbreviations: NAAT, nucleic acid amplification testing; PID, pelvic inflammatory disease.

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Supplement: Guideline Development and Recommendation Ratings

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Developer	New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program
Funding source	NYSDOH AI
Program manager	Clinical Guidelines Program, Johns Hopkins University School of Medicine, Division of Infectious Diseases. See Program Leadership and Staff.
Mission	To produce and disseminate evidence-based, state-of-the-art clinical practice guidelines that establish uniform standards of care for practitioners who provide prevention or treatment of HIV, viral hepatitis, other sexually transmitted infections, and substance use disorders for adults throughout New York State in the wide array of settings in which those services are delivered.
Expert committees	The NYSDOH AI Medical Director invites and appoints committees of clinical and public health experts from throughout New York State to ensure that the guidelines are practical, immediately applicable, and meet the needs of care providers and stakeholders in all major regions of New York State, all relevant clinical practice settings, key New York State agencies, and community service organizations.
Committee structure	• Leadership: AI-appointed chair, vice chair(s), chair emeritus, clinical specialist(s), JHU Guidelines Program Director, AI Medical Director, AI Clinical Consultant, AVAC community advisor • Contributing members • Guideline writing groups: Lead author, coauthors if applicable, and all committee leaders
Disclosure and management of conflicts of interest	• Annual disclosure of financial relationships with commercial entities for the 12 months prior and upcoming is required of all individuals who work with the guidelines program, and includes disclosure for partners or spouses and primary professional affiliation. • The NYSDOH AI assesses all reported financial relationships to determine the potential for undue influence on guideline recommendations and, when indicated, denies participation in the program or formulates a plan to manage potential conflicts. Disclosures are listed for each committee member.
Evidence collection and review	• Literature search and review strategy is defined by the guideline lead author based on the defined scope of a new guideline or update. • A comprehensive literature search and review is conducted for a new guideline or an extensive update using PubMed, other pertinent databases of peer-reviewed literature, and relevant conference abstracts to establish the evidence base for guideline recommendations. • A targeted search and review to identify recently published evidence is conducted for guidelines published within the previous 3 years. • Title, abstract, and article reviews are performed by the lead author. The JHU editorial team collates evidence and creates and maintains an evidence table for each guideline.
Recommendation development	• The lead author drafts recommendations to address the defined scope of the guideline based on available published data. • Writing group members review the draft recommendations and evidence and deliberate to revise, refine, and reach consensus on all recommendations. • When published data are not available, support for a recommendation may be based on the committee's expert opinion. • The writing group assigns a 2-part rating to each recommendation to indicate the strength of the recommendation and quality of the supporting evidence. The group reviews the evidence, deliberates, and may revise recommendations when required to reach consensus.

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Review and approval process	• Following writing group approval, draft guidelines are reviewed by all contributors, program liaisons, and a volunteer reviewer from the AI Community Advisory Committee. • Recommendations must be approved by two-thirds of the full committee. If necessary to achieve consensus, the full committee is invited to deliberate, review the evidence, and revise recommendations. • Final approval by the committee chair and the NYSDOH AI Medical Director is required for publication.
External reviews	• External review of each guideline is invited at the developer's discretion. • External reviewers recognized for their experience and expertise review guidelines for accuracy, balance, clarity, and practicality and provide feedback.
Update process	• JHU editorial staff ensure that each guideline is reviewed and determined to be current upon the 3-year anniversary of publication; guidelines that provide clinical recommendations in rapidly changing areas of practice may be reviewed annually. Published literature is surveilled to identify new evidence that may prompt changes to existing recommendations or development of new recommendations. • If changes in the standard of care, newly published studies, new drug approval, new drug-related warning, or a public health emergency indicate the need for immediate change to published guidelines, committee leadership will make recommendations and immediate updates and will invite full committee review as indicated.

Table S2: Recommendation Ratings and Definitions		
Strength	**Quality of Evidence**	
A: Strong B: Moderate C: Optional	1	Based on published results of at least 1 randomized clinical trial with clinical outcomes or validated laboratory endpoints.
	*	Based on either a self-evident conclusion; conclusive, published, in vitro data; or well-established practice that cannot be tested because ethics would preclude a clinical trial.
	2	Based on published results of at least 1 well-designed, nonrandomized clinical trial or observational cohort study with long-term clinical outcomes.
	2†	Extrapolated from published results of well-designed studies (including nonrandomized clinical trials) conducted in populations other than those specifically addressed by a recommendation. The source(s) of the extrapolated evidence and the rationale for the extrapolation are provided in the guideline text. One example would be results of studies conducted predominantly in a subpopulation (e.g., one gender) that the committee determines to be generalizable to the population under consideration in the guideline.
	3	Based on committee expert opinion, with rationale provided in the guideline text.