

Expert Interviews

National STD Curriculum Podcast

Clinical Management of Mycoplasma Genitalium

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Dr. Ina Park, Professor at the University of California, San Francisco and Principal Investigator of the California Prevention Training Center discusses the clinical management of *Mycoplasma genitalium*, including testing and treatment options, with Dr. Meena Ramchandani.

Topics:

- M genitalium
- M gen
- mycoplasma
- resistance

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[Disclosures](#)**Disclosures for Ina Park, MD, MS**

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Transcript

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[intro--background](#)**[00:00] Intro & Background**

Hello everyone. My name is Meena Ramchandani. I'm an infectious disease physician at the University of Washington in Seattle. This podcast is dedicated to an STI [sexually transmitted infections] literature review for health care professionals who are interested in remaining up to date on the diagnosis, management, and prevention of STIs.

For this episode, we welcome Dr. Ina Park. Dr. Park is a professor at the University of California, San Francisco, and principal investigator at the California Prevention Training Center. Dr. Park is a national authority on sexually transmitted infections and the author of *Strange Bedfellows: Adventures in the Science, History, and Surprising Secrets of STDs*, a great book that uses storytelling to help destigmatize STIs and educate on sexual health. I recommend that for all of you. Welcome, Dr. Park. It's wonderful to have you on this episode.

Dr. Park

Well, thank you, Dr. Ramchandani/Meena.

[testing-for](#)**[00:58] Testing for *M genitalium***

Dr. Ramchandani

I'd like to focus this episode on clinical aspects and management of *Mycoplasma genitalium*, as it can sometimes be a difficult and frustrating STI to treat. So, the first question I have is when should we test for *Mycoplasma genitalium* and who should we test? And I'm going to also use *M. genitalium* or *Mgen* for short.

Dr. Park

Yeah, I mean, I think what I'll do is cite the CDC [Centers for Disease Control and Prevention] guidance, and then I'll cite what some folks out there in the community are doing. And let me start by saying *Mycoplasma* is actually very common, and it's certainly a very common cause of syndromes such as urethritis and cervicitis. And it also can cause PID [pelvic inflammatory disease] and may also be associated with proctitis, although that association is not quite as clear. But I have to say that the CDC recommends actually testing for *Mycoplasma genitalium* after empiric treatment for urethritis and cervicitis has failed. And just to remind listeners, typically when someone's coming in with urethritis, if gonorrhea is not suspected or it's been ruled out, you'd be treating with doxycycline (doxy) for seven days, so that's 100 milligrams BID [twice a day]. And the CDC recommends that if someone fails that treatment, then to test for *Mycoplasma genitalium* and to treat accordingly.

It's a little bit different for PID. The recommended regimens, first-line regimens for PID are not all that effective against *Mycoplasma*. And we do know that *Mycoplasma* is certainly associated with PID, so there is a recommendation to consider testing an initial presentation for PID. And there actually aren't any recommendations in the CDC guidelines specifically for proctitis at this time, but we do know that folks in the community are testing for that, but typically after other causes of proctitis have been ruled out first.

[symptoms-syndromes](#)**[02:42] Symptoms and Syndromes**

Dr. Ramchandani

So, it causes clinical syndromes of urethritis, PID, cervicitis, and potentially proctitis. Is that correct?

Dr. Park

That's correct.

Dr. Ramchandani

Can it also cause other extragenital infections, such as pharyngitis? Has there ever been an association with *Mgen* and pharyngitis?

Dr. Park

It's interesting because there are studies when people look for *Mycoplasma* in the throat, you can find it, but as far as we know, there's no association with a syndrome of pharyngitis like you might get with gonorrhea, although most gonorrhea is asymptomatic. It can be associated in rare cases with pharyngitis. That does not seem to be the case of *Mycoplasma genitalium*. And so, certainly, extragenital screening of any kind is not recommended for that.

Dr. Ramchandani

When patients have failed treatment for cervicitis or urethritis, that's really when providers should start thinking about alternative infections, such as *Mgen*, correct?

Dr. Park

Yeah, that's correct. And because a lot of those people, as I mentioned, are going to get treated with doxycycline. The thing about doxycycline is that it's about 30 to 40% effective at treating *Mycoplasma genitalium*. And so, some people are going to get better with their *Mycoplasma genitalium* just from taking doxycycline, but it's certainly not the majority of folks. And some people are going to have these prolonged symptoms and are then going to require an additional course of antibiotics to fully eradicate the infection.

[prevalence](#)**[04:04] Prevalence**

Dr. Ramchandani

How common is the organism? How prevalent is it, or what is the incidence?

Dr. Park

So, in the general population, it's pretty common. The way I like folks to think about it is that it's less common than chlamydia, but in the general population, it's more common than gonorrhea. So, gonorrhea is less than a half a percent (0.5%) in terms of general population prevalence, but *Mycoplasma genitalium* is about 1%. So, it's certainly out there and it's certainly something that I was saying to you at different times that we've talked that I don't think it gets enough respect, and I have been humbled very much in the past few years about how challenging it can be to treat.

Dr. Ramchandani

Same here.

[diagnostic-evaluation](#)**[04:45] Diagnostic Evaluation**

Dr. Ramchandani

How would a clinician screen a patient for *Mgen*? What's the best test to use?

Dr. Park

Oh, that's great. Well, first of all, I think you just said a trigger word, which is screening, and that we definitely don't want to be screening patients for *Mycoplasma genitalium*. I think you did that on purpose, Meena, to trick me. For diagnostic testing, then we definitely want people to use a nucleic acid amplification test [NAAT]. And the funny thing is, is that those were only FDA [Food and Drug Administration]-cleared at the end of 2019 in December, and then we all know what happened in 2020. So, it's been interesting that testing for *Mycoplasma genitalium* has really only taken off in the past three or four years because I think a lot of testing didn't happen right after the test was initially released.

Dr. Ramchandani

So, a provider wouldn't screen a patient who doesn't have symptoms. It's really someone who's presenting for care. And then the best test to use, would it be a NAAT, a culture? What type of test would you do?

Dr. Park

You should definitely be using a NAAT. And so, you could do that for someone who is experiencing vaginal discharge; you could do either a vaginal swab or a cervical swab. You can also do a urine for females. And then for male patients, then a urine would be perfect. You don't have to do any sort of intraurethral swab or anything like that. So, just the typical NAAT, many of the platforms that folks are already using for chlamydia and gonorrhea have the additional *Mycoplasma* tests that can be ordered on the same specimen. So usually, another specimen does not have to be collected.

Dr. Ramchandani

That's great. So that's really convenient for both the patient and the provider.

Dr. Park

For sure.

[treatment](#)**[06:22] Treatment**

Dr. Ramchandani

Let's say a person has been diagnosed with *Mgen*. You talked about doxycycline. You said doxycycline doesn't always work. What would be the recommended treatment?

Dr. Park

Yeah, and I would even say doxycycline doesn't often work, right? But let's say someone comes in, they have urethral discharge, you treated them empirically with doxycycline, and you ordered a chlamydia and gonorrhea test, and that test is negative, but they still have symptoms. You order a *Mycoplasma* test, it's positive. Then you'd want to be giving them a week of moxifloxacin of 400 milligrams. So typically, the recommended regimen is a week of doxycycline, which leads straight into a week of moxifloxacin, 400 milligrams daily times seven days. So, if you have a situation where someone got empirically treated with doxycycline and now several weeks have passed and now, they're coming in with new symptoms, if their

Mycoplasma test is positive, you want to restart that course of doxycycline seven days and then give them moxifloxacin for seven days. So, they'd be taking a total of 14 days of antibiotics if that makes sense.

Dr. Ramchandani

Why is doxycycline given prior to moxifloxacin for *Mgen* treatment? We don't do sequential therapy for a lot of STIs. Why do we do it for *Mgen*?

Dr. Park

Theoretically, as I mentioned, it's not effective necessarily at eradicating the infection, but certainly we've seen from multiple studies that it can lower the organism load or bacterial load, which then gives the moxifloxacin an opportunity or a greater chance of efficacy in eradicating the infections. So, I think the intention with that first week of doxy lead-in is not necessarily that we're going to eradicate the infection, but that we will lower the bacterial burden, and then we will have a higher likelihood of successful treatment once you add the moxifloxacin in.

[natural-history](#)[08:08] **Natural History**

Dr. Ramchandani

And why treat this infection? What if we didn't treat *Mgen*? What's the natural history of *Mgen* without treatment? What are they seeing in studies?

Dr. Park

Okay. So, Meena, that's a great question because if people were just walking around with asymptomatic *Mycoplasma* and it was not going to have any consequences, then would we really need to chase our tails trying to eradicate this infection? And I will say that certainly you can clear *Mycoplasma genitalium* spontaneously. So, there have been some studies, not many, unfortunately, that have looked at persistence or clearance without intervention or treatment. And the problem is, is that the range of what happens in those studies varies widely. So, in some studies it's three months or so it takes to clear the infection. In one study, it took up to 15 months. And then the issue is, is that for females, it is linked with adverse reproductive outcomes, such as preterm birth. There is increasing evidence that it's linked to low birth weights, and then there has been association as well with those complicated upper tract infections like PID.

And then for male patients, I think the fact that someone has symptomatic discharge, I think is reason alone to treat *Mycoplasma*, you're not going to have many friends if you don't treat people who are symptomatic. So, I think that's the primary goal for male patients. And then we don't know, Meena, as we sort of alluded to earlier, around the association with *Mycoplasma* and proctitis. So, if you were to let an asymptomatic *Mycoplasma* infection just sit there, would it actually develop into proctitis? We don't know, but certainly someone with symptomatic proctitis is going to want relief. And therefore, if you did find *Mycoplasma* there after ruling out other causes of proctitis, I think it would behoove you to treat that in order to get relief for the patient.

Dr. Ramchandani

So, really decreasing the morbidity of the symptoms and then also the potential for transmission to others.

Dr. Park

And the truth is, it is possible that for some people asymptomatic colonization with *Mgen* is fine, but we don't know who those people are. We don't know how to risk-stratify who is going to have a complication and who's not going to have a complication. So, for now, when people are symptomatic, especially if they're persistently

symptomatic, we just want to get them to feel better. We may not even successfully eradicate the infection, which we can talk about in the treatment portion of this discussion.

[10:37] *Ureaplasma* Testing

Dr. Ramchandani

I've seen some labs that have results where the patient's not infected with *Mgen* or *Mycoplasma genitalium*, but the lab comes back positive for *Ureaplasma* or other *Mycoplasma* species. What is your approach to that? My approach is not to treat because those have not been associated as an STI or with the clinical syndromes of sexually transmitted infections, but what is your approach?

Dr. Park

So, I wish the listeners could see me rolling my eyes right now, and I wish that laboratories would not test for *Ureaplasma* or *M. hominis*, for example. Every time I see that, I cringe a little bit. And the issue is that those are incredibly common and can be asymptomatic colonizers. And in some studies that I've actually looked at in my *Mycoplasma* journey, I've seen some studies where over 50% of the folks in the study had *Ureaplasma*, for example, and were asymptomatic. So, if we have something that common and we're looking for it and telling people that they have some sort of pathogen, it's causing a lot of anxiety and a lot of antibiotic use and not reaping any benefits. So, I actually ignore those, and I tell people why I'm ignoring them and reassure them that we don't think that these are serious pathogens.

Dr. Ramchandani

Yeah, that's the same approach that I have too. I mean, we have millions of organisms in our bodies, so we don't treat a lot of those. Some of those are just part of the natural microbiome and that's okay.

Dr. Park

That's exactly how I talk about it, too. And then I will say, though, there are rare circumstances in which someone has a genital syndrome, and every other cause has been ruled out, and *Ureaplasma* is the only thing that people can point to, but I just feel like that is so uncommon and not to discount the experience of patients who have dealt with it, because certainly there have been. If you go to Reddit, you'll see it. But I just want to say that in general, it's not something that we should be looking for actively.

Dr. Ramchandani

So, you checked out the Reddit.

Dr. Park

Oh, yes.

Dr. Park

I highly recommend people go and look at patient experiences around *Mycoplasma*, *Ureaplasma*, et cetera, and see what people are talking about. There's definitely some people really anxious and freaking out about them.

[treatment-failure](#)**[12:46] Treatment Failure**

Dr. Ramchandani

Let's turn to treatment. I think that'll be helpful for providers to talk a little bit more about that. Are clinicians seeing treatment failures with this organism? How difficult is it to treat *Mgen*, let's say, compared to chlamydia infection or syphilis?

Dr. Park

Oh my gosh, I wish people would have chlamydia or syphilis. They're so much easier to treat. And you know this too, Meena, because I know you've dealt with this in your own practice, is that *Mycoplasma* is becoming increasingly more difficult to treat. There've now been systematic reviews looking at antibiotic resistance both to macrolides and to fluoroquinolones. And we've seen an enormous increase in macrolide resistance in the United States, for example. I would say in many urban jurisdictions where there's STI clinics, there's a national study actually done by one of your colleagues, Lisa Manhart, and they found prevalence of macrolide resistance to be over 50 to 60% in some of these locations that have STI clinics. And so, we've seen worldwide the prevalence of fluoroquinolone resistance markers increasing to over 10%. And so, as we mentioned, moxifloxacin is one of the mainstays of treatment, and, therefore, given that resistance is increasing, we're going to see more treatment failures.

And for our younger listeners who may not have been as familiar with using single-dose azithromycin (azithro) in the past for urethritis, I do think that has led in some part to the increase in antibiotic resistance that we've seen in *Mgen*.

Dr. Ramchandani

Now the STI treatment guidelines talks about different recommended treatment options for a patient with *Mgen*, and they say, "If resistance testing is available, this is the path that you would follow." So, I wanted to ask you, is resistance testing for *Mgen* available in the U.S., and will it be if not?

Dr. Park

Well, so there was some wishful thinking, I think, with those guidelines in the hopes actually that there were some companies looking to release resistance testing into the U.S. However, that did not come to pass. And so, the majority of your listeners are not going to have access to resistance testing. So, for the most part, you'll be using that doxycycline to moxifloxacin regimen of two weeks. I also wanted to make listeners aware that commercial laboratories in the U.S., such as LabCorp, actually do have macrolide resistance testing available. And for cases that are really difficult, the University of Alabama, Birmingham, offers both fluoroquinolone and macrolide resistance testing through their laboratory. That's something that people would need to search for online. It comes up pretty easily with Google, but the folks there at the lab are really nice. They're actually pretty easy to get in touch with. And so, if you are working up a very difficult case, that's a place that you could go.

But, generally speaking, the average provider out there, including in STI clinics where I practice, does not have access to resistance testing. So, for the most part, you're going to be using doxycycline and moxifloxacin for most of your cases.

Dr. Ramchandani

I haven't had access to resistance testing, but I do know that abroad, in other countries, they have access to that, and I think that helps to guide their management, right?

Dr. Park

Absolutely. So, in Australia and in Europe, resistance testing is routinely done. So, anyone who is macrolide sensitive can use doxycycline and then followed by an extended azithro regimen, which is 2.5 grams over four days.

Dr. Ramchandani

Dr. Park, thank you for taking us through this wonderful discussion on *Mycoplasma genitalium*. It's been really helpful for our audience, and we appreciate your time.

Dr. Park

Thank you, Meena.

[credits](#) **[16:25] Credits**

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