INESSS
LE SAVOIR PREND FORME

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PHARMACOLOGICAL TREATMENT

STBBI

CONFIRMED *MYCOPLASMA GENITALIUM* INFECTION

This optimal usage guide is intended for primary care physicians. It is provided for information purposes only and should not replace the judgement of the clinician who performs activities reserved under an act or a regulation. The recommendations concern persons 14 years of age and older[1]. They were developed using a systematic process and are supported by the scientific literature and the knowledge and experience of Québec clinicians and experts. For further details, go to the section *Guides d'usage optimal at inesss.qc.ca.*

GENERAL CONSIDERATIONS

- When a person presents with a syndrome consistent with an STBBI and screens negative for *C. trachomatis* and *N. gonorrhoeae* and an appropriate syndromic treatment for the syndrome has proven ineffective, it is important to consider the possibility of the presence of other pathogenic agents or chronic conditions.
- Nonchlamydial/nongonococcal infections can have different etiologies, including *Mycoplasma genitalium*.
- This optimal usage guide applies to individuals for whom appropriate microbiological testing has been performed **AND** whose results show the presence of *M. genitalium*. For further details, please consult the practice guide Analyses de laboratoire pour le diagnostic des infections génitales à *Mycoplasma genitalium*.
- It should be noted that confirmed *M. genitalium* infection is not a notifiable disease.

MANAGEMENT

INTERVENTION WITH THE INFECTED PATIENT

The intervention should include:

- An appropriate treatment and a follow-up of the infected patient;
- A recommendation to abstain from sexual contact until the end of treatment **AND** until the symptoms are resolved[2]:
  - If in doubt regarding abstinence, a recommendation to use barrier methods for all types of sexual contact (genital, oral-genital, anal or oral-anal).

INTERVENTION WITH SEXUAL PARTNERS

Partners should be contacted if they have had sexual contact with the infected patient:

- While the infected patient had symptoms; **OR**
- Before the end of treatment for *M. genitalium*.

The intervention should include:

- Treatment for *M. genitalium* whether or not the partner has any signs or symptoms (microbiological testing for detecting *M. genitalium* in the partners of the infected patient is not necessary);
- A clinical assessment including identification of risk factors for other STBBIs;
- Screening for other STBBIs based on the identified risk factors. Consult the tool *ITSS à rechercher selon les facteurs de risque décelés*.

MEDICATION FREE OF CHARGE

For persons registered with the Québec health insurance plan (RAMQ) and who have a valid health insurance card, claim slip or temporary proof of eligibility for medication: enter on the prescription the code **K** (for the infected patient) or the code **L** (for sexual partners).

ANTIBIOTIC RESISTANCE

M. genitalium resistance to the different antibiotics is increasing rapidly, and the recommended treatments might eventually be modified according to changing susceptibility profiles based on mutations conferring resistance to antibiotics used for treatment. Practitioners should be vigilant because:

- Resistance to azithromycin is well established;
- Resistance to the fluoroquinolones is on the increase.

1. For cases of suspected sexual abuse, refer to the *Guide d'intervention médicosociale pour répondre aux besoins des victimes d'agression sexuelle.*
2. If the patient does not comply with the abstinence instructions, consult an experienced colleague to determine the appropriate management.

MYCOPLASMA GENITALIUM INFECTION

TREATMENT PRINCIPLES

- When the screening results for macrolide or fluoroquinolone resistance mutations are known, antibiotic resistance should be taken into account when choosing a treatment for *M. genitalium*.
- Since the use of azithromycin can induce macrolide resistance, retreatment with azithromycin in a multi-day dosing regimen should not be prescribed to individuals who did not respond to this antibiotic during the initial treatment of a syndrome consistent with an STBBI.
- The use of moxifloxacin as first-line therapy in all cases of confirmed *M. genitalium* infection is not recommended, as the other treatment options are limited. Moxifloxacin is recommended in cases of prior use of azithromycin during syndromic treatment, suspected or confirmed macrolide resistance, or a complicated infection.

TREATMENT

INFECTED PATIENT

UNCOMPLICATED INFECTIONS: CERVICITIS OR URETHRITIS

Confirmed macrolide susceptibility OR No data concerning macrolide susceptibility in a person who did not receive azithromycin during syndromic treatment	Suspected or confirmed macrolide resistance OR Prior use of azithromycin during syndromic treatment	Suspected or confirmed fluoroquinolone resistance
Azithromycin[1] 500 mg PO daily x 1 day, then 250 mg PO daily x 4 days	Moxifloxacin[1, 2] 400 mg PO daily x 7 days	Consult an experienced colleague. *For example, pristinamycin could be prescribed. This antibiotic is available through Health Canada's Special Access Program (SAP) for drugs.*

COMPLICATED INFECTIONS: PELVIC INFLAMMATORY DISEASE (PID) OR EPIDIDYMITIS/EPIDIDYMO-ORCHITIS

Consult an experienced colleague.
The antibiotic combination to be used should include: Moxifloxacin[1, 2] 400 mg PO daily x 14 days

CURRENT SEXUAL PARTNER OF THE INFECTED PATIENT

EMPIRICAL TREATMENT

Same antibiotic therapy as for the infected patient,
unless there are resistance data suggesting a different approach.

PREGNANT OR BREAST-FEEDING WOMAN

UNCOMPLICATED INFECTIONS: CERVICITIS OR URETHRITIS (INFECTED PATIENT)
COMPLICATED INFECTIONS: PID (INFECTED PATIENT)
EMPIRICAL TREATMENT (CURRENT SEXUAL PARTNER OF THE INFECTED PATIENT)

Consult an experienced colleague.

1. Not approved by Health Canada for this indication.
2. A warning has been issued about the use of fluoroquinolones in patients under 18 years of age. Consult an experienced colleague.

TESTS OF CURE

If the symptoms persist or recur, repeat the microbiological tests for detecting *M. genitalium* at least 3 weeks after the end of treatment.

REFERENCES

To consult the references, see the report in support of the OUG.

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