

Nongonococcal Urethritis (NGU)

Understanding Urethral Inflammation, Chlamydia, Mycoplasma genitalium, Persistent Urethritis, Diagnosis, Treatment, Partner Management, Fertility and the Supportive Role of Unani Medicine

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A Message From Dr. Nizamuddin Qasmi

When a man comes to me and says:

“Doctor, I have burning while passing urine and a little discharge from the penis. I took antibiotics, but the problem has come back. Is this gonorrhoea?”

my answer is:

Not necessarily.

Inflammation of the urethra can have several causes. If gonorrhoea is not responsible, the condition is commonly called:

Nongonococcal Urethritis — NGU

or sometimes:

Non-Gonococcal Urethritis.

The important point is that **NGU is not one single infection**. It is a clinical syndrome—meaning inflammation of the urethra caused by something other than *Neisseria gonorrhoeae*, the bacterium that causes gonorrhoea.

The latest **British Association for Sexual Health and HIV (BASHH) 2026 guideline** identifies *Chlamydia trachomatis* and *Mycoplasma genitalium* as the most important organisms associated with NGU, while other causes include *Trichomonas vaginalis*, adenovirus, herpes simplex virus, *Haemophilus* species and, less commonly, other



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organisms. Importantly, even after appropriate investigation, no specific pathogen is found in approximately **10–45% of NGU cases**.

This is why I tell patients:

“Persistent burning does not mean you simply need a stronger antibiotic.”

The correct questions are:

Is urethral inflammation actually present?

Has gonorrhoea been excluded?

Has chlamydia been tested?

Could Mycoplasma genitalium be present?

Could trichomoniasis or a viral infection be responsible?

Was the partner evaluated?

Could this now be pelvic-floor or chronic pelvic pain rather than continuing infection?

Modern treatment therefore depends upon **accurate diagnosis, antimicrobial stewardship and partner management**, not repeated empirical antibiotic courses.

What Is the Urethra?

The urethra is the tube through which urine passes from the bladder to the outside of the body.

In men, the urethra runs through:

the prostate, pelvic floor and penis.

It also carries semen during ejaculation.

Because the male urethra has both:

urinary

and:

reproductive

functions, inflammation in this area may produce symptoms involving:

- urination,
- penile discharge,



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- sexual activity,
- ejaculation.

What Is Urethritis?

Urethritis means:

inflammation of the urethra.

It is commonly associated with symptoms such as:

burning or pain during urination, urethral discomfort, irritation or itching inside the penis, and discharge from the urethral opening.

The newest BASHH 2026 guideline describes urethritis as a multifactorial condition that is sexually acquired in the majority of symptomatic cases and may present with discharge, dysuria or urethral discomfort, although some cases can be asymptomatic.

What Does “Nongonococcal” Mean?

Urethritis is traditionally divided into two broad categories.

Gonococcal urethritis

This is caused by:

Neisseria gonorrhoeae

—the bacterium that causes gonorrhoea.

Nongonococcal urethritis

This means urethral inflammation in which gonorrhoea is not identified as the cause.

The term:

NGU

therefore does **not** tell us which organism is responsible.

It only tells us:

gonorrhoea is not the explanation for the urethritis.

Further testing is often needed to find the exact cause.

Is NGU a Sexually Transmitted Infection?



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In many cases:

yes.

The majority of clinically important NGU in sexually active men is associated with organisms transmitted sexually.

However, this distinction is important:

NGU is a syndrome, not one particular STI.

Some cases have:

- no identified organism,
- possible noninfectious causes.

Therefore, a diagnosis of NGU should not automatically be interpreted as proof that one particular sexually transmitted bacterium is present.

Does NGU Occur in Women?

The term NGU is used mainly to describe:

penile urethritis.

Women can certainly develop:

- urethritis,
- cervicitis,
- reproductive-tract infection

from the same organisms—particularly:

- chlamydia,
- *M. genitalium*,
- trichomoniasis.

But female genital infection is usually described according to the anatomical syndrome, such as:

- cervicitis,
- PID,
- urethritis,

rather than routinely being labelled NGU in the same way as male penile urethritis.



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This distinction is important because the female partner of a man with NGU can have a clinically significant infection even when she has:

no symptoms.

What Causes Nongonococcal Urethritis?

There is no single cause.

The **BASHH 2026 NGU guideline** found *Chlamydia trachomatis* in approximately **22–48%** of NGU cases in the case-control studies it reviewed, while *Mycoplasma genitalium* was found in approximately **9–33%**. Other organisms occurred less consistently.

The major causes are discussed below.

Chlamydia trachomatis

One of the most important causes of NGU is:

***Chlamydia trachomatis*.**

Chlamydia is an intracellular bacterial STI.

It may produce:

- urethral discharge,
- painful urination,
- urethral irritation.

Many infections can also be:

asymptomatic.

Chlamydia is particularly important because infection may involve reproductive structures beyond the urethra and can be transmitted to a female partner, where untreated infection can cause:

- cervicitis,
- pelvic inflammatory disease,
- tubal damage,
- ectopic pregnancy,
- infertility.



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For this reason, identifying chlamydia has implications beyond simply relieving a man's burning urination.

Mycoplasma genitalium

Another major cause is:

***Mycoplasma genitalium*.**

This organism has become increasingly important because:

antibiotic resistance is now common.

CDC estimates that *M. genitalium* causes approximately **15–20% of NGU**, around **20–25% of non-chlamydial NGU**, and approximately **40% of persistent or recurrent urethritis**.

The 2026 BASHH guideline now recommends *M. genitalium* NAAT testing in symptomatic men with confirmed NGU where the test is available.

This represents a major change in modern urethritis management.

Repeated azithromycin without identifying *M. genitalium* can contribute to:

antimicrobial resistance.

Trichomonas vaginalis

Trichomonas vaginalis is a sexually transmitted protozoan parasite.

It can cause NGU particularly among:

men who have sex with women.

Its prevalence varies greatly by country and population.

The BASHH evidence review found *T. vaginalis* in approximately **1–13%** of NGU cases across reviewed case-control studies, although prevalence is low in some European populations and higher in other regions.

In India, where prevalence may differ from Western clinic populations, trichomoniasis remains an important consideration in:

persistent or recurrent urethral discharge.

India's updated 2024 national STI/RTI guidance specifically recommends considering *T. vaginalis* and *M. genitalium* in persistent or recurrent urethral-discharge syndromes.



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Ureaplasma

Organisms such as:

- *Ureaplasma urealyticum*,
- *Ureaplasma parvum*

can be found in the genital tract.

However, their relationship with urethritis is more complicated.

Many people can carry ureaplasmas without disease.

The BASHH 2026 guideline notes that *U. urealyticum* has been inconsistently associated with NGU and suggests that urethral inflammation may be more likely when the organism is present at a high bacterial load.

Therefore:

a positive Ureaplasma PCR does not automatically mean it is the cause of symptoms.

Clinical interpretation matters.

Haemophilus Species

One interesting update in the **BASHH 2026 guideline** is greater recognition of:

- *Haemophilus influenzae*,
- *Haemophilus parainfluenzae*

as probable causes of some cases of NGU.

These organisms usually live in the respiratory tract.

Evidence suggests they may sometimes reach the urethra through:

condomless oral sex.

This demonstrates why the causes of urethritis cannot always be predicted purely from a history of vaginal intercourse.

Neisseria meningitidis

A bacterium better known for causing meningitis—



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Neisseria meningitidis

—has also been linked to occasional clusters of urethritis.

This is uncommon, but it is another example of why urethral inflammation has multiple possible causes.

Adenovirus

Not every case of NGU is bacterial.

Adenovirus

can produce urethritis.

The 2026 BASHH guideline describes a typical pattern involving:

- severe burning,
- inflammation of the urinary opening or meatitis,
- sometimes conjunctivitis or red eyes,
- little or no urethral discharge.

Adenoviral urethritis may follow:

- oral sexual contact,
- genital or anal contact.

Symptoms are usually self-limiting and generally resolve within a few weeks.

Giving repeated antibiotics to viral urethritis does not treat the cause.

Herpes Simplex Virus

HSV-1 or HSV-2 can occasionally cause urethritis.

Possible clues include:

- significant dysuria,
- marked inflammation at the urethral opening,
- genital ulcers,
- groin lymph-node enlargement.

Interestingly, obvious external herpes ulcers do not have to be present.



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The latest BASHH guidance recommends considering HSV NAAT when severe dysuria, meatitis, lymphadenopathy or genital ulceration suggests a viral cause.

Idiopathic or Organism-Negative NGU

This is an extremely important concept.

Even after appropriate testing:

no specific pathogen is found in approximately 10–45% of NGU cases.

This is known as:

idiopathic NGU

or:

pathogen-negative NGU.

Some cases may represent organisms that are not yet fully understood.

Others may be:

- inflammatory,
- mechanical,
- chemical,
- related to urethral microbiome changes,
- noninfectious.

Therefore:

no organism detected does not automatically mean the patient is imagining the symptoms.

But it also does not justify endless antibiotics.

Can NGU Be Noninfectious?

Yes.

Not every urethral inflammation is caused by an STI.

Possible noninfectious contributors can include:

- urethral instrumentation,
- foreign bodies,



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- chemical irritation,
- trauma,
- vigorous friction,
- urethral stricture,
- chronic pelvic-floor dysfunction.

A urinary tract infection can also sometimes resemble urethritis.

BASHH notes that UTI symptoms may overlap with NGU and recommends urine testing when the history suggests urinary frequency, urgency, haematuria or other features more typical of UTI.

Symptoms of Nongonococcal Urethritis

The typical symptoms are relatively simple but can vary considerably.

A patient may experience:

urethral discharge,

which is often:

- clear,
- whitish,
- mucoid,
- mucopurulent.

There may also be:

burning during urination,

irritation at the tip of the penis,

itching inside the urethra,

general urethral discomfort.

Some men have only one symptom.

Others have several.

Some may have:

no visible discharge at the time of examination.



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The latest BASHH guideline lists urethral discharge, dysuria, penile-tip irritation, urethral discomfort or itching as typical presentations.

Is NGU Discharge Always White?

No.

The discharge may be:

- clear,
- whitish,
- cloudy,
- mucous-like.

Appearance alone cannot reliably identify:

- chlamydia,
- Mgen,
- trichomoniasis,
- another organism.

A thick yellow or green purulent discharge may increase suspicion of gonorrhoea, but laboratory testing remains important.

Burning Without Discharge

Some patients say:

“Doctor, there is no discharge. Only burning.”

That can still occur in urethritis.

But burning urination has several possible explanations, including:

- NGU,
- gonorrhoea,
- UTI,
- prostatitis,
- bladder disease,
- stones,



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- genital herpes,
- chemical irritation.

Therefore:

burning urine is a symptom—not a diagnosis.

Burning Urine in the Unani Tradition

In Unani medicine, burning during urination has traditionally been described under:

Hurqat-i Bawl.

CCRUM's official Unani Treatment Guidelines describe *Hurqat-i Bawl* as burning experienced during urination and discuss it within urinary-tract disorders.

This traditional description is useful for symptom recognition.

However, modern diagnosis has added something extremely important:

we can now identify specific sexually transmitted organisms using molecular tests.

Therefore, a traditional symptom such as *Hurqat-i Bawl* should not automatically be treated as one single constitutional condition when a specific transmissible infection such as:

- chlamydia,
- *M. genitalium*,
- trichomoniasis

may be present.

How Soon Do Symptoms Begin After Sexual Exposure?

There is no single incubation period for NGU because:

NGU has many causes.

Chlamydia may take:

- days to a few weeks

before symptoms become apparent.

Other organisms behave differently.

Some infections remain asymptomatic.



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Therefore:

the timing of symptoms cannot reliably identify the causative organism.

Does NGU Prove Recent Infidelity?

No.

Some NGU-related infections can remain:

- asymptomatic,
- unrecognized

for a period of time.

A newly recognized episode does not necessarily tell us:

- exactly when infection was acquired,
- which partner was infected first.

Partner counselling should therefore be conducted medically and respectfully rather than using a diagnosis as automatic proof of infidelity.

How Is Nongonococcal Urethritis Diagnosed?

A good diagnosis has two components.

First:

confirm that urethral inflammation is actually present.

Second:

determine the likely cause.

This is increasingly important because modern guidelines discourage treating repeated genital symptoms indefinitely without objective evidence of inflammation.

Physical Examination

The clinician examines for:

- urethral discharge,
- redness at the penile opening,
- ulcers,



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- balanitis,
- lymph-node enlargement,
- testicular or epididymal tenderness where relevant.

Sometimes the examination is:

completely normal.

That does not automatically exclude urethritis, but objective testing becomes particularly valuable.

Urethral Smear Microscopy

A urethral smear can demonstrate inflammatory white cells known as:

polymorphonuclear leucocytes — PMNLs.

The 2026 BASHH guideline uses a commonly accepted microscopic definition of approximately:

five or more PMNLs per high-powered field averaged across the most inflamed fields

as objective evidence supporting urethritis.

If characteristic intracellular Gram-negative diplococci are seen, gonorrhoea becomes strongly suspected.

When gonococci are absent but inflammation is present:

NGU becomes the syndrome.

First-Voided Urine

For STI molecular testing in men, clinicians often use:

first-void urine.

This means the earliest portion of the urine stream—not a midstream sample.

Why?

Because organisms such as:

- chlamydia,
- *M. genitalium*,



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- gonorrhoea

are present in urethral cells and secretions that are washed out in the first part of urination.

The BASHH 2026 guideline recommends NAAT on first-void urine as the specimen of choice for common NGU pathogens in symptomatic men.

NAAT Testing

NAAT means:

Nucleic Acid Amplification Test.

This includes PCR-type molecular tests that detect the genetic material of an organism.

NAAT is now central to STI diagnosis because it is highly sensitive for organisms that may be difficult or impossible to identify with ordinary bacterial culture.

In confirmed NGU, important NAAT testing includes:

Chlamydia trachomatis

and:

Neisseria gonorrhoeae.

The BASHH 2026 guideline additionally recommends:

Mycoplasma genitalium NAAT

for symptomatic men with confirmed NGU where available.

Why Is Gonorrhoea Testing Still Necessary If We Think It Is NGU?

Because symptoms overlap.

A man with:

- discharge,
- burning

cannot reliably distinguish:

- gonorrhoeal urethritis,
- NGU.



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Gonorrhoea is also increasingly important because antimicrobial resistance is a major global concern.

Therefore, a modern urethritis evaluation should attempt to identify:

gonorrhoea as well as nongonococcal causes.

Should *Mycoplasma genitalium* Be Tested?

This is an area where international recommendations have evolved.

CDC particularly emphasizes Mgen testing for:

recurrent NGU.

The new BASHH 2026 guideline goes further and recommends Mgen NAAT at the first presentation in symptomatic men with confirmed NGU where appropriate testing is available.

This difference reflects the rapid evolution of Mgen diagnostics and antimicrobial-resistance concerns.

In practical care, testing should depend upon:

- clinical presentation,
 - available laboratory facilities,
 - local guidance,
 - previous treatment.
-

Should *Trichomonas* Be Tested?

Testing becomes particularly relevant in:

- persistent or recurrent NGU,
- men who have female partners,
- populations where trichomoniasis is sufficiently common.

BASHH recommends considering *T. vaginalis* NAAT in persistent NGU when local prevalence makes it clinically relevant.

India's NACO 2024 guidance also specifically recognizes trichomoniasis as a cause requiring coverage in recurrent/persistent urethral-discharge syndromes.



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HIV and Syphilis Testing

STIs frequently coexist.

India's updated 2024 national STI/RTI guidance recommends screening clients attending STI services for:

HIV

and:

syphilis.

This does not mean that a man with NGU necessarily has HIV or syphilis.

It means that an STI diagnosis is an opportunity for comprehensive sexual-health screening.

NGU Versus Urinary Tract Infection

Men sometimes receive repeated UTI treatment when the real problem is urethritis.

Typical UTI features may include:

- urinary frequency,
- urgency,
- bladder discomfort,
- haematuria.

NGU more typically produces:

- urethral discharge,
- penile-tip irritation,
- dysuria associated with a sexual-health history.

But overlap exists.

If UTI is suspected, a:

midstream urine culture

may be appropriate.

This is different from the:

first-void urine sample

used for STI NAAT.



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Understanding the difference prevents confusion.

Current Treatment of Acute NGU

Once NGU has been objectively diagnosed, treatment should ideally be directed at the actual pathogen.

However, test results may not always be immediately available.

Both current CDC guidance and the new BASHH 2026 guideline use:

doxycycline 100 mg orally twice daily for seven days

as the principal recommended regimen for uncomplicated acute NGU.

This dosing information is provided for professional education.

Individual patients should still receive a proper prescription based on:

- allergy,
 - pregnancy possibility where relevant,
 - interacting medicines,
 - specific infection results.
-

Why Has Doxycycline Become Preferred?

There are several reasons.

Doxycycline is highly effective against:

chlamydial urethritis.

The BASHH 2026 evidence review reports approximately **97% efficacy in chlamydia-positive men** treated with a seven-day doxycycline course.

It also has some activity against:

M. genitalium,

although doxycycline alone is not sufficiently reliable to eradicate Mgen in many patients.

Another advantage is that doxycycline does not appear to drive macrolide resistance in Mgen in the way inappropriate azithromycin exposure can.



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What About Azithromycin?

This area has changed.

Older NGU regimens commonly used:

azithromycin 1 gram as one dose.

However, the **BASHH 2026 guideline no longer recommends single-dose azithromycin 1 g as treatment for NGU**, largely because of lower efficacy in some infections and concerns about selecting macrolide resistance in *M. genitalium*.

When azithromycin is used as an alternative, BASHH now recommends:

an extended multidose regimen

rather than the old one-dose strategy.

This illustrates why old internet treatment advice can become outdated.

Indian Treatment Approach — NACO 2024

India's treatment system must also address a practical reality:

In many clinics, a man with urethral discharge presents **before laboratory confirmation** of gonorrhoea or chlamydia is available.

India's updated **2024 National Technical Guidelines on STI/RTI** therefore recommend syndromic coverage for uncomplicated urethral-discharge syndrome with:

ceftriaxone for gonorrhoea

plus:

doxycycline for chlamydia.

The guideline's first-line syndromic regimen uses ceftriaxone 500 mg intramuscularly once plus doxycycline 100 mg twice daily for seven days.

This does not mean that every confirmed nongonococcal infection needs ceftriaxone.

It means:

when gonorrhoea has not yet been excluded, India's public-health syndromic approach covers both gonorrhoea and chlamydia.

Once an exact organism is identified, treatment can become pathogen-directed.

Why Antibiotic Stewardship Matters



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We are entering an era in which indiscriminate STI antibiotic use creates real clinical problems.

M. genitalium has developed substantial resistance to:

- macrolides,
- increasingly fluoroquinolones.

Gonorrhoea also has a serious global antimicrobial-resistance problem.

Therefore:

“take an antibiotic just in case”

is not always good medicine.

India's 2024 STI guidance specifically emphasizes increased laboratory diagnosis where available to improve precision and reduce antimicrobial resistance.

Treatment of Chlamydia-Positive NGU

If chlamydia is identified, the infection should be treated according to:

current chlamydia guidance.

Doxycycline is highly effective.

Partner management becomes particularly important because untreated chlamydia in a female partner can progress to:

- PID,
- tubal infertility.

Patients should also follow the appropriate retesting recommendations for chlamydia because reinfection is common.

Treatment of Mycoplasma genitalium-Positive NGU

Mgen should not simply be treated as ordinary NGU.

Because resistance is common, management ideally uses:

resistance-guided sequential therapy.

India's 2024 STI guideline specifically introduced a two-stage approach for Mgen:

doxycycline followed by moxifloxacin



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as its first-line strategy in the circumstances described in the national guidance.

Treatment choices continue to evolve as resistance changes.

Therefore, confirmed Mgen deserves:

targeted treatment—not repeated single-dose azithromycin.

Treatment When Trichomoniasis Is Found

If *Trichomonas vaginalis* is identified, treatment requires:

an effective nitroimidazole medicine

such as metronidazole or an appropriate alternative according to guideline and patient circumstances.

The sexual partner must also be treated because reinfection is common when only one partner receives therapy.

Viral NGU Does Not Automatically Need Antibiotics

If urethritis is caused by:

- adenovirus,
- HSV,

ordinary antibacterial medication does not treat the viral cause.

Adenoviral urethritis is often:

self-limited.

Herpes-related urethritis may require specific antiviral management according to:

- severity,
- associated genital herpes.

This is another reason microbiological diagnosis can prevent inappropriate antibiotic use.

Sexual Intercourse During Treatment

Patients should generally avoid sexual intercourse until:

- they have completed the relevant treatment,



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- current partner treatment has been completed where required,
- symptoms have resolved according to the treatment plan.

The BASHH 2026 guideline specifically advises patients with NGU to abstain until they and relevant partner or partners have completed treatment and follow-up.

This protects against:

- transmission,
- immediate reinfection.

Partner Management

Partner care is not an optional extra.

A man may improve completely after treatment but then become reinfected by an untreated partner.

Current BASHH guidance recommends that ongoing sexual partners be:

tested

and treated when an identified infection is found.

India's 2024 national guidance also places strong emphasis on:

partner notification and management

to prevent transmission and reinfection.

When a specific pathogen such as:

- chlamydia,
- Mgen,
- trichomoniasis

is identified, partner management should follow that infection's specific recommendations.

Why Treating Only the Man May Fail

Imagine a man has chlamydial NGU.

He receives treatment.

His partner has:



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asymptomatic cervical chlamydia.

She receives no testing or treatment.

They resume sexual intercourse.

The man develops infection again.

This is not necessarily antibiotic failure.

It may simply be:

reinfection.

That is why I repeatedly tell patients:

STI treatment is often couple-based treatment.

Persistent or Recurrent NGU

This is one of the most important areas of the article.

The BASHH 2026 guideline defines persistent or recurrent NGU as symptoms that:

- fail to resolve,
- or recur

within approximately 90 days after initial treatment.

It reports this in about:

5–25% of men.

But another crucial fact is:

an infectious organism is identified in fewer than half of persistent/recurrent cases.

Therefore, persistent symptoms should not automatically trigger another antibiotic prescription.

First Question in Persistent NGU: Was Treatment Taken Properly?

I first ask:

Did you complete every dose?

Did you miss tablets?

Did you vomit after medication?

Adherence problems can cause:

- apparent treatment failure.

Second Question: Was There Sexual Re-Exposure?

I ask:

Was your partner treated?

Did you have intercourse before both of you completed treatment?

Was there a new sexual exposure?

Reinfection is often a more likely explanation than:

rare antibiotic failure.

Third Question: Is Urethritis Still Objectively Present?

This point is particularly important.

The latest BASHH guidance states that patients with persistent symptoms should be reassessed for:

objective urethral inflammation.

It cautions against treating symptoms alone when no continuing inflammation is demonstrated.

This prevents the harmful cycle:

burning → antibiotic → burning → stronger antibiotic → burning → another antibiotic.

Mgen in Persistent NGU

M. genitalium becomes especially important in recurrent disease.

The BASHH 2026 review reports Mgen in approximately:

20–70%

of selected men with persistent NGU after doxycycline in reviewed studies.

If it is identified:

- antimicrobial resistance,
- previous treatment



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must be considered.

Trichomonas in Persistent NGU

In populations where trichomoniasis is more common, *T. vaginalis* should also be considered.

The latest BASHH guidance recommends considering NAAT for trichomoniasis when ongoing urethritis is present and local prevalence supports testing.

India's NACO guideline likewise specifically adds coverage for:

- *T. vaginalis*,
- *M. genitalium*

in persistent or recurrent urethral-discharge syndromes.

Persistent Burning Does Not Always Mean Persistent Infection

This is a point I emphasize strongly in my clinical practice.

After infection is eliminated, some men continue to experience:

- urethral awareness,
- pelvic discomfort,
- pain after urination,
- painful ejaculation,
- genital burning.

The infection may already be gone.

Repeated antibiotics can then:

- fail,
- cause side effects,
- damage the intestinal microbiome,
- increase antimicrobial resistance.

The underlying problem may have shifted to:

chronic pelvic pain syndrome.



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Chronic Pelvic Pain Syndrome After NGU

The BASHH 2026 guideline highlights the overlap between persistent/recurrent urethral symptoms and:

Chronic Pelvic Pain Syndrome — CPPS.

After persistent infection has been excluded, increased pelvic-floor muscle tone can contribute to:

- dysuria,
- perineal discomfort,
- pelvic pain,
- pain with ejaculation,
- urethral burning.

This is particularly important in my focused practice because:

not every patient with chronic genital burning still has an STI.

Some patients need:

- explanation,
- pelvic-floor relaxation,
- pain management,
- stress management

rather than another antibiotic.

Anxiety Can Perpetuate Urethral Symptoms

After an STI scare, a patient may begin checking the penis repeatedly.

Every normal secretion becomes suspicious.

Every mild sensation becomes:

“The infection is coming back.”

Pelvic-floor muscles may remain tense.

This can amplify:

- urinary discomfort,
- penile-tip sensitivity,



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- painful ejaculation.

The 2026 BASHH guideline supports a holistic biopsychosocial approach when infection has been excluded and persistent symptoms resemble chronic pelvic pain.

This is an important bridge between:

sexual medicine

and:

infection medicine.

Complications of NGU

Complications depend on the organism responsible.

The latest BASHH guideline lists potential complications including:

epididymo-orchitis

and:

sexually acquired reactive arthritis.

Chlamydia is particularly important because untreated infection may spread within the male reproductive tract and can also seriously affect a female partner's reproductive tract.

What Is Epididymitis?

The epididymis is the long coiled structure behind the testicle in which sperm mature and are stored.

An STI such as chlamydia can sometimes spread and cause:

epididymitis.

Symptoms may include:

- unilateral testicular pain,
- swelling,
- tenderness.

Severe or sudden scrotal pain requires urgent medical assessment because:

testicular torsion



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can produce similar symptoms and is a surgical emergency.

Reactive Arthritis

Some infections—particularly chlamydia—can trigger an immune-mediated condition known as:

sexually acquired reactive arthritis.

It may involve:

- joints,
- eyes,
- urinary symptoms.

This is uncommon, but it is a recognized complication of NGU.

Nongonococcal Urethritis and Male Fertility

Patients often ask:

“Doctor, will NGU make me infertile?”

The answer is:

NGU itself does not automatically mean infertility.

Remember that NGU is a syndrome caused by different organisms.

The reproductive implications therefore depend upon:

- the responsible pathogen,
 - duration of infection,
 - whether infection spread to epididymis or other reproductive structures,
 - whether other infertility factors exist.
-

Chlamydia and Male Infertility

Among NGU pathogens, chlamydia deserves particular reproductive attention.

A major **2025 systematic review and meta-analysis**, including 26 case-control studies and more than 11,000 participants, found a statistical association between *Chlamydia trachomatis* infection and male infertility. However, the authors emphasized important



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limitations including heterogeneity, confounding and publication bias and cautioned that causal inference remains imperfect.

Therefore, it is reasonable to say:

chlamydia may contribute to male fertility problems in some men.

It is not reasonable to say:

every man who once had chlamydial NGU will become infertile.

How Might Infection Affect Male Fertility?

Potential mechanisms include:

- inflammation of the reproductive tract,
- epididymal involvement,
- changes in seminal fluid,
- oxidative stress,
- possible effects on sperm motility and viability.

However, male infertility is frequently multifactorial.

A man with previous NGU may also have:

- varicocele,
- hormonal abnormalities,
- genetic factors,
- obesity,
- smoking,
- heat exposure,
- previous testicular disease.

A fertility evaluation must therefore remain comprehensive.

Mycoplasma genitalium and Male Fertility

The relationship is less certain.



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Some studies and systematic reviews suggest an association between genital mycoplasmas and male infertility, but CDC has historically considered the evidence insufficient to establish Mgen as a definite cause of chronic male infertility.

Therefore, if a man with Mgen has an abnormal semen analysis:

we should treat the infection,

but we should not assume that it explains every fertility abnormality.

NGU and Female Fertility — Why the Partner Matters

One of the greatest fertility consequences of male NGU may occur in:

the female partner.

A man with asymptomatic or mildly symptomatic chlamydial NGU can transmit chlamydia to his partner.

The woman may remain asymptomatic while the organism travels upward and causes:

- endometritis,
- salpingitis,
- pelvic inflammatory disease.

Tubal inflammation can eventually contribute to:

- infertility,
- ectopic pregnancy.

Therefore:

treating male NGU can also protect female reproductive health.

Can NGU Directly Block a Man's Sperm Ducts?

It is uncommon for one uncomplicated episode of NGU to automatically cause permanent obstruction.

However, significant or repeated reproductive-tract infection can potentially affect structures such as:

- epididymis.

If a man has infertility with:

- very low semen volume,
- azoospermia,
- evidence of obstruction,

a proper urological and fertility investigation is required.

Do not assume NGU alone is the explanation.

When Should Semen Analysis Be Considered?

An uncomplicated episode of NGU does not require every man to perform a semen analysis.

Semen analysis becomes appropriate when there is an actual fertility concern, for example:

- the couple has been trying unsuccessfully for pregnancy,
- there is a history of significant epididymitis,
- another male fertility problem is suspected.

This avoids unnecessary testing and anxiety.

Can Fertility Recover After Infection Treatment?

Often, yes.

If infection and inflammation contributed temporarily to poorer semen quality, improvement may occur after successful treatment.

However, sperm production takes approximately several weeks to months.

Therefore, immediate semen testing during acute infection may not always represent the long-term fertility state.

If abnormalities persist, a structured male infertility evaluation is needed.

Can a Couple Conceive Naturally After NGU?

Yes.

After:

- the infection has been appropriately treated,



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- relevant partners have been managed,
- no independent infertility factor is present,

natural conception can usually be attempted.

NGU does not automatically require:

- IUI,
- IVF,
- ICSI.

Assisted reproduction should be used because there is a true fertility indication.

NGU and Erectile Dysfunction

NGU does not usually directly destroy erectile function.

However, a patient may develop:

- fear of infecting the partner,
- fear that discharge will recur during sex,
- guilt,
- performance anxiety.

These psychological factors can produce:

situational erectile dysfunction.

Once infection has been treated, sexual-health counselling may be important to help the patient regain confidence.

NGU and Painful Ejaculation

Active urethral inflammation may cause:

- burning,
- discomfort during or after ejaculation.

Persistent painful ejaculation after confirmed infection has cleared can also be associated with:

- pelvic-floor dysfunction,
- chronic pelvic pain syndrome,



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- prostatitis-like symptoms.

Therefore:

painful ejaculation should not automatically lead to repeated STI antibiotics.

Can Masturbation Cause NGU?

Masturbation does not transmit a sexually transmitted organism unless contaminated devices or another person's secretions are involved.

Very vigorous friction may occasionally produce:

- temporary urethral or penile irritation.

This would be:

noninfectious irritation,

not sexually acquired NGU.

Persistent discharge or significant burning still deserves appropriate evaluation.

Can Oral Sex Cause NGU?

Yes.

This is an important modern finding.

Organisms associated with the mouth and respiratory tract, including:

- *Haemophilus influenzae*,
- *Haemophilus parainfluenzae*,
- adenovirus,
- HSV

can be associated with urethritis following oral-genital exposure.

Therefore:

“I only had oral sex” does not completely exclude sexually acquired urethritis.

Can NGU Spread Through a Toilet?

Ordinary toilet contact is not regarded as a major mechanism for classic sexually acquired NGU.



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Organisms such as:

- chlamydia,
- Mgen,
- trichomoniasis

are transmitted primarily through intimate sexual contact.

Patients do not need to isolate themselves from:

- family,
- toilets,
- ordinary household life.

Prevention

Prevention depends primarily on reducing exposure to the infections that cause NGU.

Correct condom use reduces transmission of:

- chlamydia,
- gonorrhoea,
- Mgen,
- trichomoniasis

although no method should be represented as eliminating every STI risk absolutely.

Prompt testing and treatment also prevent transmission.

Partner care is equally important.

Antibiotics Should Not Be Taken Before Every Sexual Encounter

Some people take antibiotics after intercourse because they are afraid of STIs.

This practice can:

- select resistant organisms,
- alter normal microbial flora,
- produce adverse effects.



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M. genitalium resistance demonstrates why antibiotic misuse can create serious future treatment problems.

The correct strategy is:

prevention + appropriate testing + targeted treatment.

The Unani Perspective on Nongonococcal Urethritis

As a physician trained in **Unani medicine** and with a specialist-focused practice in **Sexual Disorders & Infertility**, I look at NGU from two perspectives simultaneously.

The first is:

modern microbiological diagnosis.

The second is:

the patient's complete urinary, sexual and constitutional health.

Classical Unani medicine has long recognized symptoms such as:

- burning micturition,
- urinary discomfort,
- abnormal urinary or genital secretions

within its traditional urinary and reproductive framework.

CCRUM's official treatment guidelines describe:

Hurqat-i Bawl

for burning micturition.

These traditional concepts can be useful for understanding symptoms and supportive care.

However:

modern NGU did not exist as a microbiologically defined category in classical Unani literature.

Today we can identify:

- chlamydia DNA,
- Mgen DNA,
- trichomoniasis,



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- gonorrhoea

through laboratory testing.

That knowledge must be incorporated into responsible contemporary Unani practice.

How Unani Medicine May Be Useful

The role I consider most appropriate is:

individualized supportive and integrative management.

Depending upon the patient, this may focus on:

- appropriate hydration,
- nutritional wellbeing,
- digestive health,
- recovery after infection,
- general urinary comfort,
- sleep,
- psychological stress,
- sexual wellbeing.

These factors are particularly valuable when a patient has:

- prolonged symptoms,
- anxiety,
- pelvic-floor tension,
- post-infectious discomfort.

Can Unani Medicine Replace Antibiotics for Chlamydial NGU?

Based upon present scientific evidence:

No.

There is not sufficient high-quality clinical evidence that an Unani formulation reliably eradicates *Chlamydia trachomatis* from the human urethra and prevents transmission and reproductive complications as effectively as established antimicrobial treatment.

Therefore, confirmed chlamydial NGU should receive:



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evidence-based antimicrobial treatment.

Can Unani Medicine Replace Mgen Treatment?

Again:

no reliable evidence currently supports doing so.

M. genitalium is already difficult to eradicate because of antimicrobial resistance.

The priority in confirmed Mgen infection is:

resistance-aware targeted antimicrobial treatment.

Using an unproven treatment instead could allow:

- persistence,
 - partner transmission,
 - continued inflammation.
-

Can Unani Medicine Help After the Infection Is Cleared?

This is an area where integrative care may be particularly helpful.

Some patients remain troubled by:

- mild urinary burning,
- pelvic heaviness,
- painful ejaculation,
- sexual anxiety

even after appropriate tests show that infection has cleared.

Once serious pathology is excluded, management can focus on:

- hydration,
- digestive and nutritional wellbeing,
- reduction of irritants,
- sleep,
- stress management,
- pelvic-floor relaxation,



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- individualized Unani supportive measures.

The aim changes from:

killing an organism

to:

restoring normal function and comfort.

Unani Treatment Should Be Diagnosis-Led

I do not support the approach:

“Every burning urine case gets the same Unani medicine.”

A patient with:

- chlamydial NGU,
- kidney stone,
- UTI,
- genital herpes,
- pelvic-floor dysfunction

may all complain of:

burning urination.

But they do not have the same disease.

Therefore:

diagnosis comes first.

This principle makes traditional treatment safer and more clinically useful.

No Strong Direct Unani Trial Evidence for Modern NGU

Although Unani literature and CCRUM guidance address urinary symptoms such as *Hurqat-i Bawl*, there is currently insufficient high-quality modern clinical evidence specifically demonstrating a Unani regimen that eradicates microbiologically confirmed:

nongonococcal urethritis

across its major infectious causes.



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This limitation should be acknowledged openly.

A responsible integrative physician should distinguish:

- traditional symptom management

from:

- proven eradication of a sexually transmitted pathogen.
-

Avoid Strong Local Remedies in the Urethra

The urethral opening is highly sensitive.

Patients should not insert:

- oils,
- corrosive herbal liquids,
- antiseptics,
- acidic preparations,
- powders

inside the urethra without appropriate medical indication.

These products may produce:

- chemical urethritis,
 - additional inflammation,
 - scarring.
-

Special Treatment Approach by Dr. Nizamuddin Qasmi

When a man with suspected NGU consults me, I do not simply ask:

“What antibiotic have you taken?”

My assessment begins with:

Is urethritis actually present?

Then I ask:

Could this be gonorrhoea?

Has chlamydia NAAT been performed?



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Could Mgen be involved?

Is trichomoniasis relevant?

Was there oral sex suggesting a viral or Haemophilus cause?

Has the partner been evaluated?

Has the patient taken multiple antibiotics already?

Is there testicular pain suggesting epididymitis?

Are symptoms now behaving more like chronic pelvic pain than infection?

Is infertility also present?

This approach prevents one of the most common mistakes in urethritis care:

treating the symptom repeatedly without understanding the cause.

My Clinical Approach at Saira Health Care

At **Saira Health Care**, my approach to NGU can be summarized as:

Stage One — Confirm urethritis

Burning alone is not enough.

Whenever practical, we look for:

- clinical discharge,
- inflammatory evidence,
- appropriate urine or urethral testing.

Stage Two — Exclude gonorrhoea

Gonorrhoeal and nongonococcal urethritis overlap clinically.

Stage Three — Identify common pathogens

The priority organisms may include:

- chlamydia,
- Mgen,
- trichomoniasis where appropriate.

Stage Four — Use treatment appropriate to the organism

Avoid unnecessary antibiotic switching.



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Stage Five — Address the partner

Because untreated partner infection can cause reinfection.

Stage Six — Review persistent symptoms carefully

Do not automatically assume active infection.

Stage Seven — Evaluate fertility only when clinically indicated

Semen analysis and broader fertility investigations are used when conception is actually difficult.

Stage Eight — Integrate supportive Unani care

Where clinically suitable, treatment may support:

- urinary comfort,
- nutrition,
- digestion,
- sleep,
- sexual wellbeing,
- recovery after infection.

Patient Example: First Episode of Mild NGU

A young man develops:

- mild clear discharge,
- burning with urination

after sexual exposure.

The wrong approach would be:

buying three different antibiotics from a pharmacy.

The better approach is:

obtain appropriate STI testing.

If objective urethritis is confirmed, treatment can begin according to current guidance while pathogen results are obtained where available.

Patient Example: Severe Urethral Discharge

A man has:

- significant purulent discharge,
- severe burning.

Gonorrhoea must be considered immediately.

Where laboratory separation is not immediately available, India's NACO syndromic approach appropriately covers:

- gonorrhoea,
- chlamydia

rather than assuming NGU alone.

Patient Example: Burning Returns After Doxycycline

Now I ask:

Did you complete treatment?

Was your partner treated?

Did you have sex before treatment finished?

Was Mgen tested?

Could trichomonas be involved?

Only after answering those questions should further treatment be chosen.

Patient Example: Persistent Burning but All Tests Are Negative

This is where medicine requires restraint.

If:

- gonorrhoea,
- chlamydia,
- Mgen,
- relevant other infections

have been excluded,

and there is no continuing urethral inflammation, more antibiotics may do more harm than good.



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The patient may need evaluation for:

CPPS / pelvic-floor dysfunction.

The newest BASHH guideline specifically recommends reassurance, pelvic-floor relaxation and holistic management when persistent symptoms occur without objective continuing urethritis.

Patient Example: NGU and Testicular Pain

This should not be ignored.

Testicular or epididymal pain can indicate:

- epididymitis.

Severe sudden scrotal pain can also indicate:

testicular torsion,

which requires urgent medical attention.

The patient needs examination rather than simply another urethritis prescription.

Patient Example: NGU in a Couple Trying to Conceive

The first priority is:

cure active transmissible infection.

Both partners may need appropriate assessment.

After infection is controlled, if pregnancy does not occur, we investigate fertility normally.

For the male partner that may involve:

- semen analysis,
- reproductive examination,
- hormones where indicated.

For the female partner:

- ovulation,
- ovarian reserve when appropriate,
- uterus,



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- fallopian tubes.

This prevents infertility from being wrongly blamed on one previous urethritis episode.

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, my focused work in Sexual Disorders & Infertility allows NGU to be approached beyond the immediate infection.

The patient's real concern is often not:

“What is the name of this bacterium?”

It may be:

“Can I infect my wife?”

“Will this come back?”

“Has my sperm been damaged?”

“Why does ejaculation still hurt?”

“Why am I afraid of sexual intercourse now?”

“Can we safely try for pregnancy?”

These questions belong within comprehensive sexual and reproductive care.

Our contribution is therefore centred on:

accurate infection assessment, rational treatment, partner protection, sexual rehabilitation and evidence-based fertility evaluation.

NGU Does Not Mean Sexual Weakness

I also want to correct an important misconception.

NGU does not automatically mean:

- erectile weakness,
- low testosterone,
- “loss of masculinity,”
- permanent sexual dysfunction.

It is primarily:

an inflammatory urethral condition.



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If erectile dysfunction appears after an STI episode, anxiety and fear may be more important than permanent physical damage.

This is where careful sexual-health counselling can be extremely helpful.

Does Semen Loss Cause NGU?

No.

NGU is not caused because a man has:

- ejaculated too frequently,
- lost semen,
- become physically weak.

Infectious NGU is caused mainly by:

specific microorganisms.

Noninfectious NGU involves other inflammatory or mechanical processes.

Sexual-health education is important because myths about semen loss can create unnecessary anxiety.

Diet and NGU

No food can eradicate:

- chlamydia,
- Mgen,
- trichomoniasis.

Good nutrition and hydration can support recovery.

Some patients find very irritating foods, excessive caffeine or dehydration temporarily aggravate urinary discomfort.

These changes can improve symptoms but should not be presented as:

curative treatment for an STI.

Frequently Asked Questions

What is nongonococcal urethritis?



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NGU is inflammation of the urethra in which gonorrhoea is not identified as the cause.

Is NGU one specific infection?

No.

It is a syndrome caused by multiple infectious and sometimes noninfectious conditions.

What are the two most important infectious causes?

Current BASHH 2026 guidance identifies:

- *Chlamydia trachomatis*,
- *Mycoplasma genitalium*

as the most common recognized pathogens.

What percentage of NGU is caused by chlamydia?

In case-control studies summarized by BASHH 2026, chlamydia was found in approximately **22–48%** of NGU cases.

How common is Mycoplasma genitalium?

BASHH studies found approximately **9–33%** in NGU, while CDC estimates roughly 15–20% overall and a much larger proportion of persistent/recurrent cases.

Can trichomoniasis cause NGU?

Yes.

Its importance varies according to local prevalence and sexual population.

Can herpes cause urethritis?

Yes.

HSV-1 and HSV-2 can occasionally cause urethritis, especially with severe dysuria, meatitis, genital ulcers or lymph-node enlargement.



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Can oral sex cause NGU?

Yes.

Adenovirus and organisms such as *Haemophilus* species have been associated with NGU following oral sexual exposure.

Can no infection be found?

Yes.

No pathogen is identified in approximately **10–45%** of NGU cases in current evidence.

What symptoms does NGU cause?

Typical symptoms include:

- urethral discharge,
- burning during urination,
- penile-tip irritation,
- urethral discomfort or itching.

Can NGU have no symptoms?

Yes.

Asymptomatic urethral inflammation can occur, although modern guidelines do not recommend screening asymptomatic men simply by urethral microscopy.

Does white discharge mean chlamydia?

Not necessarily.

The appearance of discharge cannot reliably identify the organism.

Does green discharge mean gonorrhoea?

Purulent yellow-green discharge may raise suspicion, but laboratory testing is needed.



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What is the best test for chlamydia and gonorrhoea?

NAAT is the preferred modern diagnostic method.

For men, first-void urine is commonly used.

Is ordinary urine culture enough?

No.

Routine bacterial urine culture does not reliably diagnose:

- chlamydia,
- Mgen.

Specific molecular tests are required.

Should I be tested for *Mycoplasma genitalium*?

It should particularly be considered in:

- persistent/recurrent NGU.

The 2026 BASHH guideline now recommends Mgen NAAT for symptomatic men with confirmed NGU when testing is available.

Do I need HIV and syphilis testing?

Comprehensive STI care commonly includes HIV and syphilis screening.

India's updated NACO guidance recommends these tests for clients attending STI services.

What is the current main treatment for confirmed acute NGU?

Doxycycline 100 mg twice daily for seven days is the recommended first-line regimen in current CDC and 2026 BASHH guidance.

This is educational information, not an individual prescription.

Is single-dose azithromycin still recommended?

The 2026 BASHH guideline specifically no longer recommends azithromycin 1 g as a single standalone dose for NGU because of efficacy and antimicrobial-resistance concerns.

Why does India's urethral-discharge treatment sometimes include ceftriaxone?

Because before test results are available, clinicians may not yet know whether the discharge is caused by gonorrhoea or NGU.

India's 2024 syndromic guideline therefore covers both:

- gonorrhoea with ceftriaxone,
 - chlamydia with doxycycline.
-

Does ceftriaxone treat ordinary nongonococcal chlamydial urethritis?

It is primarily used to treat:

gonorrhoea.

Once gonorrhoea is excluded and the causative organism is known, treatment should be pathogen-specific.

Why does NGU come back?

Possible reasons include:

- untreated partner,
 - new exposure,
 - missed medication,
 - Mgen,
 - trichomoniasis,
 - antibiotic resistance,
 - persistent noninfectious inflammation.
-

How common is recurrent NGU?

The 2026 BASHH guideline reports persistent or recurrent NGU in approximately **5–25%** of men after initial treatment.

Does persistent burning always mean the infection survived?

No.

Persistent symptoms can continue despite elimination of the original pathogen.

Pelvic-floor dysfunction or chronic pelvic pain may be responsible.

Should antibiotics be repeated whenever burning returns?

No.

Current guidance recommends demonstrating ongoing urethritis and investigating reinfection and specific pathogens before further treatment whenever practical.

What is chronic pelvic pain syndrome?

It is a condition in which pelvic, urinary or ejaculatory symptoms persist without continuing bacterial infection in many patients.

Increased pelvic-floor muscle tone can contribute to symptoms.

Can NGU cause epididymitis?

Certain underlying infections—especially chlamydia—can cause epididymal inflammation.

Can NGU cause arthritis?

Sexually acquired reactive arthritis is a recognized but uncommon complication, particularly in association with chlamydial infection.

Does NGU cause infertility?

Not automatically.

The fertility risk depends mainly on:



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- the organism,
- severity,
- reproductive-tract involvement.

Can chlamydia affect male fertility?

Recent systematic-review evidence finds an association between chlamydia and male infertility, but important heterogeneity and confounding mean that infection should not automatically be considered the sole cause in an individual man.

Can NGU affect my wife's fertility?

If the NGU is caused by chlamydia or another upper-genital-tract pathogen and is transmitted to a female partner, reproductive complications such as PID can occur.

This is one reason partner management is essential.

Does one episode mean my sperm are permanently damaged?

No.

Should I have a semen analysis after every NGU episode?

No.

Semen analysis is most useful when there is an actual fertility indication.

Can I father children after NGU?

Yes.

Most men with appropriately treated NGU can continue normal reproductive life.

Do I automatically need IVF?

No.

Can NGU cause erectile dysfunction?



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It usually does not directly cause permanent erectile dysfunction.

Anxiety after STI diagnosis may contribute to situational erectile problems.

Can NGU cause painful ejaculation?

Yes, active urethral inflammation can produce discomfort during or after ejaculation.

Persistent pain after infection has cleared should be evaluated for chronic pelvic pain or other causes.

Should my partner also be tested?

Yes, partner evaluation is an important part of management, particularly when a specific STI is identified.

Can we have sex during treatment?

Generally, sexual intercourse should be avoided until appropriate treatment requirements for both patient and relevant partner have been completed and symptoms have resolved.

Can condoms prevent NGU?

Condoms substantially reduce exposure to common sexually transmitted causes of NGU.

Can NGU come from a toilet?

Ordinary toilet contact is not considered a major route of sexually acquired NGU.

Can masturbation cause NGU?

Masturbation does not create chlamydia or Mgen.

Excessive friction can occasionally cause noninfectious irritation.

Is burning urination called Hurqat-i Bawl in Unani medicine?



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Yes.

CCRUM's official Unani guidance describes burning micturition under the traditional term *Hurqat-i Bawl*.

Can Unani medicine cure chlamydial NGU?

There is currently insufficient high-quality direct evidence showing that Unani treatment alone reliably eradicates microbiologically confirmed chlamydia from the urethra.

Evidence-based antimicrobial treatment should therefore not be replaced.

Can Unani medicine cure Mycoplasma genitalium?

There is currently insufficient evidence for replacing resistance-guided antimicrobial therapy with Unani treatment.

Is Unani medicine useful in NGU at all?

Yes, its most responsible role is:

supportive integrative care.

It may help address selected problems such as:

- nutritional wellbeing,
- digestion,
- general recovery,
- urinary comfort,
- sexual wellbeing,
- stress.

This role becomes especially relevant after active infection has been appropriately treated.

Can Unani medicine help persistent burning after infection is gone?

Potentially, as part of individualized supportive treatment after:

- persistent infection,

- UTI,
- other structural disease

have been excluded.

Pelvic-floor relaxation and chronic pelvic-pain management may also be important.

Red-Flag Symptoms That Need Prompt Medical Evaluation

A patient should seek prompt or urgent medical assessment if urethral symptoms are accompanied by:

- sudden or severe testicular pain,
- significant scrotal swelling,
- high fever,
- inability to pass urine,
- visible blood in the urine,
- severe pelvic or abdominal pain,
- persistent vomiting,
- rapidly worsening genital swelling,
- symptoms that remain severe despite appropriate treatment.

These symptoms may indicate:

- epididymitis,
- testicular torsion,
- complicated urinary infection,
- another urological condition

rather than uncomplicated NGU.

A Message From Dr. Nizamuddin Qasmi to Patients

If you have urethral burning or discharge, my first advice is:

do not panic.

But my second advice is equally important:



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do not repeatedly self-medicate.

A discharge from the penis may be caused by:

- gonorrhoea,
- chlamydia,
- Mgen,
- trichomoniasis,
- viral urethritis,
- another cause.

The medicines required for these conditions are:

not identical.

The modern approach is therefore:

diagnose first and treat intelligently.

What I Tell a Patient Whose Symptoms Keep Returning

I tell him:

“Before I give you another antibiotic, I want to know whether the urethra is still inflamed and whether the original organism is still present.”

That question may save the patient from months of unnecessary treatment.

If infection remains:

treat it appropriately.

If infection is gone:

stop treating an organism that is no longer there.

Then investigate:

- pelvic-floor dysfunction,
 - chronic pelvic pain,
 - other urinary causes.
-

What I Tell Couples



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If NGU is caused by a transmissible organism:

both partners matter.

The person without symptoms may still carry infection.

Treating one partner while ignoring the other can lead to:

repeated reinfection.

Partner management is not about blame.

It is about:

breaking the transmission cycle.

What I Tell Men Concerned About Fertility

I explain:

“One episode of NGU does not mean you are infertile.”

If conception is difficult, we assess:

- semen concentration,
- motility,
- morphology,
- reproductive history,
- hormonal or other male factors.

If the female partner is also being evaluated, we look at:

- age,
- ovulation,
- ovarian reserve when appropriate,
- fallopian tubes,
- uterus.

That is the correct way to determine fertility.

What I Tell Patients About Unani Treatment

As a Unani physician, I consider:



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- constitutional health,
- diet,
- digestion,
- urinary wellbeing,
- reproductive health,
- sexual wellbeing.

These areas can contribute meaningfully to recovery.

But I do not confuse:

symptom relief

with:

microbiological cure.

If chlamydia or Mgen is demonstrated, we need an effective antimicrobial plan.

After infection is controlled, individualized Unani care can be used responsibly to support:

- overall health,
- recovery,
- sexual and urinary comfort.

This is the model of integrative medicine I prefer at Saira Health Care.

Current Medical Understanding — 2026 Update

Modern NGU care has changed in several important ways.

The **new BASHH NGU guideline was published in 2026**, replacing older UK guidance. It confirms that chlamydia and *M. genitalium* remain the two most important recognized causes of NGU.

It now recognizes *Haemophilus influenzae*, *H. parainfluenzae* and *Neisseria meningitidis* more clearly as possible NGU pathogens and includes automated urine flow cytometry as an additional objective diagnostic method.

The new guideline recommends *M. genitalium* NAAT in symptomatic men with confirmed NGU and suggests HSV NAAT when a viral presentation is suspected.

One particularly important change is that:



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azithromycin 1 g as a single standalone dose is no longer recommended in the 2026 BASHH NGU guideline.

The preferred acute NGU treatment is doxycycline 100 mg twice daily for seven days, while alternative azithromycin therapy uses an extended regimen.

Persistent NGU is increasingly recognized as a condition requiring:

re-diagnosis rather than automatic retreatment.

BASHH reports persistent/recurrent NGU in approximately 5–25% of patients and notes that an infectious pathogen is found in fewer than half of these cases.

This has major implications for antibiotic stewardship.

When persistent infection has been excluded, some patients have:

chronic pelvic pain syndrome,

with pelvic-floor hypertonicity contributing to dysuria and pain with ejaculation. A biopsychosocial and pelvic-floor approach may then be more appropriate than additional antibiotics.

India's **2024 National Technical Guidelines on STI/RTI** have also modernized urethral-discharge management by using ceftriaxone plus doxycycline as first-line syndromic coverage for gonorrhoea and chlamydia and specifically incorporating *T. vaginalis* and *M. genitalium* into persistent/recurrent urethral-discharge management. Unresolved cases should be referred for etiological testing and antimicrobial-susceptibility assessment where possible.

These developments represent an important shift in STI medicine:

from repeated empirical antibiotics toward targeted, laboratory-supported and antimicrobial-resistance-aware treatment.

Conclusion

Nongonococcal urethritis is inflammation of the urethra caused by something other than gonorrhoea.

It is not a single disease and it should not be treated as though every patient has the same infection.

The most important recognized causes are:

Chlamydia trachomatis

and:

Mycoplasma genitalium.

Other possible causes include:

- *Trichomonas vaginalis*,
- ureaplasmas in selected cases,
- *Haemophilus* species,
- adenovirus,
- herpes simplex virus,
- occasional other organisms.

And in approximately:

10–45% of cases,

no causative pathogen is identified despite investigation.

The typical patient experiences:

- urethral discharge,
- burning urination,
- penile-tip irritation,
- urethral itching or discomfort.

But these symptoms are not specific.

Modern diagnosis should therefore attempt to:

demonstrate urethral inflammation

and:

identify the responsible STI where possible.

NAAT testing for:

- gonorrhoea,
- chlamydia

is fundamental.

M. genitalium testing is increasingly important, particularly in recurrent disease, and the BASHH 2026 guideline now recommends it more broadly in confirmed symptomatic NGU.



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Doxycycline remains the recommended first-line treatment for acute confirmed NGU in current major guidelines, while India's syndromic urethral-discharge programme also covers gonorrhoea with ceftriaxone when the exact cause has not yet been separated.

Repeated single-dose azithromycin should not be used casually.

The reason is particularly important:

Mycoplasma genitalium antimicrobial resistance.

Persistent symptoms should trigger a structured review of:

- treatment adherence,
- sexual re-exposure,
- Mgen,
- trichomoniasis,
- continuing objective inflammation.

If infection is no longer present, further antibiotics may be inappropriate.

Some men instead develop:

chronic pelvic pain syndrome

in which pelvic-floor tension can produce:

- burning,
- pelvic discomfort,
- painful ejaculation.

From the fertility perspective:

NGU does not automatically cause infertility.

The risk depends on the organism and reproductive-tract involvement.

Chlamydial infection has been associated with impaired male fertility in recent meta-analysis, although confounding and heterogeneity mean that individual causation cannot simply be assumed.

For female partners, untreated sexually transmitted pathogens—particularly chlamydia—can have important reproductive consequences through:

- cervicitis,
- PID,

- tubal disease.

Therefore, partner management is essential.

From the **Unani perspective**, traditional concepts such as *Hurqat-i Bawl* recognize symptoms such as burning micturition, and individualized Unani care can contribute usefully to:

- urinary comfort,
- general health,
- nutrition,
- digestive wellbeing,
- sexual and psychological recovery.

However:

there is currently insufficient direct high-quality evidence to use Unani medicine alone to eradicate microbiologically confirmed chlamydial or Mgen NGU.

Therefore, at **Saira Health Care**, my approach is integrative but evidence-aware:

confirm urethritis, identify the causative organism where possible, treat infection according to current antimicrobial guidance, manage the sexual partner, avoid unnecessary repeat antibiotics, recognize chronic pelvic pain when infection has resolved, investigate fertility properly when required, and integrate individualized Unani supportive care for the patient's broader urinary, sexual and reproductive wellbeing.

My most important message to patients is:

Recurrent burning does not automatically mean recurrent infection.

And:

Nongonococcal urethritis should be diagnosed accurately—not treated by repeatedly changing antibiotics.

That approach protects:

- your sexual health,
- your partner,
- your fertility,
- and the effectiveness of antibiotics for the future.



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About the Author

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Dr. Nizamuddin Qasmi is a well-qualified physician with a **specialist-focused clinical practice in Sexual Disorders & Infertility** at Saira Health Care.

His clinical approach to nongonococcal urethritis emphasizes that urethral symptoms should not be separated from a patient's broader:

- sexual health,
- partner health,
- reproductive health,
- fertility concerns.

Depending upon the patient's presentation, assessment may include evaluation of urethral discharge and dysuria, review of previous STI investigations and antibiotics, appropriate molecular testing for sexually transmitted pathogens, partner-management counselling, assessment for persistent/recurrent infection, evaluation for chronic pelvic pain when infection is no longer present, and male or couple-based infertility assessment where conception is difficult.

Where clinically appropriate, individualized principles of Unani medicine may be incorporated to support:

- nutrition,
- digestion,
- urinary wellbeing,
- sexual wellbeing,
- general recovery



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while ensuring that microbiologically confirmed sexually transmitted infection receives appropriate evidence-based antimicrobial treatment.

At **Saira Health Care**, the objective is not merely:

“stop the discharge.”

The objective is to understand:

why it developed, whether infection has truly been eliminated, whether the partner is protected, whether fertility has been affected, and how normal sexual and reproductive health can be restored.

Medical Disclaimer

This article is intended for professional education and public health awareness. It does not establish an individual diagnosis or prescribe treatment for a specific patient.

Penile discharge and painful urination can be caused by:

- gonorrhoea,
- chlamydia,
- *Mycoplasma genitalium*,
- trichomoniasis,
- herpes,
- adenovirus,
- UTI,
- other urological or inflammatory conditions.

Patients should not self-diagnose NGU solely from symptoms.

Medication doses mentioned in this article reflect published professional guidance and must not be treated as an individual prescription.

Antibiotic selection should consider:

- diagnostic results,
- antimicrobial resistance,
- medication allergies,
- previous antibiotic exposure,



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- clinical severity,
- individual medical conditions.

Repeated empirical antibiotics for persistent burning without evidence of ongoing urethral inflammation are discouraged because they may cause:

- adverse effects,
- antimicrobial resistance,
- unnecessary treatment.

Severe or sudden testicular pain, fever, major scrotal swelling, inability to urinate, significant bleeding or severe pelvic symptoms requires prompt clinical assessment.

Individualized Unani supportive treatment may be used where medically appropriate, but it should not delay:

- STI testing,
- appropriate antimicrobial treatment,
- partner management,
- evaluation for epididymitis,
- fertility investigation where indicated.

There is currently insufficient high-quality evidence to recommend Unani medicine as a stand-alone substitute for proven treatment of microbiologically confirmed sexually transmitted causes of NGU.

