

Mycoplasma genitalium

Understanding an Emerging Sexually Transmitted Infection, Persistent Urethritis, Cervicitis, Pelvic Inflammatory Disease, Antibiotic Resistance, Fertility and the Supportive Role of Unani Medicine

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health — ISRH, UNFPA

A Message From Dr. Nizamuddin Qasmi

When a patient comes to me with persistent burning during urination, recurrent urethral discharge, unexplained cervicitis, pelvic pain or an infection that seems to return even after antibiotics, one organism that increasingly deserves consideration is:

Mycoplasma genitalium

or:

M. genitalium / Mgen.

This is a sexually transmitted bacterium that many members of the public have never heard of.

Even some patients who have repeatedly been treated for:

- “urine infection,”
- nongonococcal urethritis,
- cervicitis,
- pelvic inflammatory disease

may never have specifically been tested for *M. genitalium*.

The infection is particularly important for another reason:

antibiotic resistance has become a major problem.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

In the past, patients with persistent genital symptoms were sometimes repeatedly given:

- azithromycin,
- doxycycline,
- other antibiotics

without identifying the responsible organism.

That approach is increasingly inappropriate for *M. genitalium*.

Current CDC guidance states that *M. genitalium* causes approximately **15–20% of nongonococcal urethritis in men, around 20–25% of non-chlamydial nongonococcal urethritis, and roughly 40% of persistent or recurrent urethritis.**

In women it is associated with:

- cervicitis,
- endometritis,
- pelvic inflammatory disease,
- reproductive complications

and it has been detected in approximately **10–30% of women with clinical cervicitis** in studies reviewed by CDC.

This means that when genital symptoms keep returning, we should not simply keep changing antibiotics.

We should ask:

“Do we know which organism we are treating?”

That question can prevent:

- prolonged symptoms,
- unnecessary antibiotic use,
- antibiotic resistance,
- repeated infection between partners,
- possible reproductive complications.

What Is Mycoplasma genitalium?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Mycoplasma genitalium is a very small bacterium that infects the human genital and urinary tract.

It was first isolated in the early 1980s from men with nongonococcal urethritis.

Today it is recognized as an important sexually transmitted pathogen.

It can infect both:

- men,
- women.

It can produce symptoms, but it can also remain:

completely asymptomatic.

BASHH's current 2025 guidance notes that many genital *M. genitalium* infections do not produce recognized disease, while infection may persist for prolonged periods in some people.

This asymptomatic behaviour is one reason the infection may move between partners without either person realizing it.

Why Is *Mycoplasma genitalium* Different From Many Other Bacteria?

One unusual biological feature is extremely important.

***M. genitalium* has no cell wall.**

This means antibiotics that work by attacking bacterial cell-wall synthesis are ineffective against it.

CDC specifically states that beta-lactam antibiotics—including:

- penicillins,
- cephalosporins

do not work against *M. genitalium* because the organism lacks the cellular structure these medicines are designed to attack.

Therefore, medicines such as:

- amoxicillin,
- amoxicillin-clavulanate,
- many cephalosporins

should not be expected to eradicate confirmed *M. genitalium* infection.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

This is one reason accurate diagnosis matters.

Is *Mycoplasma genitalium* the Same as *Mycoplasma hominis*?

No.

Patients frequently receive laboratory reports listing several organisms together:

- *Mycoplasma genitalium*,
- *Mycoplasma hominis*,
- *Ureaplasma urealyticum*,
- *Ureaplasma parvum*.

These organisms should not automatically be treated as identical.

M. genitalium has a particularly well-established role in:

nongonococcal urethritis

and growing evidence links it with:

- cervicitis,
- PID.

The clinical significance of other genital mycoplasmas and ureaplasmas varies much more by organism, bacterial load and clinical context.

Therefore:

a laboratory report saying “*Mycoplasma* positive” is not enough.

The exact organism matters.

Is *Mycoplasma genitalium* an STI?

Yes.

M. genitalium is predominantly transmitted through sexual contact.

It has been detected in:

- genital infection,
- rectal infection

depending on sexual exposure.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Partner concordance is common, supporting sexual transmission. CDC states that partners of infected men and women frequently also carry the organism.

Therefore it should be approached as a:

sexually transmitted infection.

But like other STIs, diagnosis should be handled professionally rather than morally.

An infection is:

a medical condition—not a judgement about character.

Does a Positive Test Prove Recent Infidelity?

No.

This is an important counselling point.

Many people have:

- no symptoms,
- very mild symptoms.

Infection may therefore remain unrecognized for some time.

BASHH notes that spontaneous clearance may sometimes occur within months, while persistence extending up to approximately two years has also been reported.

A positive test therefore does not reliably tell us:

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

It should not automatically be used as proof of recent infidelity.

How Does Mycoplasma genitalium Spread?

The main route is:

sexual contact.

Transmission can occur during genital sexual contact through exposure to infected:

- urethral,
- cervical,
- vaginal,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- rectal secretions.

Condom use reduces the opportunity for transmission.

Because infection can be asymptomatic, a person may transmit the organism without knowing that infection is present.

Can Mycoplasma genitalium Be Transmitted Through Toilets?

Ordinary toilet-seat use is not considered a typical route of transmission.

Likewise, *M. genitalium* should not be approached like an infection spread through:

- eating together,
- casual household contact,
- shaking hands.

It is fundamentally a sexual/reproductive-tract infection.

Symptoms in Men

In men, the most established clinical presentation is:

nongonococcal urethritis — NGU.

Typical symptoms may include:

- burning during urination,
- irritation inside the urethra,
- urethral discharge,
- discomfort at the tip of the penis.

Some men notice only:

- mild morning discharge,
- slight urethral tingling.

Others have no symptoms.

BASHH's current guidance identifies:

- urethral discharge,
- urethral irritation



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

as common symptomatic presentations in affected men.

What Is Nongonococcal Urethritis?

Urethritis means:

inflammation of the urethra.

When gonorrhoea is not the cause, it is called:

nongonococcal urethritis — NGU.

Possible causes include:

- *Chlamydia trachomatis*,
- *Mycoplasma genitalium*,
- other infectious and noninfectious causes.

M. genitalium has become particularly important in patients whose urethritis:

keeps returning after treatment.

CDC estimates that it may be responsible for approximately:

40% of persistent or recurrent urethritis.

This is why persistent urethritis should not simply be managed by repeating the same antibiotic indefinitely.

What Does Urethral Discharge Look Like?

The discharge may be:

- clear,
- whitish,
- mucoid,
- scant.

Its appearance cannot reliably distinguish:

- *M. genitalium*,
- chlamydia,
- gonorrhoea,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- another cause.

Laboratory testing is therefore far more informative than guessing from:

- colour,
 - thickness.
-

Symptoms in Women

Women frequently have:

no obvious symptoms.

When symptoms occur, they may be associated with:

- cervicitis,
- pelvic inflammatory disease.

Possible complaints include:

- abnormal discharge,
- bleeding after intercourse,
- bleeding between periods,
- pelvic pain,
- painful intercourse,
- burning with urination.

BASHH identifies a particularly important association between *M. genitalium* and:

cervicitis and post-coital bleeding.

However, symptoms such as:

- vaginal discharge,
- itching,
- odour

are nonspecific and cannot by themselves establish *M. genitalium* infection.

What Is Cervicitis?

The cervix is the lower part of the uterus that opens into the vagina.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Cervicitis means:

inflammation of the cervix.

It may cause:

- abnormal cervical discharge,
- bleeding after intercourse,
- bleeding between periods,
- pelvic discomfort.

Possible infectious causes include:

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

CDC reports that *M. genitalium* can be found in approximately **10–30% of women with clinical cervicitis** in studied populations.

What Is Post-Coital Bleeding?

Post-coital bleeding means:

bleeding after sexual intercourse.

It has several possible causes, including:

- cervical inflammation,
- cervical ectropion,
- polyps,
- trauma,
- cervical precancer or cancer.

Because *M. genitalium* can cause cervicitis, it can be associated with post-coital bleeding.

But:

every woman with bleeding after intercourse should not simply be given antibiotics.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Persistent post-coital bleeding requires appropriate gynecological assessment so that significant cervical disease is not missed.

Mycoplasma genitalium and Pelvic Inflammatory Disease

This is one of the most important reproductive-health concerns.

Pelvic inflammatory disease—PID—is infection/inflammation involving upper female reproductive structures such as:

- endometrium,
- fallopian tubes,
- ovaries,
- surrounding pelvic tissues.

M. genitalium is detected more often in women with PID than in women without PID.

CDC reports prevalence ranging from approximately:

4–22%

among women with PID in reviewed studies.

PID matters because upper genital tract inflammation can potentially contribute to:

- chronic pelvic pain,
- tubal damage,
- ectopic pregnancy,
- infertility.

Symptoms Suggesting PID

Possible symptoms include:

- lower abdominal pain,
- pelvic pain,
- pain during intercourse,
- abnormal discharge,
- irregular bleeding,
- fever.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Severe:

- pelvic pain,
- fever,
- vomiting,
- fainting,
- pregnancy with abdominal pain

requires prompt medical assessment.

PID is a clinical syndrome and should not be delayed while waiting indefinitely for one laboratory result.

Standard PID Treatment May Not Reliably Eradicate *M. genitalium*

This is a clinically important point.

CDC notes that standard recommended PID regimens are not reliably effective against *M. genitalium*.

Therefore, if *M. genitalium* is detected in a patient with persistent PID-related symptoms, management may need to be modified under specialist supervision.

This is another reason that persistent symptoms after apparently standard treatment deserve reconsideration.

Can *Mycoplasma genitalium* Cause Infertility in Women?

The evidence suggests an association, particularly because the organism can cause:

- cervicitis,
- endometritis,
- PID.

CDC summarizes observational evidence showing that *M. genitalium* infection in women has been associated with approximately a twofold increase in several adverse reproductive outcomes—including infertility—although the strength of evidence differs across outcomes.

A meta-analysis of genital mycoplasma infections also found a significant association between *M. genitalium* and female infertility.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

However:

association does not mean that every infected woman becomes infertile.

Many infected women will not develop:

- tubal damage,
- infertility.

Evidence From India and Female Infertility

An important North Indian study conducted at PGIMER, Chandigarh evaluated women with infertility using PCR testing.

M. genitalium was detected in approximately **16% of the infertile women studied and in none of the fertile controls**. Many positive patients were asymptomatic. Tubal occlusion was identified in some of the positive women.

This study is clinically interesting for India.

However, it was:

- relatively small,
- observational.

It therefore supports an association but does not prove that *M. genitalium* was the sole cause of infertility in every positive patient.

Does *M. genitalium* Automatically Block the Fallopian Tubes?

No.

A positive test should not automatically lead to the statement:

“Your tubes are blocked.”

If a woman has infertility, tubal health should be assessed objectively when indicated through appropriate methods such as:

- HSG,
- ultrasound-based tubal testing,
- laparoscopy in selected cases.

Infection history can increase clinical suspicion.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

It does not replace proper fertility testing.

Can Mycoplasma genitalium Cause Ectopic Pregnancy?

Because *M. genitalium* may contribute to:

- PID,
- tubal inflammation,

researchers have investigated possible links with ectopic pregnancy.

Evidence is less definitive than the association between:

- chlamydia,
- tubal damage.

Therefore, *M. genitalium* should be considered a possible reproductive-tract pathogen rather than automatically labelled a proven cause of every ectopic pregnancy.

Mycoplasma genitalium and Male Fertility

The male infertility relationship is less certain.

CDC states that evidence remains insufficient to firmly implicate *M. genitalium* as a cause of chronic male complications such as:

- infertility,
- chronic prostatitis,
- epididymitis.

However, a 2023 systematic review and meta-analysis of genital mycoplasmas reported a statistical association between *M. genitalium* infection and male infertility.

The correct interpretation is:

the possible male fertility relationship deserves attention, but causality is not yet firmly established.

Should Every Infertile Man Be Tested for M. genitalium?

No.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Routine screening of all asymptomatic men is not currently recommended simply because they are having fertility difficulty.

CDC specifically advises against routine screening of asymptomatic men and women for *M. genitalium*.

Testing becomes more relevant when the man has:

- persistent or recurrent urethritis,
- an infected sexual partner,
- other clinical indication.

A complete infertility investigation should still include the established major causes.

Other Causes of Male Infertility Must Not Be Missed

An infertile man with *M. genitalium* can also have:

- varicocele,
- hormonal abnormalities,
- genetic infertility,
- previous undescended testis,
- testicular injury,
- smoking-related sperm impairment,
- obesity,
- other infections.

Therefore:

never stop the infertility investigation at one infection test.

Pregnancy and Mycoplasma genitalium

Research has associated *M. genitalium* with possible adverse pregnancy outcomes, including:

- preterm birth,
- spontaneous abortion

in some observational studies.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

However, evidence is not completely consistent.

CDC acknowledges associations with adverse reproductive outcomes while also recognizing limitations in the available evidence.

A systematic review of *M. genitalium* treatment recommendations in pregnancy found that international guidelines differed because evidence is limited and treatment options are constrained.

Therefore:

pregnancy requires specialist treatment rather than self-medication.

Treatment During Pregnancy Is More Complicated

The problem is that some medicines commonly used outside pregnancy are unsuitable or avoided during pregnancy.

A 2024 systematic review of international guidelines found that the reviewed pregnancy guidelines generally recommended:

azithromycin

as first-line treatment in pregnancy and advised against:

moxifloxacin.

However, dosing recommendations and management of resistant infection varied substantially between guidelines.

Therefore, pregnant women with confirmed *M. genitalium* should be managed by an experienced:

- obstetrician,
 - sexual-health/infectious-disease specialist.
-

Can Mycoplasma genitalium Cause Miscarriage?

Some studies have reported an association.

But the evidence is not sufficient to say:

“M. genitalium caused this miscarriage”

in an individual woman without other supporting evidence.

Miscarriage has many possible causes, including:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- chromosomal abnormalities,
- maternal age,
- uterine conditions,
- endocrine problems,
- other infections.

Research should inform counselling without creating unnecessary guilt.

Diagnosis of Mycoplasma genitalium

The preferred diagnosis is based on:

nucleic acid amplification testing — NAAT.

These tests detect the genetic material of the organism.

CDC notes that NAAT can be used on appropriate specimens such as:

- first-void urine,
- urethral specimens,
- vaginal swabs,
- endocervical samples

depending on the assay and patient.

Why Is Culture Not Used Routinely?

M. genitalium is extraordinarily difficult and slow to culture.

CDC notes that culture can take:

up to approximately six months

and is generally confined to specialized research laboratories.

Therefore:

ordinary bacterial urine culture cannot reliably diagnose *M. genitalium*.

This is extremely important.

A patient may say:

“My urine culture was normal, so I cannot have Mycoplasma.”



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

That conclusion is incorrect.

The correct test is generally a:

molecular NAAT/PCR-type test.

Can Routine Urine Microscopy Diagnose It?

No.

Routine urine analysis may show:

- inflammatory cells,

but it cannot identify *M. genitalium* reliably.

A specific molecular test is required.

Which Men Should Be Tested?

Current CDC guidance recommends testing men with:

recurrent nongonococcal urethritis.

Testing is especially relevant when:

- gonorrhoea is excluded,
 - chlamydia is excluded or appropriately treated,
 - urethral symptoms persist.
-

Which Women Should Be Tested?

CDC recommends testing women with:

recurrent cervicitis

and considering testing in women with:

pelvic inflammatory disease.

This does not mean every asymptomatic woman needs screening.

Should Everyone Be Screened for Mycoplasma genitalium?

No.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

This is an important difference from some better-established STI screening programmes.

CDC does **not** recommend routine screening of asymptomatic men or women.

BASHH's current guidance similarly cautions that routine asymptomatic screening has not demonstrated benefit and can potentially contribute to harm through unnecessary antibiotic exposure and antimicrobial resistance.

This is a very modern principle:

more testing is not always better testing.

Testing should answer a clinically meaningful question.

Why Routine Screening Can Be Harmful

Suppose a completely asymptomatic person receives a large multiplex PCR panel.

M. genitalium is detected.

They then receive antibiotics.

The treatment:

- may cause side effects,
- may fail because of resistance,
- may further select resistant organisms.

If there is no evidence that treating every asymptomatic infection improves long-term outcomes, indiscriminate screening can potentially create more antimicrobial resistance without proven population benefit.

Therefore:

targeted testing is more responsible than testing everyone.

Resistance Testing

The ideal test does more than simply say:

“M. genitalium detected.”

Where available, molecular resistance testing can identify mutations associated with resistance to:

- macrolides,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- sometimes quinolones.

This allows:

resistance-guided treatment.

CDC reports that resistance-guided sequential treatment has achieved cure rates above approximately 90% in studied settings.

Unfortunately, resistance testing is not yet widely available everywhere.

Antibiotic Resistance Is the Major Challenge

This is perhaps the single most important modern issue in *M. genitalium* management.

Macrolide resistance has increased dramatically.

CDC reports macrolide-resistance markers ranging from approximately:

44–90%

in studies from the United States, Canada, Western Europe and Australia.

The BASHH 2025 guideline resource summarizes newer international evidence showing a global pooled prevalence of genotypic macrolide resistance around **one-third**, with substantially higher rates in some populations and regions.

This is why casual repeated use of azithromycin is no longer appropriate.

Indian Evidence on Antibiotic Resistance

India also has emerging resistance data.

A 2024 pilot study from AIIMS New Delhi examined *M. genitalium* among 180 men who have sex with men attending an STI clinic.

The organism was detected in 13 participants—approximately:

7.2%.

Among these infections, mutations associated with:

- macrolide resistance were found in approximately **46%**;
- quinolone resistance in approximately **15%**.

The study was small and involved a specific population, so the numbers cannot be generalized to every Indian patient. Nevertheless, it demonstrates that clinically important antimicrobial resistance is already present in India.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

This is precisely why antibiotic stewardship matters.

Why a Single 1-Gram Dose of Azithromycin Is No Longer Recommended

For many years, single-dose azithromycin was widely used for nongonococcal urethritis.

For *M. genitalium*, this strategy has become problematic.

CDC specifically states:

a single 1-g dose of azithromycin should not be used to treat *M. genitalium*.

This is because:

- treatment failure is common,
- treatment itself can select additional macrolide resistance.

CDC estimates that resistance can emerge during a single-dose course in approximately **10–12% of initially susceptible infections**.

Patients should therefore not repeatedly self-purchase single-dose azithromycin for recurrent genital symptoms.

Why Doxycycline Alone Is Often Not Enough

Doxycycline can reduce the amount of organism present.

But on its own, its microbiological cure rate for *M. genitalium* is relatively low.

BASHH summarizes eradication rates of roughly:

30–40%

with doxycycline monotherapy.

Its important modern role is often as the:

first stage of sequential therapy.

By reducing bacterial load first, subsequent targeted treatment may work more effectively.

Current Principle of Treatment

Modern treatment increasingly follows the principle:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

first reduce organism load → then use the most appropriate active antibiotic.

CDC recommends:

two-stage sequential therapy,

ideally guided by resistance testing.

When macrolide susceptibility is documented, extended-dose azithromycin can be used after doxycycline.

When macrolide resistance is present, moxifloxacin is generally used after doxycycline in nonpregnant appropriate patients.

The precise regimen should be prescribed by a clinician.

Current CDC Treatment Approach

When resistance testing is available, CDC recommends treatment according to susceptibility.

For macrolide-sensitive infection, treatment involves:

- doxycycline first,
- followed by an extended azithromycin regimen.

For macrolide-resistant infection:

- doxycycline,
- followed by moxifloxacin.

When resistance testing is unavailable and *M. genitalium* is confirmed, CDC currently recommends:

- doxycycline for seven days,
- followed by moxifloxacin for seven days

in appropriate nonpregnant adults.

These doses are mentioned here for medical education, not as an individual prescription.

Why Patients Should Not Self-Treat

Treatment choice depends on:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- pregnancy,
- age,
- previous antibiotic use,
- allergy,
- heart rhythm risk,
- liver/kidney function,
- resistance pattern,
- treatment history.

Moxifloxacin, for example, is a valuable medicine but can cause important adverse effects in selected patients.

Repeated unsupervised antibiotics can also create:

multidrug-resistant infection.

Therefore:

confirmed *M. genitalium* deserves targeted treatment, not random antibiotic experimentation.

What If Moxifloxacin Also Fails?

This has become an important international problem.

Resistance to fluoroquinolones is also increasing, particularly in parts of the Asia-Pacific region. BASHH's updated guidance highlights rising quinolone resistance internationally.

Specialist options for multidrug-resistant infections may include drugs such as:

- minocycline,
- pristinamycin in some countries,
- other specialist regimens.

BASHH's 2025 guidance discusses short-term minocycline as an option for drug-resistant infection in appropriate circumstances.

These are:

specialist treatments.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

They should not be started by patients independently.

New Treatments Are Being Studied

Research continues because antibiotic resistance has reduced the effectiveness of older regimens.

A 2025 pilot study investigated:

lefamulin

for difficult treatment-resistant *M. genitalium*, although cure rates were modest and gastrointestinal adverse effects were common.

In 2026, clinical studies are also evaluating other antibiotics such as:

solithromycin

for *M. genitalium*.

These developments illustrate an important point:

M. genitalium treatment is a rapidly evolving area of sexual medicine.

Experimental or investigational medicines should not be treated as routine therapy until stronger evidence and guidelines support them.

A 2026 Randomized Trial and Antibiotic Resistance

A randomized study published in 2026 compared extended azithromycin with moxifloxacin in adults with PCR-confirmed *M. genitalium* when resistance assays were not used.

Microbiological cure occurred in approximately:

- **87% with moxifloxacin,**
- **61% with azithromycin**

in the intention-to-treat analysis.

This recent trial reinforces the clinical consequences of high macrolide resistance.

However, one study does not replace individualized guideline-based care, particularly because:

- resistance patterns differ geographically,
- fluoroquinolone resistance is also increasing.

The best long-term strategy remains:

resistance-guided therapy whenever feasible.

Test of Cure

A test of cure means repeating molecular testing after treatment to determine whether infection has been eradicated.

CDC does not require routine test-of-cure in every asymptomatic patient who received a recommended regimen.

However, test-of-cure becomes particularly important when:

- alternative treatment was used,
- resistance is suspected,
- symptoms persist,
- treatment failure occurred.

Testing too early can create misleading results because residual bacterial genetic material may remain briefly after therapy.

Timing should therefore follow the relevant regimen and guideline.

Persistent Symptoms After a Negative Test

Not every patient whose discomfort continues still has *M. genitalium*.

Persistent symptoms can result from:

- another STI,
- pelvic floor dysfunction,
- prostatitis/chronic pelvic pain syndrome,
- vulvodynia,
- urinary disease,
- residual inflammation,
- anxiety related to previous infection.

Therefore:

do not keep prescribing antibiotics purely because symptoms continue.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Confirm whether the organism remains present.

Partner Management

Partner management is essential.

CDC reports high concordance of infection among sexual partners.

For the recent partners of a symptomatic infected patient:

- testing can be offered,
- a positive partner should be treated.

If testing is not possible, empiric partner treatment may sometimes be considered according to clinical guidance.

The purpose is to reduce:

- ongoing transmission,
 - possible reinfection.
-

Should My Partner Take Antibiotics Even Without Symptoms?

A partner may carry *M. genitalium* without symptoms.

The best approach where testing is available is:

test appropriately and treat if positive.

Where partner testing is not practical, treatment strategies may differ by local guideline and clinical circumstances.

This should be decided by the treating clinician.

When Can Sexual Intercourse Resume?

Couples should avoid sex until treatment requirements have been satisfied according to the treating clinic's advice.

A practical objective is to prevent:

- transmission,
- immediate reinfection

before treatment has had adequate time to work.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Condom use should also be discussed.

Condoms and Mycoplasma genitalium

Correct condom use lowers the risk of acquiring many sexually transmitted infections, including *M. genitalium*.

Condoms are particularly useful when:

- partner infection status is unknown,
- treatment is underway,
- multiple partners are involved.

However, condoms do not replace:

- diagnosis,
 - treatment,
 - partner management.
-

Should We Test for Other STIs?

Often yes.

A patient diagnosed with one STI may have another.

Depending on exposure and symptoms, testing may include:

- chlamydia,
- gonorrhoea,
- syphilis,
- HIV,
- trichomoniasis.

The 2024 New Delhi *M. genitalium* study, for example, found substantial chlamydia coinfection among the infected study participants.

A comprehensive sexual-health approach is therefore more appropriate than treating one organism in isolation.

Mycoplasma genitalium and HIV



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Observational studies have reported an association between *M. genitalium* infection and HIV.

CDC notes that urogenital *M. genitalium* has been associated with HIV in both men and women, although much of the evidence is observational.

A patient diagnosed with *M. genitalium* may therefore benefit from a wider STI risk assessment.

This does not mean:

M. genitalium causes HIV.

They are completely different infections.

Can Mycoplasma genitalium Be Completely Cured?

Yes, bacterial eradication is achievable in most appropriately treated infections.

But treatment is becoming more difficult because of:

- macrolide resistance,
- emerging fluoroquinolone resistance.

This is very different from lifelong viral infections such as:

- HIV,
- genital herpes.

M. genitalium is a bacterial STI that can be eradicated, but:

the antibiotic must actually be active against the strain.

Can Infection Return?

Yes.

A positive test after treatment can represent:

- treatment failure,
- resistance,
- reinfection from an untreated partner.

Determining which is most likely is important before repeatedly changing medicines.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Is There a Vaccine?

No routinely available vaccine currently prevents *M. genitalium*.

Prevention therefore relies on:

- safer sexual practices,
- appropriate condom use,
- targeted testing,
- correct treatment,
- partner management.

Mycoplasma genitalium and Sexual Dysfunction

The organism does not usually directly produce erectile dysfunction.

However, men with recurrent urethritis may develop:

- anxiety about sex,
- fear of infecting a partner,
- performance anxiety,
- avoidance of intercourse.

Women with:

- pelvic discomfort,
- cervicitis,
- PID

may develop:

- painful intercourse,
- sexual avoidance.

Therefore, the sexual-health consequences can continue beyond the infection itself.

At Saira Health Care, I believe restoring:

- sexual confidence,
- comfortable intercourse

is part of complete reproductive care.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Painful Intercourse in Women

Dyspareunia associated with active infection may improve when:

- cervicitis,
- PID,
- inflammation

are successfully treated.

But if pain continues after microbiological cure, the clinician should consider other causes such as:

- pelvic floor dysfunction,
- endometriosis,
- vulvodynia,
- vaginal dryness.

Persistent dyspareunia should not lead to endless antibiotic courses.

Mycoplasma genitalium and Infertility Evaluation

When an infertile couple has a history of *M. genitalium*, I ask two separate questions:

Question One

Has the infection been treated and cleared?

Question Two

Is there evidence of lasting reproductive damage or another infertility factor?

For a woman, assessment may include:

- ovulation,
- ovarian reserve when indicated,
- uterus,
- tubal patency.

For a man:

- semen concentration,

- motility,
- morphology,
- reproductive examination,
- hormones or genetics when indicated.

This prevents us from attributing every infertility problem to one infection.

If M. genitalium Is Treated, Will Fertility Automatically Return?

Not necessarily.

If the infection is present only in the lower genital tract and no lasting damage has occurred, successful treatment may remove an important reproductive health problem.

But if previous PID has already produced:

- tubal scarring,

antibiotics cannot mechanically reopen permanently scarred fallopian tubes.

This is an important distinction.

Antibiotics eradicate infection.

They do not necessarily reverse established anatomical damage.

That is why early recognition of clinically significant infection matters.

Can Men Conceive Naturally After Treatment?

Yes.

A treated infection does not automatically require:

- IUI,
- IVF,
- ICSI.

If semen quality and the rest of the couple's fertility evaluation are favourable:

natural conception may be possible.

Assisted reproductive technology should be based on genuine fertility indications.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

The Unani Perspective on Mycoplasma genitalium

As a physician trained in **Unani medicine** and focused on **Sexual Disorders & Infertility**, I believe that reproductive infections should be approached in a way that considers the whole patient.

A person with recurrent genitourinary symptoms may also be dealing with:

- digestive disturbance,
- poor nutrition,
- disturbed sleep,
- fatigue,
- stress,
- sexual anxiety,
- fertility concerns.

Unani medicine traditionally emphasizes:

- **Mizaj** or constitutional temperament,
- balanced nutrition,
- digestion,
- urinary and reproductive wellbeing,
- general health,
- sexual wellbeing.

These principles can contribute meaningfully to:

supportive and integrative care.

But a distinction is essential.

M. genitalium Is a Specific Bacterial Infection

Modern molecular medicine has identified the exact organism.

It can be detected by:

NAAT / PCR.

Its antibiotic-resistance mechanisms can also sometimes be identified molecularly.

Therefore:

improvement in burning or discharge is not sufficient proof that M. genitalium has been eradicated.

Microbiological management matters.

Can Unani Medicine Cure Mycoplasma genitalium?

At present, I do not find robust modern clinical evidence establishing a Unani formulation as a reliable replacement for guideline-directed antimicrobial treatment of confirmed *M. genitalium*.

This is important because treatment failure is already a worldwide problem.

Using an unproven alternative in place of active antibiotic treatment could allow:

- infection to persist,
- sexual transmission,
- possible progression to upper reproductive disease,
- delayed fertility care.

Therefore:

confirmed M. genitalium should receive appropriate antimicrobial management.

Does This Mean Unani Medicine Has No Role?

No.

Its responsible role is different.

Individualized Unani supportive care may be useful in selected patients for:

- general wellbeing,
- nutrition,
- digestion,
- urinary comfort after appropriate assessment,
- physical recovery,
- sexual confidence,
- reproductive wellbeing.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

If symptoms remain after infection is eradicated, supportive management of the patient's broader health can be useful.

But:

supportive care should not be confused with proven bacterial eradication.

A Crucial Principle of Integrative Medicine

I explain this to patients in simple language:

If the laboratory proves that a particular bacterium is present, I want to know:

“Has that bacterium been removed?”

Not merely:

“Has the discharge improved?”

A treatment may make a person feel better without eradicating infection.

For an STI that can be passed back to the partner, microbiological cure is important.

Why Random Herbal or Local Preparations Can Be Problematic

Patients sometimes insert:

- herbal powders,
- concentrated oils,
- antiseptic mixtures,
- caustic preparations

into the vagina or urethral area.

Sensitive genital mucosa can be injured by these products.

They may cause:

- burning,
- inflammation,
- altered vaginal microbiota,
- secondary irritation.

Local Unani or herbal therapy should therefore be:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- appropriately formulated,
- medically supervised,
- never used as a substitute for eradication treatment of confirmed *M. genitalium*.

Antibiotic Stewardship Is Also Compatible With Unani Principles

Responsible medicine does not mean using antibiotics for every minor symptom.

In fact, *M. genitalium* provides an excellent example of why unnecessary antibiotics should be avoided.

Excess antibiotic exposure has contributed to:

antimicrobial resistance.

Therefore my approach is:

- do not give antibiotics blindly;
- test when clinically indicated;
- identify the organism;
- use the appropriate targeted regimen;
- avoid unnecessary repeat antibiotics;
- use supportive care where it can genuinely benefit the patient.

This is a rational integrative approach.

Special Treatment Planning by Dr. Nizamuddin Qasmi

When a patient comes to me with suspected *M. genitalium*, I do not treat the words:

“burning”

or:

“discharge.”

I first determine the disease process.

I ask:

Is this urethritis?

Is gonorrhoea excluded?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Has chlamydia been tested?

Is M. genitalium NAAT available?

Has the patient already taken azithromycin?

Has doxycycline been used?

Has moxifloxacin been used?

Has resistance testing been performed?

Does the partner have symptoms or a positive test?

Is pregnancy present?

Does the woman have pelvic pain suggesting PID?

Is infertility also present?

The answers change the entire treatment plan.

What “Special Treatment” Means at Saira Health Care

Special treatment does not mean:

one secret medicine for every patient.

It means:

accurate diagnosis + antibiotic-resistance awareness + couple-based sexual-health management + reproductive assessment + individualized supportive care.

Consider several examples.

Patient One — Man With First Episode of Urethral Burning

He has:

- discharge,
- burning during urination.

The first step is not automatically:

“M. genitalium.”

Other important causes include:

- gonorrhoea,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- chlamydia.

The patient needs appropriate STI assessment.

Patient Two — Persistent Urethritis After Chlamydia Treatment

His gonorrhoea and chlamydia tests are negative or appropriately treated, but urethritis continues.

Now:

M. genitalium becomes particularly important.

CDC identifies it as one of the leading causes of recurrent NGU.

A specific NAAT is preferable to repeatedly prescribing antibiotics blindly.

Patient Three — Woman With Recurrent Cervicitis

She repeatedly develops:

- cervical discharge,
- post-coital bleeding.

Routine causes have been excluded or treated.

M. genitalium testing deserves consideration.

If the result is positive, treatment must account for antibiotic resistance.

Patient Four — Woman With PID

She has:

- lower abdominal pain,
- cervical tenderness,
- fever.

Treatment for PID should not be delayed while waiting for every test.

But if *M. genitalium* is identified—particularly with persistent symptoms—the treatment plan may need modification because standard PID regimens do not reliably eradicate it.

Patient Five — Infection Returns After Azithromycin



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

I do not simply prescribe:

another identical azithromycin dose.

Repeated macrolide exposure can select resistance.

The patient needs reassessment for:

- actual persistent infection,
- reinfection,
- macrolide resistance.

Patient Six — Both Partners Have Positive Tests

Both need appropriate management.

Treating only one partner may allow:

- reinfection,
- continued transmission.

Sexual contact should be managed according to the treatment plan until the couple is considered safe from immediate reinfection.

Patient Seven — Pregnant Woman With *M. genitalium*

This needs specialist treatment.

Some standard nonpregnant regimens are unsuitable during pregnancy.

The 2024 review of international guidelines found:

- azithromycin generally preferred,
- moxifloxacin avoided.

Self-treatment is particularly inappropriate.

Patient Eight — Infertile Woman With Previous *M. genitalium*

I do not tell her:

“Your infection is definitely the reason you cannot conceive.”

Instead, I evaluate:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- infection status,
- fallopian tubes,
- ovulation,
- ovarian reserve where appropriate,
- uterus,
- partner's semen.

The old infection may be relevant.

It may not be the only problem.

Patient Nine — Man With *M. genitalium* and Abnormal Semen

The possible association with male infertility is scientifically interesting, but current CDC evidence does not prove a direct causal relationship.

Therefore, I investigate:

- varicocele,
- hormones,
- testicular history,
- lifestyle,
- other infections,
- genetics where indicated.

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, our particular contribution is at the intersection of:

STI medicine + sexual function + fertility.

A person with *M. genitalium* may have far more concerns than:

“Which antibiotic should I take?”

They may ask:

“Can I infect my wife?”

“Can I marry?”



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

“Has this damaged my sperm?”

“Can my tubes become blocked?”

“Can we try for pregnancy?”

“Why does sex hurt even after treatment?”

These deserve complete answers.

Our aim is to help restore:

- sexual confidence,
- reproductive health,
- responsible partner management.

My Approach to Couples Trying for Pregnancy

If active *M. genitalium* infection has been diagnosed:

treat the infection appropriately first.

There is little benefit in deliberately exposing the partner to an untreated STI while trying to conceive.

After treatment:

- confirm cure where clinically required,
- address partner infection,
- then plan conception.

If pregnancy still does not occur, begin or continue the appropriate fertility work-up.

Does *M. genitalium* Mean IVF Is Required?

No.

A diagnosis does not automatically mean:

- IUI,
- IVF,
- ICSI.

ART becomes necessary only when there is a reproductive indication such as:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- severe male factor,
- tubal infertility,
- ovulatory problems,
- prolonged unexplained infertility,
- another established cause.

Can IVF Be Performed After *M. genitalium*?

Yes, after appropriate treatment and reproductive assessment.

Active genital infection should generally be dealt with before fertility procedures when clinically feasible.

Fertility specialists may have specific protocols regarding:

- infection clearance,
- partner testing.

What Patients Should Avoid

I advise patients with suspected or confirmed *M. genitalium* to avoid:

- repeated self-treatment with azithromycin;
- assuming every urethral symptom is gonorrhoea;
- relying on ordinary urine culture to exclude *M. genitalium*;
- using penicillin or cephalosporins expecting them to eradicate Mgen;
- treating only one partner and ignoring the other;
- assuming persistent symptoms always mean persistent infection;
- delaying PID treatment in a woman with significant pelvic symptoms;
- assuming a positive test automatically explains infertility;
- taking moxifloxacin or other specialist antibiotics without medical assessment;
- relying only on herbal therapy for proven infection.

When Urgent Medical Assessment Is Needed



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Seek prompt care if symptoms include:

- severe pelvic or lower abdominal pain,
- fever,
- vomiting,
- fainting,
- pregnancy with pelvic pain,
- suspected PID,
- severe testicular pain or swelling,
- significant genital bleeding,
- persistent symptoms despite appropriate treatment.

These symptoms may indicate:

- upper genital tract disease,
- another diagnosis

that needs immediate attention.

Frequently Asked Questions

What is *Mycoplasma genitalium*?

It is a small sexually transmitted bacterium that can infect the:

- urethra,
 - cervix,
 - upper female genital tract.
-

Is *M. genitalium* common?

It is less well known than chlamydia but is an important cause of urethritis.

CDC estimates it causes approximately:

- 15–20% of NGU,
 - around 40% of persistent/recurrent urethritis.
-



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Is Mycoplasma genitalium an STI?

Yes.

Can I have M. genitalium without symptoms?

Yes.

Many infections are asymptomatic.

What symptoms occur in men?

Possible symptoms include:

- urethral discharge,
 - burning urination,
 - urethral irritation.
-

What symptoms occur in women?

Possible manifestations include:

- cervicitis,
- post-coital bleeding,
- pelvic pain,
- PID.

Some women remain asymptomatic.

Does M. genitalium cause vaginal itching?

It may coexist with genital symptoms, but itching alone is nonspecific.

Other conditions such as:

- candidiasis,
- bacterial vaginosis,
- dermatological disease

are often more likely.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Can it cause discharge?

Yes, through urethritis or cervicitis.

But discharge appearance cannot reliably identify the organism.

Can it cause bleeding after intercourse?

Yes.

M. genitalium is associated with cervicitis and post-coital bleeding.

Can it cause pelvic inflammatory disease?

Yes, an association with PID is established.

Can it cause infertility?

Evidence supports an association with female infertility and suggests a possible male fertility relationship, but infection does not mean infertility is inevitable.

Can it block fallopian tubes?

Upper genital tract infection and PID can potentially contribute to tubal damage.

A positive Mgen test alone does not prove tubal blockage.

Is there Indian evidence linking it with infertility?

Yes.

A North Indian study detected *M. genitalium* in 16% of women in an infertility group and none of the fertile controls, although this observational study does not prove causation.

Can it affect sperm?

A relationship with male infertility has been reported in meta-analysis, but CDC considers evidence insufficient to firmly establish chronic male infertility as a complication.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

What is the best test?

A specific molecular:

NAAT / PCR

is the preferred diagnostic method.

Can routine bacterial culture find it?

Usually not.

M. genitalium is extremely slow-growing and culture is largely restricted to specialist research laboratories.

Can routine urine culture be normal even if I have it?

Yes.

Should everyone be screened?

No.

CDC and BASHH do not recommend routine asymptomatic population screening.

Who should be tested?

Testing is particularly important for:

- recurrent NGU in men;
- recurrent cervicitis in women.

It can also be considered in PID.

Why is *M. genitalium* difficult to treat?

Because resistance to:

- macrolides,
- increasingly fluoroquinolones



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

has become common.

How common is azithromycin resistance?

CDC reports macrolide-resistance markers ranging from approximately 44–90% in several studied Western populations.

Rates vary greatly by population and region.

Is there antibiotic-resistant *M. genitalium* in India?

Yes.

A 2024 New Delhi pilot study found macrolide-resistance mutations in about 46% and quinolone-resistance mutations in about 15% of positive isolates in a specific MSM clinic population. These figures should not be generalized to the whole Indian population.

Can I take azithromycin 1 gram once?

Current CDC guidance specifically advises against single-dose 1-g azithromycin for confirmed Mgen because of high resistance and risk of selecting further resistance.

Does doxycycline cure it?

Doxycycline alone has relatively low eradication rates but can substantially reduce bacterial load and is often used as the first stage of sequential therapy.

What is resistance-guided treatment?

The laboratory checks whether the organism has mutations suggesting resistance.

Treatment can then be selected accordingly.

This approach can achieve cure rates above 90% in studied settings.

What treatment is generally used when macrolide resistance is present?

Current CDC guidance uses:

- initial doxycycline,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- followed by moxifloxacin

for suitable nonpregnant patients.

Individual prescription remains necessary.

Why should moxifloxacin not be taken casually?

Fluoroquinolones can cause important adverse effects, and quinolone resistance is also emerging.

The medicine should be reserved for appropriate clinical circumstances.

What happens if moxifloxacin fails?

Specialist-directed options may be considered.

BASHH's 2025 guidance discusses minocycline for selected drug-resistant infections, while other therapies remain under investigation.

Are new antibiotics being researched?

Yes.

Recent studies have investigated drugs such as:

- lefamulin,
- solithromycin

for difficult resistant infection, but these are not routine first-line treatments.

Do I need a test of cure?

Not every asymptomatic patient treated with a recommended regimen requires one under CDC guidance.

It becomes particularly relevant with:

- alternative regimens,
 - treatment failure,
 - persistent symptoms.
-



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Should my partner be tested?

Yes, partner testing is useful because partner concordance is high.

Positive partners should be appropriately treated.

Does my partner need treatment without symptoms?

Possibly.

Where testing is available, testing and treating positive partners is preferred.

When testing is unavailable, the clinician may consider partner treatment according to guideline and circumstance.

Can M. genitalium come back after treatment?

Yes.

This may result from:

- reinfection,
 - antibiotic resistance,
 - incomplete eradication.
-

Does it create lifelong immunity after cure?

There is no reason to assume permanent immunity.

Future sexual exposure can result in reinfection.

Can a pregnant woman be treated?

Yes, but treatment requires specialist selection because several common nonpregnancy antibiotics are unsuitable.

A 2024 systematic review found international pregnancy guidelines generally preferred azithromycin and advised against moxifloxacin.

Can I take moxifloxacin during pregnancy?

It is generally avoided in pregnancy in current international Mgen guidance.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Does M. genitalium cause preterm birth?

Some observational studies and meta-analyses report an association, although evidence remains less definitive than for its role in urethritis and cervicitis.

Does it mean I cannot have children?

No.

Many infected patients retain normal fertility.

Early diagnosis and treatment are particularly important when upper reproductive-tract disease is suspected.

Can a couple try naturally after treatment?

Yes, when infection has been appropriately managed and there is no separate fertility problem.

Does Mgen automatically require IVF?

No.

Can condoms reduce transmission?

Yes.

Correct condom use reduces exposure to sexually transmitted organisms.

Is there a vaccine?

There is currently no routinely available vaccine.

Can penicillin cure M. genitalium?

No.

The organism has no cell wall, so beta-lactam antibiotics such as penicillins and cephalosporins are ineffective.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Is *M. genitalium* the same as Ureaplasma?

No.

Is it the same as chlamydia?

No.

They are different bacterial sexually transmitted infections.

Can one person have *M. genitalium* and chlamydia together?

Yes.

Coinfection occurs.

A New Delhi study found chlamydia in a substantial proportion of its *M. genitalium*-positive participants.

Does Mgen cause HIV?

No.

They are completely different infections.

Can Unani medicine cure *M. genitalium*?

There is currently insufficient high-quality direct clinical evidence to recommend Unani treatment as a replacement for guideline-directed antimicrobial eradication of confirmed *M. genitalium*.

Can Unani treatment still be useful?

Yes, as individualized supportive care addressing areas such as:

- general health,
- nutrition,
- digestion,
- sexual wellbeing,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- recovery after appropriate infection treatment.

Can an herbal medicine replace antibiotics because antibiotics have resistance?

No.

Antibiotic resistance means we need:

more precise antimicrobial treatment,

not abandonment of microbiological treatment.

Can improvement in discharge prove the infection has gone?

No.

Symptoms can improve even while infection persists.

Where clinically required, microbiological follow-up provides more meaningful information.

Should I use strong herbal medicines inside the vagina?

Not without appropriate medical supervision.

Irritant preparations can cause:

- burns,
- inflammation,
- altered vaginal health.

A Message From Dr. Nizamuddin Qasmi to Men With Recurrent Urethritis

If you have taken treatment several times but burning or discharge returns, do not assume:

“I need a stronger dose of the same antibiotic.”

The right questions are:

Was gonorrhoea excluded?

Was chlamydia tested?

Was M. genitalium tested by NAAT?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Was the partner evaluated?

Could antibiotic resistance be present?

That is how persistent urethritis should be approached.

A Message to Women With Recurrent Cervicitis

If you repeatedly experience:

- post-coital bleeding,
- cervical discharge,
- pelvic discomfort

despite usual treatment, *M. genitalium* may deserve consideration.

But the evaluation should also rule out:

- chlamydia,
- gonorrhoea,
- trichomoniasis,
- cervical lesions.

Do not let repeated antibiotic prescriptions replace proper diagnosis.

A Message to Couples With Infertility

If either partner has *M. genitalium*, treat the infection appropriately.

But do not automatically assume:

“This explains all our infertility.”

Infertility is often multifactorial.

At Saira Health Care I prefer:

couple-based evaluation.

For men:

- semen parameters,
- reproductive examination,
- appropriate hormonal/genetic assessment.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

For women:

- ovulation,
- ovarian reserve,
- uterus,
- tubal factors.

That gives the couple a much more accurate understanding of their reproductive situation.

A Message About Antibiotics

M. genitalium teaches us a powerful lesson:

antibiotics should be used intelligently.

Repeated unselected treatment can convert an infection that was relatively easy to treat into one that becomes increasingly resistant.

Therefore:

testing before repeated treatment is often more valuable than simply changing brands of antibiotics.

A Message About Unani Medicine

As a Unani physician, I believe supportive traditional medicine can contribute to:

- constitutional wellbeing,
- nutrition,
- digestion,
- sexual and reproductive health.

But my responsibility is also to distinguish between:

supportive treatment

and:

eradication of a proven sexually transmitted bacterium.

For *M. genitalium*, current evidence supports:

- molecular diagnosis,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- resistance-aware antimicrobial treatment.

Unani care can be integrated around that foundation where appropriate.

My Clinical Philosophy at Saira Health Care

My approach can be summarized as:

identify the organism → avoid unnecessary antibiotics → assess antimicrobial resistance → treat accurately → manage the partner → protect reproductive health → investigate infertility independently when required → use Unani care responsibly for supportive whole-person management.

This is particularly important in my focused clinical work in:

Sexual Disorders & Infertility.

Successful care should not end when the laboratory test becomes negative.

The patient should also regain:

- comfortable sexual function,
 - reproductive confidence,
 - clarity about fertility.
-

Latest Medical Understanding — 2026 Update

1. *M. genitalium* is now a major recognized cause of persistent urethritis

CDC estimates that it accounts for approximately **40% of persistent or recurrent urethritis.**

2. It is an important cause of cervicitis

Studies reviewed by CDC find it in approximately **10–30% of women with clinical cervicitis.**

3. It is associated with PID

M. genitalium has been detected in approximately **4–22% of women with PID** in reviewed studies.

4. Routine asymptomatic screening is not recommended



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Both CDC and current BASHH guidance emphasize targeted testing rather than population screening because the benefit of detecting every asymptomatic infection is uncertain and unnecessary treatment can contribute to antimicrobial resistance.

5. NAAT is the key diagnostic technology

The organism is too slow and difficult to culture for ordinary clinical practice.

6. Single-dose azithromycin should no longer be used for confirmed Mgen

High macrolide resistance and selection of new resistance make this strategy inappropriate.

7. Resistance-guided sequential treatment is preferred

Where resistance testing is accessible, it permits more rational selection of azithromycin versus moxifloxacin after initial doxycycline and has produced cure rates above 90% in studied settings.

8. Drug resistance is already documented in India

A New Delhi pilot study found macrolide- and quinolone-resistance mutations among *M. genitalium* infections, emphasizing that India is not isolated from the global resistance problem.

9. New antibiotics are being investigated

Recent studies involving lefamulin and ongoing trials of solithromycin illustrate the need for new options for multidrug-resistant infection.

10. Fertility evidence requires balance

Female infertility associations are supported by observational studies and meta-analysis, including research from India. Male infertility associations remain less firmly established.

Conclusion

Mycoplasma genitalium is an increasingly important sexually transmitted bacterial infection that deserves much greater awareness in sexual and reproductive medicine.

It is particularly important because it can cause:

In men

- nongonococcal urethritis,
- persistent or recurrent urethritis.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

In women

- cervicitis,
- post-coital bleeding,
- pelvic inflammatory disease.

Current CDC evidence indicates that *M. genitalium* may account for approximately:

15–20% of nongonococcal urethritis

and as much as:

40% of persistent or recurrent urethritis.

The organism is difficult to diagnose using ordinary laboratory methods because:

culture may take months.

Therefore:

NAAT / molecular testing is the preferred diagnostic approach.

One of the most important changes in modern *M. genitalium* management is recognition of:

antimicrobial resistance.

Macrolide resistance is now widespread, and fluoroquinolone resistance is also increasing.

An Indian pilot study published in 2024 identified resistance-associated mutations among *M. genitalium* isolates in an STI-clinic population in New Delhi, showing that resistance is already a relevant Indian clinical issue.

For this reason:

single-dose azithromycin should not be repeatedly used for confirmed *M. genitalium* infection.

CDC recommends modern sequential treatment, preferably guided by antimicrobial-resistance testing.

The infection is also relevant to fertility.

Research supports associations with:

- female infertility,
- pelvic inflammatory disease,
- possible adverse pregnancy outcomes.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

A North Indian study found *M. genitalium* DNA in 16% of women studied for infertility and none of the fertile controls, although the observational design means causation cannot be assumed.

Male infertility associations are also under investigation, but evidence is less definitive.

Therefore:

a positive *M. genitalium* test should never replace a complete infertility evaluation.

Pregnancy deserves special attention because treatment options are more limited, and medications that may be appropriate outside pregnancy can be unsuitable for pregnant patients. Current international guidance generally uses azithromycin-based treatment in pregnancy and avoids moxifloxacin, but specialist management is necessary because resistance complicates treatment.

From the **Unani perspective**, individualized care may be useful in supporting:

- nutrition,
- digestion,
- constitutional wellbeing,
- sexual health,
- reproductive wellbeing,
- recovery after appropriate infection treatment.

However, *M. genitalium* is a specific microbiologically identifiable bacterial STI.

There is currently insufficient robust clinical evidence that Unani medicine alone can reliably eradicate confirmed *M. genitalium* or replace resistance-aware antimicrobial therapy.

Therefore, at **Saira Health Care**, my approach is:

diagnose accurately, test when clinically indicated rather than screening indiscriminately, avoid unnecessary antibiotics, treat confirmed infection according to modern resistance-aware principles, manage the sexual partner, investigate PID and infertility appropriately, and integrate individualized Unani supportive care without compromising microbiological cure.

My most important message to patients is:

Persistent genital symptoms should not mean repeated antibiotics without a diagnosis.

If urethritis or cervicitis keeps returning:

think about *Mycoplasma genitalium*, test appropriately and treat intelligently.

This protects not only the patient but also:

- the sexual partner,
 - future fertility,
 - the effectiveness of antibiotics for future generations.
-

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health — ISRH, UNFPA

Dr. Nizamuddin Qasmi is a well-qualified physician whose clinical practice at **Saira Health Care** has a focused emphasis on:

- sexual disorders,
- male infertility,
- female infertility,
- reproductive and sexual health.

His approach to *Mycoplasma genitalium* and other reproductive-tract infections emphasizes:

- careful diagnosis before repeated antimicrobial treatment,
- modern understanding of antibiotic resistance,
- partner-based sexual-health care,
- identification of PID and other reproductive complications,
- appropriate male and female infertility evaluation,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- safe integration of Unani supportive care where clinically appropriate.

Depending upon the patient's presentation, assessment may include:

- sexual and reproductive history,
- evaluation of persistent urethritis or cervicitis,
- molecular STI testing,
- review of previous antibiotic exposure,
- evaluation of sexual partners,
- PID assessment,
- semen analysis when fertility is affected,
- female tubal and reproductive evaluation,
- sexual-function counselling.

The objective at Saira Health Care is not merely to prescribe repeated medicines for discharge or burning.

The objective is to identify:

what is causing the problem, whether infection has genuinely been eradicated, whether reproductive health has been affected, and how normal sexual and fertility function can be restored.

Medical Disclaimer

This article is intended for professional health education and general public awareness. It does not provide an individual diagnosis or prescription.

Symptoms such as:

- urethral discharge,
- painful urination,
- abnormal vaginal or cervical discharge,
- post-coital bleeding,
- pelvic pain

can result from several conditions and should not automatically be attributed to *Mycoplasma genitalium*.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Current treatment recommendations for *M. genitalium* are changing because antimicrobial resistance is rapidly evolving. Treatment should therefore be prescribed by an appropriately qualified clinician according to:

- current guidelines,
- local antibiotic-resistance patterns,
- pregnancy status,
- previous treatment,
- individual medical history.

Patients should not repeatedly self-treat genital symptoms with:

- azithromycin,
- doxycycline,
- moxifloxacin,
- other antibiotics

without appropriate evaluation.

Single-dose 1-g azithromycin should not be used as routine treatment for confirmed *M. genitalium* under current CDC guidance because it can fail and select macrolide resistance.

Pregnant or breastfeeding patients require specialist treatment because antibiotic choices are more limited.

Severe pelvic pain, fever, pregnancy-associated abdominal pain or suspected PID requires prompt medical evaluation.

There is currently insufficient high-quality clinical evidence to recommend Unani or herbal medicine as a substitute for microbiologically effective antimicrobial treatment of confirmed *M. genitalium*.

Individualized Unani medicine may be used as supportive integrative care where clinically appropriate but should not delay:

- NAAT testing,
- STI treatment,
- partner management,
- PID management,
- infertility investigation.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Patients experiencing infertility should receive a complete couple-based evaluation rather than assuming a positive or previous *M. genitalium* infection is the sole cause.