DELAYED CLEARANCE OF MYCOPLASMA GENITALIUM FOLLOWING AZITHROMYCIN TREATMENT

Seamus Cook
Ruairi Conway
Dr Nicolas Pinto-Sander
Dr Suneeta Soni
THE PROBLEM

Lack of validated testing

Syndromic management with azithromycin 1g

Macrolide resistance mutations

Quinolone resistance mutations

MR = Macrolide resistance, QR = Quinolone resistance
The Recommended Approach

1. Doxycycline pre-treatment
2. Azithromycin or moxifloxacin

Resistance testing at diagnosis:
- Recommended at 5 weeks after treatment (BASHH)
- False negatives may arise if performed before 3 weeks after treatment (Falk et al, 2015)
- No evidence for the optimum time

Test of cure:
- Patients returning for 2nd line treatment after a significant delay were negative when re-tested.
Does additional time to TOC improve Mgen clearance rates following azithromycin, without the need for further treatment?

Aims:

• Identify patients with a positive TOC after treatment

• Determine the proportion of patients with a negative TOC and hence spontaneous clearance at the time of 2nd line treatment

• Determine the mean time from azithromycin treatment to spontaneous clearance
METHODS

Setting:
• The Claude Nicol Centre, Brighton
• TOC performed routinely at 5 weeks, no resistance testing

Population:
• Patients with a positive TOC after azithromycin treatment
• October 2017 – May 2018

Intervention:
• An extra TOC when the patient returned for moxifloxacin treatment

Analysis and Statistics:
• Retrospective analysis of electronic patient records
• SPSS V.25.0 software
RESULTS:

THE SAMPLE POPULATION

12 patients with a positive TOC gave an extra TOC sample

8/12 (66.6%) male [6 NGU, 2 proctitis]
4/12 (33.4%) female [2 PID, 2 contacts]

6/12 (50%) patients (all male) received doxycycline treatment before azithromycin

All patients were adherent to azithromycin treatment
RESULTS:

THE PATIENT JOURNEY AND OUTCOMES

- 9/12 (75%) were asymptomatic
- 4/12 (33.3%) patients tested negative (3 males, 1 female)
- 2/12 (33.3%) had a reinfection risk

Azithromycin 47.2 days TOC 26.8 days Extra TOC

68.5 days (9.8 weeks)
CONCLUSIONS

- Patients can experience delayed clearance of infection
- Some patients are receiving 2nd line treatment inappropriately
LIMITATIONS

• SINGLE CENTRE
• SMALL COHORT
• RETROSPECTIVE
What is the optimum time for TOC?

Is prolonged time to TOC practical?

Benefit vs risk?
FUTURE RESEARCH

Analyse the impact of an extra TOC on the number of patients receiving 2\textsuperscript{nd} line treatment

Longitudinal study to find the optimum time to TOC
ACKNOWLEDGEMENTS

The Claude Nicol Centre

BASHH
THANK YOU FOR LISTENING QUESTIONS?


