completion of a 7-day regimen and symptoms have resolved or for 7 days after single-dose therapy). Men with NGU should be tested for HIV and syphilis.

Follow-Up

Men should be provided their testing results obtained as part of the NGU evaluation. Those with a specific diagnosis of chlamydia, gonorrhea, or trichomoniasis should be offered partner services and instructed to return 3 months after treatment for repeat testing because of high rates of reinfection, regardless of whether their sex partners were treated (*136*,*137*,*753*,*754*) (see Chlamydial Infections; Gonococcal Infections; Trichomoniasis).

If symptoms persist or recur after therapy completion, men should be instructed to return for reevaluation and should be tested for *M. genitalium* and *T. vaginalis*. Symptoms alone, without documentation of signs or laboratory evidence of urethral inflammation, are insufficient basis for retreatment. Providers should be alert to the possible diagnosis of chronic prostatitis or chronic pelvic pain syndrome in men experiencing persistent perineal, penile, or pelvic pain or discomfort; voiding symptoms; pain during or after ejaculation; or new-onset premature ejaculation lasting for >3 months. Men with persistent pain should be referred to a urologist with expertise in pelvic pain disorders.

Management of Sex Partners

All sex partners of men with NGU within the preceding 60 days should be referred for evaluation and testing and presumptive treatment with a drug regimen effective against chlamydia. All partners should be evaluated and treated according to the management section for their respective pathogen; EPT could be an alternate approach if a partner is unable to access timely care. To avoid reinfection, sex partners should abstain from sexual intercourse until they and their partners are treated.

Persistent or Recurrent Nongonococcal Urethritis

The objective diagnosis of persistent or recurrent NGU should be made before considering additional antimicrobial therapy. Symptomatic recurrent or persistent urethritis might be caused by treatment failure or reinfection after successful treatment. Among men who have persistent symptoms after treatment without objective signs of urethral inflammation, the value of extending the duration of antimicrobials has not been demonstrated. Treatment failure for chlamydial urethritis has been estimated at 6%–12% (*755*). The most common cause of persistent or recurrent NGU is *M. genitalium*, especially after doxycycline therapy (*756*,*757*). Treatment failure for *M. genitalium* is harder to determine because certain men achieve clinical cure (i.e., resolution of symptoms) but can still have detectable *M. genitalium* in urethral specimens (*758*).

The initial step in recurrent urethritis is assessing compliance with treatment or potential reexposure to an untreated sex partner (*697*,*743*). If the patient did not comply with the treatment regimen or was reexposed to an untreated partner, retreatment with the initial regimen can be considered. If therapy was appropriately completed and no reexposure occurred, therapy is dependent on the initial treatment regimen. Ideally, diagnostic testing among men with recurrent or persistent symptoms, including those with gonorrhea, chlamydia, *M. genitalium*, and trichomoniasis, can be used to guide further management decisions.

T. vaginalis is also known to cause urethritis among men who have sex with women. In areas where *T. vaginalis* is prevalent, men who have sex with women with persistent or recurrent urethritis should be tested for *T. vaginalis* and presumptively treated with metronidazole 2 g orally in a single dose or tinidazole 2 g orally in a single dose; their partners should be referred for evaluation and treatment, if needed.

If *T. vaginalis* is unlikely (MSM with NGU or negative *T. vaginalis* NAAT), men with recurrent NGU should be tested for *M. genitalium* by using an FDA-cleared NAAT. Treatment for *M. genitalium* includes a two-stage approach, ideally using resistance-guided therapy. If *M. genitalium* resistance testing is available it should be performed, and the results should be used to guide therapy (see *Mycoplasma genitalium*). If *M. genitalium* resistance testing is not available, doxycycline 100 mg orally 2 times/day for 7 days followed by moxifloxacin 400 mg orally once daily for 7 days should be used. The rationale for this approach is that although not curative, doxycycline decreases the *M. genitalium* bacterial load, thereby increasing likelihood of moxifloxacin success (*759*). Higher doses of azithromycin have not been effective for *M. genitalium* after azithromycin treatment failures. Men with persistent or recurrent NGU after treatment for *M. genitalium* or *T. vaginalis* should be referred to an infectious disease or urology specialist.

Special Considerations

HIV Infection

NGU might facilitate HIV transmission (*760*). Persons with NGU and HIV infection should receive the same treatment regimen as those who do not have HIV.

Cervicitis

Two major diagnostic signs characterize cervicitis: 1) a purulent or mucopurulent endocervical exudate visible in the endocervical canal or on an endocervical swab specimen (commonly referred to as mucopurulent cervicitis), and