

performed simultaneously among neonates with gonococcal infection (see Chlamydial Infection Among Neonates). Follow-up examination is not required.

Management of Mothers and Their Sex Partners

Mothers who have gonorrhea and their sex partners should be evaluated, tested, and presumptively treated for gonorrhea (see Gonococcal Infection Among Adolescents and Adults).

Gonococcal Infection Among Infants and Children

Sexual abuse is the most frequent cause of gonococcal infection among infants and children (see Sexual Assault or Abuse of Children). For preadolescent girls, vaginitis is the most common manifestation of this infection; gonococcal-associated PID after vaginal infection can be less common among preadolescents than adults. Among sexually abused children, anorectal and pharyngeal infections with *N. gonorrhoeae* are frequently asymptomatic.

Diagnostic Considerations

Culture can be used to test urogenital and extragenital sites for girls and boys. NAAT can be used to test for *N. gonorrhoeae* from vaginal and urine specimens from girls and urine for boys (see Sexual Assault or Abuse of Children). Although data regarding NAAT from extragenital sites (rectum and pharynx) among children are more limited, and performance is test dependent, no evidence supports that performance of NAAT for detection of *N. gonorrhoeae* among children differs from that among adults (553). Because of the implications of a *N. gonorrhoeae* diagnosis in a child, only validated FDA-cleared NAAT assays should be used with extragenital specimens. Consultation with an expert is necessary before using NAAT to minimize the possibility of cross-reaction with nongonococcal *Neisseria* species and other commensals (e.g., *N. meningitidis*, *Neisseria sicca*, *Neisseria lactamica*, *Neisseria cinerea*, or *M. catarrhalis*) and to ensure correct interpretation of results.

Gram stains are inadequate for evaluating prepubertal children for gonorrhea and should not be used to diagnose or exclude gonorrhea. If evidence of DGI exists, gonorrhea culture and antimicrobial susceptibility testing should be obtained from relevant clinical sites (see Disseminated Gonococcal Infection).

Recommended Regimen for Uncomplicated Gonococcal Vulvovaginitis, Cervicitis, Urethritis, Pharyngitis, or Proctitis Among Infants and Children Weighing ≤45 kg

Ceftriaxone 25–50 mg/kg body weight IV or IM in a single dose, not to exceed 250 mg IM

Recommended Regimen for Uncomplicated Gonococcal Vulvovaginitis, Cervicitis, Urethritis, Pharyngitis, or Proctitis Among Children Weighing >45 kg

Treat with the regimen recommended for adults (see Gonococcal Infections)

Recommended Regimen for Bacteremia or Arthritis Among Children Weighing ≤45 kg

Ceftriaxone 50 mg/kg body weight (maximum dose: 2 g) IM or IV in a single dose daily every 24 hours for 7 days

Recommended Regimen for Bacteremia or Arthritis Among Children Weighing >45 kg

Ceftriaxone 1 g IM or IV in a single dose daily every 24 hours for 7 days

Other Management Considerations

Follow-up cultures are unnecessary. Only parenteral cephalosporins (i.e., ceftriaxone) are recommended for use among children. All children identified as having gonococcal infections should be tested for *C. trachomatis*, syphilis, and HIV (see Sexual Assault or Abuse of Children).

Mycoplasma genitalium

M. genitalium causes symptomatic and asymptomatic urethritis among men and is the etiology of approximately 15%–20% of NGU, 20%–25% of nonchlamydial NGU, and 40% of persistent or recurrent urethritis (697,909,910). Infection with *C. trachomatis* is common in selected geographic areas (911–913), although *M. genitalium* is often the sole pathogen. Data are insufficient to implicate *M. genitalium* infection with chronic complications among men (e.g., epididymitis, prostatitis, or infertility). The consequences of asymptomatic infection with *M. genitalium* among men are unknown.

Among women, *M. genitalium* has been associated with cervicitis, PID, preterm delivery, spontaneous abortion, and infertility, with an approximately twofold increase in the risk for these outcomes among women infected with *M. genitalium* (766). *M. genitalium* infections among women are also frequently asymptomatic, and the consequences associated with asymptomatic *M. genitalium* infection are unknown.

M. genitalium can be detected among 10%–30% of women with clinical cervicitis (767,770,772,914–916). The existing evidence between *M. genitalium* and cervicitis is mostly supportive of a causal association. Elevated proinflammatory cytokines have been demonstrated among women with *M. genitalium*, with return to baseline levels after clearance of the pathogen (917).