

and did not investigate for these potential sources of contamination. In the absence of identification of any reservoir and despite the new measures adopted, new cases might still occur.

In conclusion, these missing data are needed for other hospitals to identify epidemiogenic *Achromobacter* isolates. Complete information would help in implementing control measures to contain and prevent outbreaks.

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Macrolide-Resistant *Mycoplasma genitalium* in Southeastern Region of the Netherlands, 2014–2017

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DOI: <https://doi.org/10.3201/eid2511.190912>

To the Editor: We read with interest the article by Martens et al., which analyzed the frequency of macrolide resistance–mediating mutations in *Mycoplasma genitalium* infections in the southeastern region of the Netherlands during 2014–2017 (1). The authors reported high rates of macrolide resistance in *M. genitalium* infections (281/827; 34.0%) and observed a decrease in the rate in 2017 (115/290; 39.7%) compared with 2016 (92/207; 44.4%), after an increase in the number of tests of cure performed.

Increasing rates of macrolide resistance in *M. genitalium* are a problem not only in the Netherlands but also worldwide: 77.4% in New Zealand (2) and 41% in the United Kingdom (3). Macrolide resistance in *M. genitalium* as a consequence of single-dose azithromycin treatment has been previously reported (4). European Academy of Dermatology and Venereology guidelines recommend azithromycin in an extended regimen (500 mg day 1, 250 mg days 2–5, orally) as a first-line treatment, followed by a test of cure 4–6 weeks after treatment (5).

In northern Spain, local protocols for the treatment of *M. genitalium* infections are based on the European guideline. We performed a prospective/retrospective study during August 2015–October 2018. We confirmed 173 cases of *M. genitalium* infection; mean patient age was 29.4 years, and 57.2% (99/173) were male. We found macrolide-resistant *M. genitalium* strains in 21.8% (27/124) patients, which is a lower rate than was found in the Netherlands. Most of the patients attending post-treatment follow-up showed wild-type *M. genitalium*, and only 10.9% (5/46) became resistant to azithromycin treatment, in contrast with 89.6% (60/67) reported by Martens et al. We suggest that the decrease in macrolide resistance resulted from the increased number of posttreatment follow-ups. Our data confirm this. We believe that giving local advice on the basis of extended azithromycin treatment and posttreatment follow-up can limit the spread of macrolide resistance.

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