LETTERS

CONDOM USE AND MALE HOMOSEXUAL PORNOGRAPHY

The recent article by Grudzen et al.[1] is an important look at the workplace safety of pornography performers in the United States. We are concerned, however, that its portrayal of condom use in pornography viewed by men who have sex with men (MSM) may be inaccurate and thus may divert attention from an issue with important public health implications. The authors report that 80% of penile–anal contacts in male homosexual pornography were protected by condoms; we believe that the frequency of protected sex in male homosexual pornography may be much lower, especially if one considers all forms of video pornography viewed by MSM.

Grudzen et al. analyzed only pornography available on DVD. A substantial proportion of pornography, however, is produced for Internet distribution only. 42% of Internet users in a recent survey reported viewing pornography online during the prior 12 months, an unknown portion of which was distributed only online.[2] Grudzen et al. surveyed a limited catalog of DVD offerings, which may have underrepresented "bareback" pornography (pornography depicting intentional condomless sex), a practice not uncommon among MSM.[3,4]

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Gonaives, Haiti. *"No Mercy: Hurricane Season '08."* Medical Technician Aucy Saint-Aude conducts preliminary tests on a young woman at a school-turned-clinic for Doctors Without Borders. Photograph by Patrick Farrell. Copyright 2008 by The Miami Herald. Printed with permission.

Internal penile–anal ejaculations also were excluded because the presence of a condom at ejaculation could not be verified with certainty. The researchers also defined "protected" as use of a condom for any duration. Each of these factors might have contributed to an overestimation of protected sexual encounters in male homosexual pornography.

We recently completed an Internet survey of 821 MSM at a high risk of HIV transmission or acquisition. A full report is in preparation, but 77.2% of respondents reported viewing "bareback" pornography in the last 90 days.

In sum, the portrayal of unprotected sex in pornography targeted at MSM may be more common than indicated by Grudzen et al. A comprehensive analysis is warranted, because the viewing of unprotected sex by MSM may lead to a community-wide impression that unprotected sexual practices are the norm. This perception may cause an increase in the frequency of unprotected sexual practices and thus increase the risk of acquisition and transmission of HIV, HIV superinfection, and other sexually transmitted infections. ■

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This letter was accepted April 27, 2009.
doi:10.2105/AJPH.2009.169912

Contributors

Richard Silvera and Dylan Stein drafted and edited this letter. Robert Hagerty and Michael Marmor edited this letter. Richard Silvera, Dylan Stein, and Michael Marmor conceived of and executed the original research mentioned in this letter. Michael Marmor finalized this letter.

Acknowledgments

This work was supported in part by grant P01 AI057127 and a grant from the Center for AIDS Research (P30 AI

27742) from the National Institute on Allergy and Infectious Diseases, National Institutes of Health.

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GRUDZEN ET AL. RESPOND

We would like to thank Silvera et. al. for their thoughtful response to our research article. We agree that there appears to be a recent rise in the production of "bareback" pornography, and we are similarly concerned by the reemergence of intentional unsafe sexual practices by men who have sex with men (MSM) both in adult films and in the community. We would also like to emphasize the important difference between an individual who chooses to engage in unsafe sexual practices and unsafe workplace practices imposed on an employee by an employer.

Our aim was to compare the safety practices for workers in a legal industry after the California Occupational Safety and Health Administration (CalOSHA) issued a model Exposure Control Plan and Industry Illness and Prevention Plan for the adult film industry after an HIV outbreak in 2004.[1] We were chiefly concerned with workers' rights and safety, and our study was not designed to determine the preferences of viewers, or effects on their behavior, though we believe these are important and understudied topics. We concluded that both industries are out of compliance with CalOSHA requirements but that the homosexual adult film industry is in comparatively better compliance.

Though it has not been rigorously studied, key informant interviews suggest that "bareback" pornography has increased in the last few years, making our findings of 80% condom use in homosexual films more likely out of date than because of our choice of sampling frame. Nonetheless, this is further proof that neither industry is complying with CalOSHA regulations. We also agree that adult film is increasingly being sold as video on demand rather than as a DVD. However, we know from in-depth interviews with adult film performers that, at least at the time of our study, adult content was typically recycled from DVD to the Internet.[2]

The most important message from our manuscript and Silvera et al.'s letter is that serious risk of occupational exposure to HIV and sexually transmitted infections is ongoing in both the heterosexual and homosexual adult film industry and that both segments of the industry are out of compliance with worker safety requirements. This is not only negligent, but illegal. ■

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This letter was accepted May 9, 2009.
doi:10.2105/AJPH.2009.170159

Contributors

C.R. Grudzen drafted the letter. All authors reviewed the letter for critical content and contributed to revision.

Acknowledgments

This study was funded by the Robert Wood Johnson Clinical Scholars Program.

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LIVING ARRANGEMENT AND COLORECTAL CANCER SCREENING: UPDATED USPSTF GUIDELINES

In a recent article,[1] we examined the relationship between living arrangement and preventive care use among community-dwelling persons aged 65 years and older in the United States by analyzing the 2002–2005 Medical Expenditure Panel Survey. Of the 6 preventive services examined, we defined adherence to recommended colorectal cancer screening (either fecal occult blood test within the past year or sigmoidoscopy within the past 5 years) according to the then current 2002 United States Preventive Service Task Force (USPSTF) guidelines.

In October 2008, the USPSTF revised its recommendations to advise against colorectal cancer screening in persons older than 85 years and suggested that persons aged between 76 and 85 years should consider their own health status, prior screening results, and life expectancy in their decisions to be screened.[2,3] We therefore performed additional analysis on colorectal cancer screening similar to that described in the original article but now restricted to persons aged between 65 and 75 years.

After we controlled for age, gender, race, education, income, health insurance, comorbidities, self-reported health, physical function status, and residence location, we found that elderly persons who lived with a spouse only had similar odds (odds ratio [OR] = 1.027; $P = .747$) of getting colorectal cancer screening as did those living alone, whereas elderly persons who lived with an adult offspring regardless of the presence of a spouse had significantly lower odds (adult offspring only, OR = 0.629; $P = .007$; adult offspring and a spouse, OR = 0.621; $P = .007$).

These findings did not change the conclusions of the original paper and also provide evidence that elderly persons' living arrangement is a significant factor associated with their timely use of colorectal cancer screening

according to the latest USPSTF guidelines. Interventions to improve colorectal cancer screening may need to target elderly persons in all living arrangements but especially those living with adult offspring. ■

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This letter was accepted May 23, 2009.
doi:10.2105/AJPH.2009.172916

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Denys T. Lau interpreted the data and wrote the letter. James B. Kirby analyzed and interpreted the data and approved the letter.

Acknowledgments

No sources of funding were used for the original work upon which this letter is based. During part of the original work and the writing of this letter, D. T. Lau was supported by a K-01 career development award from the National Institute on Aging (5K01AG027295 02).

Human Participant Protection

Institutional review board approval was obtained from Northwestern University for the original work upon which this letter is based.

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ERRATUM

In: Repace JL. Secondhand smoke in Pennsylvania casinos: a study of nonsmokers' exposure, dose, and risk. *Am J Public Health.* 2009;99:1478–1485. doi:10.2105/AJPH.2008.146241.

Data was incorrectly reported. On page 1479, the first sentence in the first paragraph under the "Atmospheric and Biomarker Measurements" heading in column 1 should read: A SidePak AM510 aerosol monitor (calibration factor=0.39; TSI Inc, St Paul, MN) measured real-time area RSP concentrations in 10-second intervals (i.e., $PM_{2.5}$ particulate matter less than 2.5 microns [μm] in diameter that can easily be inhaled into the lungs and is copiously emitted by cigarettes, pipes, and cigars).[21,22]

On page 1479, the second sentence of the bottom paragraph under the "Active Smoker Model" heading in column 3 should read: The units of SHS RSP are micrograms per cubic meter of air; the numerical constant incorporates the surface adsorption rate (adding 30% to the ventilation rate), the smoking rate, and the emission rate of RSP from SHS and has units of micrograms per hour per burning cigarette.

On page 1483, the last sentence in the top paragraph of the third column should read: By the workplace standards of the US Occupational Safety and Health Administration (OSHA), which employs a 45-year average time period, casino workers' risk from SHS-induced lung cancer and heart disease combined is 26 times the level indicating significant risk of material impairment of health, which includes both mortality and irreversible illness.[30]

The volume of a casino was incorrectly reported. On page 1481, the row Harrah's[d] in Table 1 should read:

TABLE 1—Physical Parameters of Study Casinos and Real-Time Air Quality Measurements: Pennsylvania, 2007

Casino	Area, ft^2	Ceiling Height, ft	Volume, m^3	No. People Present, Mean (SD)[a]	Average No. People per 1000 ft^2	No. Burning Cigarettes, mean (SD)[a]	PPAH Level, ng/m^3 (SD)	Outdoor PPAH Level, mean $\mu g/m^3$ (SD)	Indoor RSP Level, mean $\mu g/m^3$ (SD)	Outdoor RSP Level, mean $\mu g/m^3$ (SD)	Estimated Smoker Prevalence, %	Burning Cigarettes per $100m^3$	Estimated Air Exchange Rate (C_v), h^{-1}	Ratio of Total RSP to Background RSP	Ratio of Total PPAH to Background PPAH
Harrah's[d]	160 000	28.83	130 620	2875	18	169 (35)	29 (29)	5 (10)	102 (34)	28 (12)	17.6	0.13	1.14	3.6	5.8

Note. PPAH = particulate polycyclic aromatic hydrocarbons; RSP = respirable suspended particles.
[a]Smoking areas of all casinos measured with S1 SidePak (TSI Inc, St Paul, MN); nonsmoking area of Mohegan Sun measured with Stanford SidePak.
[d]Harrah's is located in Chester. Observations were made on August 31 from 8 to 9:30 PM. The maximum occupancy was 2750 people.

doi:10.2105/AJPH.2008.146241e