patients, providers, and our elected leaders can make wise decisions. ■

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This letter was accepted January 24, 2011.
doi:10.2105/AJPH.2011.300087

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ROTHMAN RESPONDS

I am pleased that our article has sparked discussion of the need for health advocacy organization (HAO) disclosure of corporate funding. Senators Chuck Grassley (R-IA) and Max Baucus (D-MT) have commented to journalists covering our article that they are considering amending the Physician Payments Sunshine Act to include all company payments to HAOs.

We agree with Harris and Garza that Eli Lilly (Lilly) has been a leader in promoting transparency.[1] However, they do not dispute our findings that 87% of Lilly's US sales in 2007 were for products in 3 areas of therapeutic interest and that 94% of its grants went to HAOs advocating in these same areas.[2] This finding suggests that the separation of marketing from grants is porous.

Visco claims that the National Breast Cancer Coalition (NBCC) disclosed Lilly's second quarter grant of $50 000 in its 2007 annual report.[3] We searched the NBCC Web site on December 4, 2008, and found no such disclosure; the 2007 annual report was not yet online.[4] Thus, neither those who attended the NBCC's Annual Advocacy Training Conference (April 28–30, 2007) nor the members of US Congress with whom the attendees met the next day to promote NBCC's advocacy priorities could know that Lilly had sponsored the training. We urge the NBCC to follow Lilly's example and disclose in a timely fashion the name, purpose, and amount of corporate funding it receives.

Rather than continue the disagreement with the National Health Council (NHC) on the dating of its various "Guiding Principles"—the document we downloaded in 2008 and analyzed is on our Web site—let us focus on the issues of disclosure that our findings raise.[4] The NHC now declares itself in favor of disclosure. However, looking back, the results are far from compelling. Of the 6 current NHC members who received Lilly money in the first 2 quarters of 2007 (our study period), 2 did not acknowledge Lilly,[4] and 1 named Lilly as a participant in a gala but gave no information on the sum Lilly donated. Of the remaining 3, 2 listed Lilly as a corporate sponsor but gave no sums, and 1 identified Lilly in its $50 000 donor category but provided no other information. This is not, we believe, a forceful record of disclosure.

Current NHC standards for disclosure fall below the information Lilly and other companies provide. The present NHC guidelines direct HAOs to disclose gifts over $5000 or 2% of all contributions reported on their tax return (Form 990). We believe that $5000 is too high a figure and the ranges for reporting too broad ($0–$50 000, $50 000-$100 000, etc.).[4]

We have not yet investigated whether current members of the NHC are complying with its standards and disclosing their funding. ■

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This letter was accepted February 3, 2011.
doi:10.2105/AJPH.2011.300088

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CHLAMYDIA SCREENING: WHAT ABOUT THE MEN?

The recent article by Braun and Provost[1] addresses increasing access to health care to improve chlamydia screening. Chlamydia rates are currently estimated at 4.2% among young adults in the general US population, and current recommendations require annual screening for all sexually active females aged 25 years or younger.[2] The *Healthy People 2010* goals regarding chlamydia are: "To reduce the proportion of adolescents and young adults with *Chlamydia trachomatis* infections to 3% by 2010," and "Increase the proportion of sexually active females aged 24 years and under who are screened annually for genital Chlamydia infections."[3] In their article, Braun and Provost explored the effects of broadening access to health care on chlamydia screening rates.

The article successfully draws attention to the issue of access to care for young women, but it also raises an interesting question about current chlamydia screening guidelines among young men. During the study, patient-delivered partner therapy was offered to patients at the discretion of each participating Title X agency. Patient-delivered partner therapy is practiced for the purpose of preventing reinfection. Although this study did not address reinfection, recent research has concluded that patient-delivered partner therapy made no difference in reinfection rates.[4] This information, coupled with the Centers for Disease Control and Prevention's report that chlamydia rates from 2008 to 2009 increased by 5% among males aged 15 to 19 years and 6% among males aged

20 to 24 years, begs the question, should guidelines include routine chlamydia screening among males younger than 25 years?

Currently, limited chlamydia screening guidelines for males underestimate its prevalence among young men and the roles young men have in its transmission. We recognize that the long-term sequelae of untreated chlamydia in females is a major concern; however, great consideration should be taken to equalizing the screening criteria to decrease transmission rates. Notwithstanding the larger concerns of increasing access to health care to male adolescents and young adults related to sexual health,[5–7] broadening screening guidelines would be a more comprehensive approach.

Braun and Provost's article is an excellent starting point for further discussions on policy that can improve access to sexual health care for both male and female adolescent patients. Further research is needed to investigate health care utilization of adolescent males in school-based health clinics. Most important, future research is needed on chlamydia screening programs directed toward adolescent and young adult males in hopes of generalizing screening guidelines and policies. ■

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This letter was accepted December 2, 2010.
doi:10.2105/AJPH.2010.300101

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All of the authors assisted in the research, writing, and editing of this letter.

Acknowledgments

The authors would like to acknowledge the faculty and staff of the Faculty Development Program at Morehouse School of Medicine.

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BRAUN AND PROVOST RESPOND

We agree with Powers et al. that chlamydia screening in males may have a positive impact on transmission and adverse health outcomes in females. The most recent Centers for Disease Control and Prevention Sexually Transmitted Diseases (STDs) Treatment Guidelines support screening sexually active young men in clinical settings with a high prevalence of chlamydia, including adolescent clinics, correctional facilities, and STD clinics.[1] The primary barriers to screening males include identifying high prevalence populations and cost.[2] In population-based surveys, the prevalence of infection among males is consistently low (2%–4% depending on age group)[3]; however, in selected settings such as correctional facilities, the prevalence is higher (7%–8%).[4,5] Unlike in females, the prevalence at which chlamydia screening in males becomes cost-effective has not been established, although evidence suggests that combining male screening with partner notification would be more cost-effective than screening alone.[6]

The Educational Partnerships to Increase Chlamydia Screening (EPICS) program did not include males for several reasons. The federal Infertility Prevention Program funded the project, and because these funds are limited and current levels of chlamydia screening in young women are inadequate, it was necessary and appropriate to prioritize support for screening females. An increase in federal funding for chlamydia screening in males may remedy some of these cost challenges. Further, previous studies of chlamydia infection in high school settings in California found a low prevalence of chlamydia in males.[7] The EPICS program was funded to support and increase cost-effective screening measures and therefore is limited to screening among high prevalence populations, such as young women.

Screening young women for chlamydia is supported by national recommendations and has proved cost-effective. Limited funding forces us to prioritize, and as promising as male screening is from a theoretical standpoint, young women continue to bear the burden of disease with high levels of infection and direct reproductive health complications. However, significant gaps remain in screening coverage. Although we support more widespread screening in males, policy and funding decisions must be balanced with evidence of effectiveness in cost and health outcomes to move this issue forward.

To clarify, randomized clinic trials evaluating the effectiveness of patient-delivered partner therapy (PDPT) have demonstrated reduced chlamydial and gonococcal reinfections in women.[8,9] Although the reduced reinfection rate did not reach statistical significance in each trial, a quantitative meta-analysis of 5 clinical trials showed an overall 27% reduced risk of recurrent infection in patients who received PDPT compared with those who received standard partner treatment methods.[10] California state guidelines for PDPT emphasize that clinicians should always attempt to bring partners in for clinical evaluation; however, for partners who are unable or unlikely to seek prompt clinical services, PDPT is an appropriate and effective method of treatment.[11] ■

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