Since then, I have discovered a very helpful paper on the subject, which discusses the psychodynamics of the situation with particular emphasis on prevention.[2]

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Accepted for publication 29 May 2003

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A population based dynamic approach for estimating the cost effectiveness of screening for *Chlamydia trachomatis*

We read the recent paper in *STI* on cost effectiveness for *Chlamydia trachomatis* screening by Honey *et al* with great interest.[1] We concur with their conclusion that more data derived from clinical trials are needed for policy making, particularly when considering the evidence on the subsequent risk of pelvic inflammatory disease (PID) in women who test positive for *Chlamydia trachomatis*.

Our paper[2] was included and discussed in this review. As our approach was rather complex, we note that some parts of our design and results may have been misinterpreted. Honey *et al* note that our study was focused on screening both men and women in general practice with an age range for evaluation of 15–64 years. Although this information is correct, it does not reflect that screening for women only was considered separately and that women older than 34 years were not included in the screening programme. This misinterpretation by Honey *et al* formed the basis for exclusion of our study from further systematic review.[1]

Our approach differs from others' in that we investigate cost effectiveness by employing a population based dynamic model (Monte Carlo simulation).[2 3] This approach enables us to simulate the *C trachomatis* transmission, the impact of prevention measures on the *C trachomatis* incidence and prevalence, and the risk for *C trachomatis* infection in a population. As a result, indirect effects (for example, future partners of current partners) over a period of several years can be considered using rates of partner change, mixing patterns, and transmission probabilities. We chose to analyse the screening programme over a period of 10 years. In our baseline analysis we assessed screening of men and women aged 15–24 years. However, in the scenario analysis we evaluated several other screening strategies, including screening of women aged 15–24, 15–29, and 15–34 years.

Despite the restriction of *C trachomatis* screening to the age groups labelled as ''young'' women, an evaluation of the transmission dynamics of *C trachomatis* in the population as described by our dynamic model requires the inclusion of men and older women in the model. For example, it may well be that *C trachomatis* is transmitted from a young woman to a man, from this man to an older woman, etc. Such transmission chains may occur over a period of years and may involve men and women of all ages. So, to adequately evaluate screening of women aged 15–24, a model is required that considers all sexually active age groups. Therefore, sexual activity was modelled for both men and women aged up to 64 years, using assumptions based on a Dutch Sex Survey.

Application of our model to the Netherlands showed that screening women aged 15–24, 15–29, and 15–34 years over a period of 10 years would result in net cost savings to society. When including (excluding) indirect costs, cost savings were reached after 2.8 (3.8) years, 3.1 (4.3) years and 3.3 (5.0) years, respectively. This evaluation considered the costs of screening (polymerase chain reaction testing, azithromycin treatment, GP fee) and partner referral as well as direct (medical) savings as a result of averted health care and indirect savings as a result of averted productivity loss.

We think that our dynamic approach leads to more realistic assessments of cost effectiveness in this area as it appropriately considers the highly infectious character of *C trachomatis*. At this time, our approach is being used to evaluate the cost effectiveness of *C trachomatis* screening programmes in two other European countries.

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Accepted for publication 13 February 2003

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Contamination of environmental surfaces by genital human papillomaviruses (HPV): a follow up study

In a previous study we investigated the contamination of environmental surfaces with human papillomavirus (HPV) DNA in two genitourinary medicine (GUM) clinics.[1] This study was intended to review the GUM clinic in which HPV DNA was found to be present. Cleaning with ''general purpose neutral liquid detergent'' (detergent) (Youngs Detergents, Lancare Ltd, UK) and water, or 2% Clearsol (disinfecting detergent, 40% VV Tar Acids; Coventry Chemicals Ltd, Coventry, UK) in 70% methylated spirits (Clearsol) was performed following the results of the previous study.

Twenty samples were collected from two treatment rooms and patients' toilets at each time of sampling. Samples were tested and typed as described previously.[1] Surfaces sampled, and accumulation of HPV DNA during a single day, are listed in table 1.

Table 1 Method of cleaning used and HPV DNA detection

	Sample 1, 16.30	Sample 2, 8.30	Sample 3, 16.30
	Detergent	Clearsol and methylated spirits	
Female treatment room			
Treatment/examination bed	11, 16	None	None
Light switch	6, 16	None	None
Examination lamp	None	None	None
Male treatment room			
Treatment/ examination bed	None	None	None
Light switch	16	None	6, 18
Examination lamp	None	None	None
Female toilet			
Light switch	None	None	None
Toilet flush handle	None	None	None
Toilet seat	None	None	None
Door handle	None	None	None
Cold tap	None	None	None
Hot tap	16	None	None
Male toilet			
Door handle	16	None	None
Hot tap	None	None	None
Cold tap	None	None	None
Light switch	None	None	None
Toilet seat	11, 16	None	None
Cryoguns			
1	6, 16, 58	Pos (6)	Pos (6, 11, 16, 18)
2	6	None	Pos (11)
3	16	None	Pos (6)