Table 1. Analysis of correlation between CPSI total scores and number of positive UPOINT domains stratified by varying placement of sexual dysfunction

		NIH-CPSI Total Score			
Cohort	Statistical Analysis	UPOINT, No SD	UPOINT, SD in "P" Domain	UPOINT, SD in "O" Domain	UPOINTS
German	Spearman's rho (*P* value)	0.8 (.104)	0.9 (.037)	0.9 (.037)	1 (<.0001)
	Kendall's τ (*P* value)	0.6 (.14)	0.8 (.05)	0.8 (.05)	1 (.01)
	Pearson's correlation coefficient (*P* value)	0.73 (.078)	0.82 (.04)	0.84 (.036)	0.96 (.004)
	P value, ANOVA	.15	.087	.072	.008
Italian	Spearman's rho (*P* value)	1 (<.0001)	1 (<.0001)	1 (<.0001)	1 (.0001)
	Kendall's τ (*P* value)	1 (.014)	1 (.014)	0.1 (<.0001)	1 (.005)
	Pearson's correlation coefficient (*P* value)	0.99 (.0003)	0.99 (.0003)	0.99 (.0003)	0.98 (.0001)
	P value, ANOVA	.0006	.0007	.0006	.0002
Merged	Spearman's rho (*P* value)	1 (<.0001)	1 (<.0001)	1 (<.0001)	1 (.001)
	Kendall's τ (*P* value)	1 (.014)	1 (.014)	1 (.014)	1 (.005)
	Pearson's correlation coefficient (*P* value)	0.98 (.001)	0.98 (.0009)	0.99 (.0001)	0.98 (.0001)
	P value, ANOVA	.002	.002	.0003	.0002
	Cronbach's α	0.48	0.47	0.47	0.47

CPSI, Chronic Prostatitis Symptom Index; NIH, National Institutes of Health; UPOINT, urinary, psychosocial, organ specific, infection, neurologic/systemic, tenderness of skeletal muscles; ANOVA, analysis of variance.

Nonparametric and parametric correlation coefficients, ANOVA, and reliability coefficients (Cronbach's α) presented.

2. Is a subjective yes/no answer to the question "do you have erection problems?" sufficient to exhaustively describe the SD profile of a patient? A validated questionnaire was used in our study to assess erectile dysfunction and also orgasmic dysfunction and changes in libido.
3. The authors demonstrated by univariate regression analysis that an SD domain does not significantly alter the CPSI total score in their patient population. However, not even the prostate-specific "O" domain of UPOINT could significantly alter the scores of the prostate-specific CPSI test. Is this population sufficiently representative of a condition such as CP/CPPS?

In conclusion, we stand for the inclusion of the SD phenotype in UPOINT or in any other CP/CPPS phenotyping system. If a "stand-alone" sexual domain is not acceptable to Samplaski et al,[1] we propose that a SD item should be included within 1 of the 6 UPOINT domains. We have simulated in our patient cohorts the inclusion of an erectile dysfunction item in the "O" or "P" UPOINT domains. Also, in this case the correlation between the total score of the CPSI and the number of UPOINT domains was significantly improved in the German tertiary-referral patients presenting with severe SD (Table 1) and, again, the data shown by the Italian population, presenting with milder symptoms, were not affected by this modification.

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Reply by the Authors

TO THE EDITOR:

Thank you for the opportunity to respond to the letter from Dr. Magri and colleagues. We believe a careful read of our article, particularly the Methods and Discussion,

will actually address the concerns raised. First, the authors say that we "question some of the conclusions of a study performed by our research group on a cohort of European patients." We did not question the veracity of their findings and acknowledged that there were differences in methodology and patient characteristics that could account for a different outcome in our North American patient cohort. We addressed in our paper the rationale for focusing only on erectile dysfunction, and the complete answer to the authors' question 2 can be found at length in the final paragraph of our discussion.

The statistical questions Magri et al raised concerning our finding are not related to our conclusion. Although the correlation between UPOINT and CPSI is relatively mild in our population (their question 1), the relationship between the two is significant and it was assessed using a multivariate analysis approach. The insignificance of the addition of S to UPOINT was based on a multivariable analysis rather than a univariate one as stated in their question 3. Our multivariable model was set up to answer the question: "Given UPOINT in the model, does S make any significant contribution?" As we reported, the answer is no with a *P* value of .53. We did see a significant relationship between S and age and therefore we took other variables, such as age and duration of the condition, into account in our multivariable analysis. A univariate correlation may not capture the true relationship, and differences among populations need to be accounted for as well.

We believe that UPOINT is an important first step to better classify and guide therapy of patients with chronic prostatitis/chronic pelvic pain syndrome and realize that changes will be made of necessity as more is learned about the condition and new treatment modalities become available. We welcome and encourage others to explore its utility in their own patient populations and make adjustments where necessary to optimize patient care and outcomes.

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