tion of renal cell carcinoma (RCC) with tumor thrombus. They also reported their experience of patch grafting (n = 11) and IVC interposition (n = 6) of the IVC during RCC tumor thrombus surgery.[1]

We have used liver transplant techniques to gain adequate exposure of the upper abdomen when dealing with urological tumors with caval involvement.[2-4] We have previously published the use of natural venovenous bypass (VVP) in patients with advanced tumor thrombus.[5] The natural bypass involved the preservation and use of collateral veins created by the longstanding obstruction of the IVC. In most of our cases, IVC clamping above and below the tumor thrombus did not result in systemic hypotension and a VVP was not necessary.

Moreover, we have learned from experience that patients with chronic obstruction of the IVC have less hemodynamic instability compared with acute obstructions.[6] With chronic obstruction of the IVC, collaterals develop with time and compensate the venous return mainly through the azygos and hemiazygos system. It is important to not interrupt the competitive collaterals that have developed with time, particularly on the contralateral side of the great vessels. In general, with chronic IVC occlusion, complications such as venous congestion and lymphatic extravasation are manageable. In the last decade we selectively reconstructed the IVC with vascular graft in few patients because of long segmental resections. However, we have safely performed surgical interruption of the IVC in several selected patients without significant postoperative morbidity. IVC graft interposition and reconstruction are time-consuming and technically demanding procedures that are not without complications. Our experience indicates that patch grafting or IVC interposition can be safely avoided for the majority of the advanced tumor thrombus cases, thereby simplifying the operation and reducing morbidity.

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Re: Samplaski et al.: Inclusion of Erectile Domain to UPOINT Phenotype Does Not Improve Correlation With Symptom Severity in Men With Chronic Prostatitis/Chronic Pelvic Pain Syndrome (Urology 2011;78:653-658)

TO THE EDITOR:

Samplaski et al[1] have recently reported the results of a retrospective study including 100 patients affected by chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS). From their findings, the authors questioned some of the conclusions of a study performed by our research group of a cohort of European patients,[2] aimed at testing the novel urinary, psychosocial, organ specific, infection, neurologic/systemic, tenderness of skeletal muscles (UPOINT) phenotyping system for CP/CPPS.[3]

Because it is widely acknowledged that sexual dysfunction (SD) is an important component of the clinical phenotype of CP/CPPS,[4] we investigated the addition of a specific SD domain to the UPOINT system. Our study population included 937 Italian patients from a secondary referral center, with mild/moderate SD, and 290 men from a German tertiary center, who were characterized by a more severe SD profile. We found that addition of an "S" domain to the UPOINT system significantly improved the correlation between the total score of the National Institutes of Health-Chronic Prostatitis Symptom Index (CPSI) and the stepwise-increasing number of UPOINTS domains in German patients. In the Italian and merged cohorts, the same correlation remained highly significant, with or without the "S" domain.

Thus, the addition of a sexual dysfunction domain allowed us to improve the correlation observed in our "German" patients *without disrupting* the correlation observed in the "Italian" patients, who presented with milder sexual symptoms (this is perhaps the specific case of the patients studied by Samplaski et al[1]). We believe this represented an overall improvement of the UPOINT system and an extension of its consistency for more diverse categories of patients.

The results shown by Samplaski et al[1] raise the following questions:

1. Is 0.27 an acceptable coefficient to establish a correlation between UPOINT domains and CPSI scores?

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,