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institutions.

the community or even in lower volume, less specialized
care referral centers, for example, may not be applicable in
scopic nephroureterectomy (LNU) at high-volume tertiary-

ideal in the general population. The findings of an RCT
the applicability of the findings from RCTs may not be

UTUC within a short or intermediate time frame. Moreover,
free relative efficacy of available treatment options for
ized trials will provide information regarding most bias-
therefore, it is doubtful that multi-institutional, random-
Unfortunately, RCTs are virtually nonexistent for UTUC;

factors and the impact of various therapeutic modalities:
databases may be used to better elucidate the effect of risk
series[1–4], and population-based registries[5].

The outcomes of upper urinary tract urothelial carcinoma
(UTUC) are relatively poorly explored. Three types of
databases may be used to better elucidate the effect of risk
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countries, no equivalent is yet available in Europe,
Asia, or Africa. Efforts should be made to develop
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on other continents. Moreover, efforts should be made
to increase the amount of information available for
each individual patient within the existing population-
based databases.

In summary, as highlighted by Liatsikos and Kallidonis
[10], Capitanio et al’s study [2] suffers from several
limitations for which the authors cannot control. Unfortu-
nately, there are no alternatives for completely circumvent-
marked selection biases that undermine the validity and
the generalizability of all databases. Consequently, it is

To circumvent this limitation, several investigators,
including the Upper Tract Urothelial Carcinoma Collabora-
tion, relied on multi-institutional databases [1–4]. The
current study by Capitanio et al [2], which specifically
dressed the efficacy of ONU versus LNU, represents an
example of a large-scale database. Despite an excellent
confidence level regarding the lack of the presence of
outcome differences, such databases are limited by
selection criteria. Patients who are treated at tertiary-
care centers that maintain clinical records and that
participate in multi-institutional studies may be different
from those treated in the community or even at less
prestigious referral centers. Moreover, the investigation,
treatment, and follow-up at such tertiary-care centers
may differ from other institutions. Consequently, results
derived from tertiary-care centers need to be validated
in the community to ensure generalizability in that
setting.

Population-based data sets, such as the Surveillance,
Epidemiology, and End Results (SEER) registry, may

circumvent the tertiary-care selection biases [6–9]. The
amount of detail that may derived from such databases,
however, cannot parallel that of either RCTs or well-
designed institutional databases. Therefore, limited spe-
cificity is the price of generalizability in population-based
databases. Moreover, population-based registries are rare.
The SEER database allows the study of urologic tumors in
the United States; however, except for the Scandinavian
countries, no equivalent is yet available in Europe,
Asia, or Africa. Efforts should be made to develop
population-based tumor registries in other countries and
on other continents. Moreover, efforts should be made
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In summary, as highlighted by Liatsikos and Kallidonis
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Reprint from Authors re: Evangelos Liatsikos, Panagiotis
Kallidonis. Laparoscopic or Open Nephroureterectomy?

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The outcomes of upper urinary tract urothelial carcinoma
(UTUC) are relatively poorly explored. Three types of
databases may be used to better elucidate the effect of risk
and the impact of various therapeutic modalities: randomized controlled trials (RCTs), multi-institutional case
series [1–4], and population-based registries [5].

RCTs are ideal for assessing therapeutic alternatives.
Unfortunately, RCTs are virtually nonexistent for UTUC;
therefore, it is doubtful that multi-institutional, random-
ized trials will provide information regarding most bias-
free relative efficacy of available treatment options for
UTUC within a short or intermediate time frame. Moreover,
the applicability of the findings from RCTs may not be
ideal in the general population. The findings of an RCT
comparing open nephroureterectomy (ONU) and laparo-
scopic nephroureterectomy (LNU) at high-volume tertiary-
care referral centers, for example, may not be applicable in
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important to critically appraise the available data before directly implementing it in clinical practice.

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