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Editorial Commentary

This large retrospective study of 9,632 patients with recurrent urethral strictures highlights the negative impact of delaying urethroplasty after failure of initial endoscopic treatment. The authors should be commended for undertaking such a study and for reaffirming the current recommendation in the AUA guideline on male urethral stricture (reference 10 in article). The findings are especially meaningful given the large cohort of patients from the VA, which is the largest integrated health care system in the U.S. The findings are aligned with the literature in that urethral strictures that have previously been treated with dilation or direct visual internal urethrotomy are unlikely to be successfully treated with another endoscopic procedure, with failure rates higher than 80%.[1,2] In addition, repeated endoscopic treatments may cause longer strictures and may increase the complexity of subsequent urethroplasty (reference 8 in article). This possibility is the basis for the recommendation in the AUA guideline, which states, "Surgeons should offer urethroplasty, instead of repeated endoscopic management for recurrent anterior urethral strictures following failed dilation or direct visual internal urethrotomy."

As the growing body of clinical evidence demonstrates, strictures respond best to initial endoscopic management when they are single, short, mild in caliber and superficial, ie confined to the urothelial layer without deep spongiofibrosis. It is critical to refer all other strictures and cases that fail initial endoscopic management to reconstructive urologists to ensure the highest quality of care. With more fellowship trained urologists in reconstructive urology the availability and access to urethroplasty will increase accordingly. Repeated endoscopic procedures or intermittent self-catheterization should be reserved as palliative measures for only a subset of patients who are unable to undergo or who decline urethroplasty.

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