



ORIGINAL ARTICLE

Predictors of urethral stricture recurrence after endoscopic urethrotomy[☆]



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KEYWORDS

Urethral stricture;
Endoscopic urethrotomy;
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Abstract

Objective: The aim of the study was to analyze the clinical-demographic variables of the series and the predictors of urethral stricture recurrence after endoscopic urethrotomy.

Material and methods: We retrospectively analyzed 67 patients who underwent Sachse endoscopic urethrotomy between June 2006 and September 2014. Those patients who had previously undergone endoscopic urethrotomy or urethroplasty were excluded. The other patients who presented urethral stricture were included.

We analyzed age, weight, smoking habit, and cardiovascular risk factors, as well as the number, location, length and etiology of the strictures, previous urethrotomies, vesical catheter duration and postsurgical dilatations.

A univariate and multivariate analysis was conducted using the chi-squared test or Fisher's test and logistic regression to identify the variables related to recurrence.

Results: Thirty-seven percent of the patients had a relapse. The majority of the patients were older than 60 years (56.7%), obese (74.6%), nonsmokers (88%) and had no cardiovascular factors (56.7%). The majority of the strictures were single (94%), <1 cm (82%), bulbar urethral (64.2%), iatrogenic (67.2%) and with no prior urethrotomy (89.6%). The majority of the patients carried a vesical catheter for <15 days (85.1%) and did not undergo postsurgical dilatation (65.7%).

Only the length of the stricture was an independent risk factor for recurrence ($p = .025$; relative risk, 5.7; 95% CI 1.21–26.41).

Conclusions: In the treatment of urethral strictures through endoscopic urethrotomy, a stricture length >1 cm is the only factor that predicts an increase in the risk of recurrence. We found no clinical or demographic factors that caused an increase in the incidence of recurrence. Similarly, technical factors such as increasing the bladder catheterization time and urethral dilatations did not change the course of the disease. Their routine use is therefore unnecessary.

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PALABRAS CLAVE

Estenosis uretral;
Uretrotomía
endoscópica;
Recidiva

Factores predictivos de recidiva de estenosis uretral tras uretrotomía endoscópica**Resumen**

Objetivo: El objetivo del trabajo fue analizar las variables clínico-demográficas de la serie y los factores predictores de recidiva de estenosis uretral tras uretrotomía endoscópica.

Material y métodos: Se analizó retrospectivamente a 67 pacientes tratados mediante uretrotomía endoscópica tipo Sachse entre junio de 2006 y septiembre de 2014. Se excluyó a los intervenidos previamente de uretrotomía endoscópica o uretroplastia y se incluyó al resto de los pacientes que presentaban estenosis uretral.

Se analizó edad, peso, hábito tabáquico, factores de riesgo cardiovascular, número, localización, longitud y etiología de la estenosis, uretrotomía previa, tiempo de sonda vesical y dilataciones posquirúrgicas.

Se realizó un análisis univariado y multivariado mediante el test de chi-cuadrado o de Fisher y regresión logística para identificar las variables relacionadas con la recidiva.

Resultados: El 37% recidivaron. La mayoría eran > 60 años (56,7%), obesos (74,6%), no fumadores (88%) y sin factores cardiovasculares (56,7%). La mayoría de las estenosis fueron únicas (94%), < 1 cm (82%), de uretra bulbar (64,2%), iatrogénicas (67,2%) y sin uretrotomía previa (89,6%). La mayoría llevaron sonda vesical durante < 15 días (85,1%) y no realizaron dilataciones posquirúrgicas (65,7%).

Solamente la longitud de la estenosis resultó factor de riesgo independiente de recidiva ($p = 0,025$) con un riesgo relativo de 5,7 para un IC 95% (1,21-26,41).

Conclusiones: En el tratamiento de la estenosis uretral mediante uretrotomía endoscópica, la longitud de la estenosis > 1 cm es el único factor que predice un incremento del riesgo de recidiva. No se encontró factores clínicos ni demográficos que condicionaran un incremento en la incidencia de recidiva. Del mismo modo, factores técnicos como incrementar el tiempo de sondaje vesical o las dilataciones uretrales no alteran el curso de la enfermedad, por lo que su uso rutinario es innecesario.

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Introduction

It is estimated that the incidence of urethral stricture is 0.6% and affects more than 5000 medical consultations per year.¹

According to the review conducted by Cochrane in 2012, nowadays there is insufficient evidence about the ideal treatment for urethral stricture disease. There are four main possible treatments: periodic dilations, endoscopic urethrotomy, indwelling ureteral stents or urethroplasty.²

Dilation was the standard treatment until the appearance of internal urethrotomy 200 years ago. From the beginning of the nineteenth century, they began to use urethrotomes that were introduced blindly and they used to open stenoses with small knives. The best known urethrotomes were the Otis urethrotome and Maisonneuve. In 1973, Sachse introduced the endoscopic urethrotomy via cold-knife incision and direct vision. Consequently, previous periodic urethrotomes were banished and it limited periodic dilations to recurrent isolated cases or as complementary use after endoscopic treatment.^{3,4}

Endoscopic urethrotomy is a simple and reproducible procedure with minimal morbidity. This led to an overuse of this technique in spite of the recurrence risk of approximately 40%⁴ according to the literature.

According to the study published by Wright et al.,⁵ urethroplasty should be indicated as first choice treatment when the expected success rate with endoscopic urethrotomy is less than 35%; or after 2 endoscopic urethrotomy

failures. For this reason, there have been several studies looking for factors that predict the risk of recurrence after internal urethrotomy.⁶⁻¹⁷

This study aims to analyze the clinical and demographic variables in a series of patients and to identify predictive factors of recurrence.

Material and methods

Patients treated with Sachse internal urethrotomy were retrospectively analyzed in our center between June 2006 and September 2014. The review was conducted between September and December 2015. The mean follow-up was 3 years with a minimum follow-up of one year. Patients who previously underwent internal urethrotomy or urethroplasty were excluded and the rest of the patients who had urethral stricture were included.

The diagnosis of urethral stricture was performed using an initial urethroscopy (trial available immediately in the query that allows us to rule out cases of prostatic hypertrophy or bladder neck incision). This was followed by a full VCUG in case stenosis was confirmed in patients with clinical voiding or flowmetry compatible with urethral stricture (Q max < 15 ml/s). The indication for surgery was in symptomatic patients or with stenosis with functional impact.

Most endoscopic urethrotomies were performed under major ambulatory surgery, except in patients of type III of the American Society of Anesthesiologists (ASA III). Anesthesia

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