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## EDITORIAL COMMENT



This paper is notable due to the authors' documentation that both trends and statistically significant alterations in the techniques of urethroplasty have occurred over a relatively short 7-year time span. Perhaps what is most remarkable is these alterations have been made in the absence of clinical data to support their adoption. Indeed, the driving force appears to be the individual surgeon's concept that the newer techniques are indeed better, in essence, a lack of equipoise. As practitioners of the clinical art and science of surgery, we must recognize that the development and adaptation of novel surgical techniques without appropriate clinical trials are not without risk. Witness how the rapid adoption of gastrocystoplasty and complete primary exstrophy closure swept through the pediatric urologic community, the complications of these innovative procedures only becoming evident with either long-term follow-up or adoption of these techniques by a multitude of individuals. Surgeons who attempt to modify and improve surgical methods should always be applauded and honored for their ingenuity. Let us remember, however, that universal adoption of a surgical technique should ideally occur when the procedure has documented scientific merit by a broad-based surgical cohort, or at a minimum, may be adopted by an individual surgeon after they have comparatively reviewed their outcome-based data.

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## AUTHOR REPLY



To our knowledge, there are only 3 published RCTs comparing open surgical techniques for urethral stricture disease.<sup>1-3</sup> None of the 3 studies reported an a priori power analysis and thus, none were adequately powered to detect surgical success differences; all had heterogeneous stricture types, lengths, and locations; all included multiple surgeons, of which individual contributions were never made clear. Still, all 3 sets of authors ultimately declared surgical superiority of 1 of the studied techniques over another based primarily subjective study outcomes and their own surgical preferences. Should we learn nothing from these RCTs then?

Surgical RCTs are notoriously difficult to perform because surgeries, unlike drugs, are heterogeneous and difficult to standardize. No 2 surgeons perform any surgery the exact same way. This variability can affect the interpretation of the study outcomes (eg, "I know what the study results showed, but that's not how I do the surgery"), and can severely inhibit study recruitment (eg, "I just

don't think flaps work"). The OPEN trial, which randomizes patients to urethrotomy vs urethroplasty, has had recruitment issues that were studied in a nested qualitative study, identifying unique issues with urethral stricture disease randomization (eg, benign disease process, length of catheter time, ease of procedure, patient biases).<sup>4,5</sup> A RCT that was attempted by the TURNS group, randomizing ventral to dorsal grafts for bulbar strictures, was closed due to poor recruitment. Anecdotally, recruitment for that study at our center was hampered by the simple patient question of "what surgery do you think is best?" (Sadly, I could not put aside my individual biases (ie, my lack of individual equipoise) toward dorsal onlay procedures for the collective equipoise necessary for recruitment).

The reviewer has correctly noted that most of the technique changes noted within the group have been made without the evidence of RCTs. Indeed, this criticism can be made for everything we do in reconstruction. Does that mean we don't know what we're doing? Hardly. The collective wisdom of the group is what is driving rapid change in the field. We are now facing surgical challenges that were once faced in isolation, but can now be crowd sourced via Twitter and YouTube. This explosion of information will help us to quickly develop best surgical practices – a necessary step before any urethroplasty RCTs that lead to meaningful results can be performed.

But we may still be putting the cart before the horse. How can any surgical RCT be performed without an accepted definition of surgical success? Without an accepted nomenclature and staging system for the disease process in question? Without an agreed upon means of postsurgical surveillance? These gaps in urethroplasty knowledge must be filled before Level 1 evidence can be pursued. In the meantime, we believe that the changes in surgical practices identified in this study should be acknowledged as collective intelligence, not simply group-think or crowd wisdom. In other words, it would seem that despite the methodology limitations found in this study, something significant and meaningful can still be learned here.

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