37%, with mean time to recurrence of 4.5 months." This means 37% is not a success rate, it is the rate of repeat (unsuccess). This rate is given in the results section of the same article as "The median duration between optical urethrotomy and recurrence was 4.5 months and recurrence rate was 34%." I am of the opinion that this information should be corrected in this valuable article of Kluth et al.

Sincerely

References

1. Kluth LA, Ernst L, Vetterlein MW, et al. Direct vision internal urethrotomy for short anterior urethral strictures and beyond: success rates, predictors of treatment failure, and recurrence management. *Urology*. 2017;106:210–215.
2. Zehri AA, Ather MH, Afshan Q. Predictors of recurrence of urethral stricture disease following optical urethrotomy. *Int J Surg*. 2009;7:361–364.

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https://doi.org/10.1016/j.urology.2018.09.036
UROLOGY 124: 312–313, 2019.

Reply: Letter-to-the-editor: Direct Vision Internal Urethrotomy for Short Anterior Urethral Strictures and Beyond: Success Rates, Predictors of Treatment Failure and Recurrence Management (Urology2018;XXX:XX-XX)

Dear Editor,

we would like to thank the author of the letter to the editor for her or his correct notion that the recurrence rate of 37% as reported publication by Zehri et al[1] was falsely referenced as success rate in our article,[2] and we would like to apologize for this erratum. However, the respective paragraph simply aims to roughly put the findings from our study into perspective of the available literature. Importantly, we did not draw any conclusions related to the erroneously assumed low success rate of 37%, and thus, we do believe that misleading or confusion due to this erratum is somehow negligible. Again, we apologize for this corrigendum.

References

1. Zehri AA, Ather MH, Afshan Q. Predictors of recurrence of urethral stricture disease following optical urethrotomy. *Int J Surg*. 2009;7:361–364.
2. Kluth LA, Ernst L, Vetterlein MW, et al. Direct vision internal urethrotomy for short anterior urethral strictures and beyond: success rates, predictors of treatment failure, and recurrence management. *Urology*. 2017;106:210–215.

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https://doi.org/10.1016/j.urology.2018.11.016
UROLOGY 124: 313, 2019.

Re: Huang et al.: The Application of Suctioning Flexible Ureteroscopy With Intelligent Pressure Control in Treating Upper Urinary Tract Calculi on Patients With a Solitary Kidney (Urology 2018;111:44-47)

TO THE EDITOR:

We read this article with great interest and would like to congratulate the authors for the innovation of a new ureteral access sheath (UAS)—11.5/15Fr with a pressure-sensing tip and irrigation and suctioning platform for use in RIRS. The authors have shown a 92.5% success rate with low operative time and low complication rate with this new device in the management of upper urinary tract calculi in a solitary kidney.

In performing RIRS, the tip of UAS is kept in upper ureter rather than pelvis to allow for deflection of the flexible ureteroscope. Thus, if the novel access sheath is placed in the upper ureter, it is unclear how pelvic pressures can be measured by the pressure-sensing channel. Furthermore, if the tip of the suctioning channel is in the upper ureter instead of pelvis, then it would be ineffective in reducing the pelvic pressure, as negative pressure in that location would cause the ureter to collapse rather than effectively removing fluid from the pelvis.

One of the benefits mentioned by the authors is reduced operative time. We would like to know how the operative time was defined (lasing time or entire procedure time). We are curious to know how many times the alarm was activated during the procedure due to raised pelvic pressures following blockage by gravel. How much time was taken to troubleshoot this problem and whether