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

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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. was falsely referenced as success rate in our article, and we would like to apologize for this error. However, the respective paragraph 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 error is somehow negligible. Again, we apologize for this corrigendum.

References

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 the 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. How much time was taken to troubleshoot this problem and whether
this time was included in the operative time? The mean operating time is mentioned as a meager 25.2 ± 14.5 minutes for a large mean stone burden of 2.37 ± 0.43 cm. Hospitalization length of 4.7 ± 1.4 days seems to be excessive for an uncomplicated RIRS, which is usually a day care procedure in most centers.1

Two patients (5%) experienced fever postoperatively in the authors’ series which is similar to incidence of fever (5.5%) shown by Skolarikos et al using a conventional UAS for stones >1 cm, questioning the utility of this novel UAS in prevention of fever and sepsis by maintenance of low ureteral pressure.1

Access sheaths have certain advantages; however, they may be associated with up to 46.5% of ureteric injury, as reported by Traxer and Thomas,2 when the access sheath used was 12/14Fr. Increasing the size of the access sheath would intuitively increase the incidence of ureteric injury. We also believe from our personal experience that Asian ureters have a smaller caliber than their counterparts in Europe, and using this size of access sheath could lead to a higher incidence of failure of sheath passage and ureteric injury in this population.

References

Vara Prasad Pilli, M.S.,
Malav Anand Modi, M.S.,
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