

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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## 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<sup>1</sup> was falsely referenced as success rate in our article,<sup>2</sup> 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.

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## 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

this time was included in the operative time? The mean operating time is mentioned as a meager  $25.2 \pm 14.5$  minutes for a large mean stone burden of  $2.37 \pm 0.43$  cm. Hospitalization length of  $4.7 \pm 1.4$  days seems to be excessive for an uncomplicated RIRS, which is usually a day care procedure in most centers.<sup>1</sup>

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.<sup>1</sup>

Access sheaths have certain advantages; however, they may be associated with up to 46.5% of ureteric injury, as reported by Traxer and Thomas,<sup>2</sup> 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.

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2. Traxer O, Thomas A. Prospective evaluation and classification of ureteral wall injuries resulting from insertion of a ureteral access sheath during retro grade intrarenal surgery. *J Urol*. 2013;189:580–584. <https://doi.org/10.1016/j.juro.2012.08.197>.

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TO THE EDITOR:

The position of the end of the ureteral sheath during surgery should be determined based on the location of the stone and the range of flexible motion of the ureteroscope at the time of lithotripsy. In lithotripsy for ureteral calculus, the sheath should be as close as possible to be beneath the ureteral calculus; in lithotripsy for kidney stones, the front end of the sheath should be as close as possible to the outlet of the renal pelvis but should not limit the moving activity of the bendable part of the flexible ureteroscope. Our previous animal experiments have demonstrated that the intracavity pressure is set to a low negative pressure value. The flexible ureteroscope enters the ureter and renal collecting system under continuous perfusion. The mucosa is not completely collapsed, and it does not restrict the flow of liquid and the transmission of hydraulic pressure. The pressure measured by the sheath and the actual pressure of the renal pelvis have a certain fluctuation range, but the difference was not statistically significant.<sup>1,2</sup>

The operative time refers to the time from the start of the laser lithotripsy to the end of stone removal. The number of occurrence of intraoperative platform alarms is related to the size of the scabbard gap, the accumulation of stone particles, and the oscillating distance between the scabbard and the sheath. Lithotripsy was performed alternately with stone suctioning. We intentionally perform front and back movement, and rotate the lens body to reduce the occurrence of gravel obstruction inside the sheath. The time that we spent in these kinds of movement was counted toward operative time. As for the average length of hospital stay, the majority of the stay was due to the long waiting time to complete preoperative