

preferences. Though there were only 6 surgeons performing the procedures, we could not account for individual surgeon's tendencies in whether or not to operate on a urethral diverticulum.

Female UD has limited data regarding its diagnosis, treatment, pathology, and clinical outcomes. Clinicians must be aware that UD can present with a broad range of symptoms beyond the classic triad of dysuria, dribbling, and dyspareunia. Preoperative workup should include a history and physical exam and may include imaging. In our cohort, MRI was the most commonly used imaging modality. Though most frequently benign, clinicians must be aware of the possibility of a urethral malignancy.

Studying female UD is made difficult by the relatively limited prevalence of the disease. However, despite the challenges, further research is needed to more fully understand the condition. Currently, most published series are data from single institutions. A regional or national database, or at least a multi-institution study, of women with female UD could help further delineate the natural history and the efficacy of surgery. Additionally, studies controlling for surgeon preference could help define the role the surgeon's characteristics has in opting for surgery. These are a few examples of the types of research still necessary to further understand the optimal management of female UD.

Acknowledgment. The authors thank Stephanie Morgan for her help in querying and managing the database.

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EDITORIAL COMMENT



We commend the attempts of the authors of “Female urethral diverticula: diagnosis, pathology, and surgical outcomes at an academic, urban medical center” for providing insight into their experience managing female urethral diverticula. The uncommon nature and unpredictable presentation of this condition indeed pose challenges to its formal, accurate study.

This study reiterates a lack of sensitivity or specificity of symptoms at presentation in predicting diagnosis—like many that have come before them.^{1–3} Stating that no patient presented with textbook symptoms reaffirms that the trinity of dysuria, dribbling, and dyspareunia is more a relic of dogma than a reflection of clinical evidence. Moreover, we are reminded that the symptomatic patient is the one most likely to proceed with surgical intervention. In addition, the ethnic variability of the population, while not reflective of U.S. demographics, does corroborate findings that African Americans are more likely to be affected¹ and undergo surgical treatment⁴ for urethral diverticula.

In fact, with regards to the pathology results presented, a 2.8% rate of adenocarcinoma is similar to the 6% quoted by Thomas et al⁵ in a larger study population (n=90) with a similar demographic makeup (34% African American).

Unfortunately, this study fails to appropriately define and meet its primary objective. Its title reads “diagnosis, pathology, and surgical outcomes”. The abstract objective states “to describe the outcomes”, and the introduction throws in a “focus on factors influencing patient selection for [surgery].” Unfortunately, there is no information on what led to surgical management (or not). Many patients did not undergo surgery because they did not return, and while the median follow up was 7.5 months, it is unclear how many patients actually had adequate follow-up.

The authors rightfully concede that the study's retrospective nature leaves something to be desired. There is no consistency with follow-up information, and there are no standard, validated outcome measures. The only outcomes data provided are descriptive rates of complications, stress urinary incontinence, and recurrence that even the authors mention, given the study's limitations, should be taken with a grain of salt.

Thus, this study only echoes back what we already know about female urethral diverticula without building on top of it and ultimately adds little new information to the literature.

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<https://doi.org/10.1016/j.urology.2018.12.053>
UROLOGY 128: 45–46, 2019. © 2019 Elsevier Inc.

AUTHOR REPLY



We agree that our findings confirm the lack of sensitivity and specificity of clinical symptoms associated with the diagnosis of female urethral diverticula. Our study supports the notion that no set of symptoms is truly pathognomonic for female urethral diverticula.

Additionally, our findings, though not unique, bolster the current literature as it pertains to the relationship between symptoms associated with urethral diverticula and the decision to proceed with surgical management.

Finally, the purpose of investigating and publishing our experience with female urethral diverticula was to share what we have learned by caring for patients at our institution, which largely serves a diverse and under-represented patient population. We recognize and have clearly acknowledged in the manuscript the limitations of our retrospective, observational study design. Furthermore, we hope this work encourages future research on the appropriate management of asymptomatic female urethral diverticula which remains an unsettled clinical scenario.

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<https://doi.org/10.1016/j.urology.2018.12.054>
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