

Author reply Re: Mannem SR, Mallikarjuna C, Bhavatej E, Taif NB, Ravichander O, Syed MG. Incidence of urethral stricture following bipolar transurethral resection of prostate: A single-center study. *Indian J Urol* 2022;38:146-50

We appreciate the comments and observations made by the readers regarding our article.^[1] Our study was conducted in a prospective manner from August 2018 to January 2020. We received the approval to conduct the study from our institutional ethical and scientific committee. The primary objective was to determine the incidence of the urethral stricture following bipolar transurethral resection of the prostate (TURP) and also the possible factors responsible for it after excluding many confounding factors.

The incidence of urethral stricture in our study was found to be 4.3%.^[1] We have used TURis bipolar system (Olympus ESG-400 HF). The readers rightly pointed out the missing point about the power settings used in this system. We have used 200 Watts for cutting and 120 Watts for coagulation as power setting in all the patients in our study. It was mentioned that leakage of current is directly proportional to the power settings used,^[2] but we could not determine such a relationship as we have used the same power settings in all the patients.

The other causes of urethral strictures are inappropriately sized resectoscopes.^[2] We have used 24-Fr or 26-Fr resectoscopes based on meatal size and prostate volume. We have highlighted that both the factors should be considered while choosing resectoscopes as inappropriately sized scopes result in submeatal stenosis which may be avoidable.

No previous studies have shown a correlation between meatal caliber and stricture incidence. We found a significant correlation between urethral stricture rate and small meatal caliber ($P=0.001$). The mean meatal caliber in patients with stricture was smaller (26 ± 2 Fr) than in those without (28 ± 2 Fr) a stricture. Patients with a narrow meatal caliber had a higher incidence of stricture when standard resectoscopes of either 24 Fr or 26 Fr were used. The readers have raised a valid question that how can meatal caliber account for stricture at a site other than submeatal location? For this, we have done subanalysis of the study but could not find any other factor resulting in stricture at other sites. For this, we probably need a longer follow-up.

The literature shows bulbomembranous urethra as the most common location of urethral stricture. In our study, at the end of the 6-month follow-up, five had submeatal stenosis, four had penile urethral stricture, and six had a bulbar urethral stricture.^[1] We have found almost similar stricture rates at submeatal, penile urethra, and bulbar urethral locations. This in contrary to the literature because we have carefully selected and excluded many confounding factors responsible for stricture in our study.

Kuo *et al.*^[3] suggest dilating the anterior urethra up to 30Fr before insertion of a resectoscope to reduce the impact of scope manipulation over the urethral mucosa. In India, instruments are either imported from the West or produced according to Western male standards. Stretching the small

caliber meatus to fit the larger resectoscope would eventually result in irregular tear in mucosa and results in stricture later, so instead of giving a long-term complication of stricture to the patient, it would be better to use and manufacture smaller resectoscope for the Indian patients.

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