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 read the article[1] with interest and would like to congratulate the authors.Urethral stricture after TURP was often overlooked in earlier times. But due to the increasing numbers of Bipolar-TURP being performed, this complication cannot be ignored anymore. As stated in the article, the incidence of urethral stricture following Bipolar-TURP is up to 6.3%,[1] but the exact etiology is still unknown.

The authors have used TURIS bipolar system (Olympus ESG-400 HF) in their study. This system uses the outer sheath as returning electrode. It has been postulated that returning current through the outer sheath of the resectoscope is the culprit. The high electrical density at the outer sheath causes electrical and thermal damage to the urethral mucosa.[2] Based on this fact, the duration of surgery should be a significant risk factor. However, it was surprising that no significant correlation could be established in this study. Since leakage of current is directly proportional to the power settings used, it was surprising that the authors do not mention the power settings used and whether the same settings were used in all the cases?

The other important cause of urethral stricture is an inappropriately sized resectoscope.[2] The authors in the present study have used 24Fr or 26Fr resectoscopes based on meatal size and prostate volume (<40 cm^3 vs. >40 cm^3). However, would it not be scientifically logical to decide on the size of the resectoscope used based only on the caliber of the urethra and not on the prostate size?

The authors suggested meatal caliber to be a risk factor for urethral stricture independent of the size of the resectoscope used. They reported almost similar stricture rates at submeatal, penile urethra, and bulbar urethral locations. How would meatal caliber account for stricture other than submeatal location? While published literature shows bulbomembranous urethra as the most common location of urethral stricture, how do the authors explain contrary finding of this 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 Asian countries, including India, the meatal caliber smaller than 26Fr is unavoidable. In India, instruments are either imported from the West or produced according to Western male standards. So, the question arises of whether to dilate the meatus or compromise the vision with the smaller resectoscopes?

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