RECONSTRUCTIVE UROLOGY

Management of Adult Anterior Urethral Stricture Disease: Nationwide Survey Among Urologists in The Netherlands

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Background: Adult anterior urethral stricture disease is most often treated with dilatation or direct vision internal urethrotomy (DVIU). Although evidence suggests that anastomotic urethroplasty for short bulbar strictures is more efficient and cost effective in the long term, no consensus exists. It is unclear by whom and how often urethroplasties are performed in The Netherlands and how results are being evaluated.
Objective: To determine national practice patterns on management of anterior urethral strictures among Dutch urologists. This information will help to define the nationwide need for training in urethral surgery.
Design, Setting, and Participants: We conducted a 16-question survey among all 323 Dutch urologists.
Results and Limitations: The response rate was 74%. DVIU was practised by 97% of urologists. Urethroplasty was performed at least once yearly by 23%, with 6% performing more than five urethroplasties annually. In the group of urologists younger than 50 yr of age, 13% performed urethroplasty, with 3% of those performing more than five annually. In the case of a 3.5-cm-long bulbar stricture, DVIU was preferred by 49% of responders. Even after two recurrences, 20% continued to manage a 1-cm-long bulbar stricture endoscopically. Of responders, 79% believed that urethroplasty should be proposed only after a failed endoscopic

attempt. Diagnostic workup and evaluation of success varied greatly.
Conclusions: Most Dutch urologists believe that urethroplasty is an option only after failed DVIU. Endoscopic procedures are widely used, even when the risk of recurrence is virtually 100%. The definition of success is hampered by nonstandardised methods of follow-up. Only a small group of mainly older urologists frequently performs urethroplasties. Training programmes seem necessary to guarantee a high standard of care for stricture disease in The Netherlands. A pan-European practice survey might be interesting to clarify the need for centralised fellowship programmes.

Editorial Comment

The authors describe the results of a survey distributed to Dutch urologists about their management of urethral stricture disease. Interestingly, these results are highly similar to a survey done of urologists in the United States a couple of years ago (1). Indeed, in both countries, the common perception is that internal urethrotomy or dilation is appropriate management of strictures that, based on currently available evidence, would be better treated with urethroplasty. Several series demonstrate that the success rate with urethral dilation or urethrotomy for strictures over 2cm or recurrent strictures in unacceptably low (2,3). Yet, rather than a misunderstanding about treatment effectiveness, these practice patterns may merely represent the reality that properly trained reconstructive urologists are not available in many parts of the world, even in highly industrialized countries like the Netherlands and U.S. Only 3% of urologists surveyed performed more than 5 urethroplasties a year. The argument in favor of training additional surgeons in these techniques is quite appropriate.

References

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