In the past decades, several surgical procedures have been invented to manage the problem of recurrent urethral stricture disease. Anastomotic urethroplasty and different types of grafts and flaps—penile skin, buccal mucosa, and skin grafts from different sites—have been used to replace the strictured urethra and to prevent a recurrence of stricture disease [1]. To date, no technique is appropriate for all types of strictures, and different techniques must be used taking into consideration the site, the length of the stricture, and the history of the patient [2]. Regarding the type of graft, there seems to be a consensus that buccal mucosa is kind of “gold standard” [1,4], and that the dorsal onlay graft urethroplasty is technically feasible in most stricture sites and correlated with good long-term results in terms of recurrence [2,3].

A huge number of papers have been published on this topic, but the emphasis of Barbagli’s paper is on the problems of urethroplasties and how to avoid them [5]. He describes an interesting new method of bulbar urethral reconstruction preserving the bulbospongious muscle with the aim of reducing the risk of postvoidal dribbling and semen sequestration. Instead of incising the bulbar muscle in the midline, it is—after being separated from the corpus spongiosum—just gently removed dorsally for ventral onlay graft urethroplasty. For dorsal onlay urethroplasty, the muscle is just left in its position, using a kind of “no touch technique.” Thus, the authors leave the lateral margins of the muscle and the central tendon intact.

Another interesting topic of the paper is the critical discussion on “good postoperative outcome.” A good outcome concerns not only the postoperative voiding function, but specifically the authors emphasize, “secondary aims.” On the one hand, normal sexual function must be preserved, and on the other hand, annoying impairments such as postoperative dribbling must be avoided.

Still, some open questions remain: How can we be sure that the postvoiding dribbling is the effect of a malfunction of the bulbospongious muscle? In our experience it is rather the problem of the more rigid urethra at the site of urethroplasty. And why should the perineal nerves be damaged by incising the muscle in the midline? The nerves are running in a lateral position and just send branches in direction to the midline. One can hardly imagine that a midline incision damages the nerves in such a way that the muscle completely loses its function. In our opinion, the damage to the muscle (or its function) happens during the procedure by putting traction on it, or, the muscle and the nerves are damaged with the suture at the end of the procedure.

Despite these points of discussion, the important aspect of this publication is the in-depth description of problems and side-effects of urethral surgery. These side-effects have a significant impact on the quality of life of our patients, and the authors must be congratulated for evaluating possible side-effects and complications by a (nonvalidated) questionnaire. Subsequently, they minimize these
side-effects by improving the surgical procedure. We strongly support the efforts of defining success in urethral surgery not only in terms of urinary flow rates and residual volumes, but on criteria beyond the pure voiding function, including sexuality and urinary dribbling.

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References


