

Re: Hamid Mazdak, Iraj Meshki and Fatemeh Ghassami. Effect of Mitomycin C on Anterior Urethral Stricture Recurrence after Internal Urethrotomy. Eur Urol 2007;51:1089–92

We read with great interest the article by Mazdak et al, which reported an innovative management for a common urologic problem—recurrence of urethral stricture after internal urethrotomy [1]. It is believed that up to 50% of urethral strictures after internal urethrotomy will recur eventually and may require more complicated reconstructive procedures [2]. According to Mazdak et al, the submucosal injection of mitomycin C decreased the recurrence rate significantly to only 10%. Though as suggested by the authors the follow-up period was short, the technique seems to be a potential breakthrough in the management of this old urologic problem.

However, we would like to point out some potential bias in the study with the hope that this can improve future studies on this issue. First of all, although the study design was randomized, the authors should state whether the one assessing the outcome was blinded from the randomization and whether the surgeons were also involved in the outcome assessment. It would be preferable if placebo were used in the control arm. For example, the control group should also receive submucosal injection of placebo, such as normal saline, during the surgery. This would help to provide a double-blind assessment for both the surgeons and patients and minimize potential bias in the study.

Second, the primary end point of the study was recurrence of stricture, which was assessed by retrograde urethrography. However, it may be difficult to have clear-cut radiologic definition for recurrence. As a result, the decision of recurrence would be a bit subjective and arbitrary. This could be particularly relevant if the outcome assessor were not blinded as to the treatment. To overcome this

potential bias, more objective criteria, such as the development of obstructive symptoms after urethrotomy or worsening of maximal urine flow rate to <10 ml/s [3], should be considered. These end points are more objective and clear-cut. In fact, the authors had reported the number of patients who complained of obstructive symptoms in the treatment arm, but the information for the control arm was not available for comparison.

Hopefully, with the consideration of these suggestions and a possible longer follow-up period, the role of submucosal mitomycin C in preventing urethral stricture recurrence can be better defined. This would lead to improvement in patient care and minimize the need for more complicated urethral reconstructive surgery.

References

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Chi-fai Ng*

Shu-yin Chan

Department of Surgery, Prince of Wales Hospital,
Shatin, Hong Kong, China

*Corresponding author. Tel. +852 26322625; Fax: +852 26377974
E-mail address: ngcf@surgery.cuhk.edu.hk (C-f Ng)

May 17, 2007

Published online ahead of print on May 29, 2007

doi:10.1016/j.eururo.2007.05.014

DOI of original article: 10.1016/j.eururo.2006.11.038