10-2021

Multi-Institutional Outcomes of a One-Sided Dorsal Onlay Buccal Mucosal Urethroplasty for Penile Urethral Strictures Accessed Via a Penoscrotal Incision

David Abramowitz

Felicia Balzano

Jay Simhan

Frank Burks

Dmitriy Nikolavsky

See next page for additional authors

Authors

David Abramowitz, Felicia Balzano, Jay Simhan, Frank Burks, Dmitriy Nikolavsky, and Stephen Blakely

more than one (Group B). Group B was less disadvantaged (0.094 vs 0.103, p = 0.021) and more affluent (0.409 vs 0.381, p=0.025) compared to A. No differences in age, gender, race, BMI, insurance type, or Charlson Comorbidity Index existed between groups.
Conclusion: Over 40% of patients who initiated BTX-A did not continue treatments. These patients were more disadvantaged and less affluent than those receiving multiple treatments.
Funding: N/A

Podium #128
MULTI-INSTITUTIONAL OUTCOMES OF A ONE-SIDED DORSAL ONLAY BUCCAL MUCOSAL URETHROPLASTY FOR PENILE URETHRAL STRICTURES ACCESSED VIA A PENOSCROTAL INCISION
David Abramowitz, MD[1], Felicia Balzano, MD[1], Jay Simhan, MD[2], Frank Burks, MD[3], Dmitriy Nikolavsky, MD[4], Stephen Blakely, MD[4], Joseph Pariser, MD[5], Craig Hunter, DO[6], Erick Ramirez, MD[7], Jonathan Warner, MD[1]
[1]City of Hope, [2]Einstein Medical Center, [3]William Beaumont Hospital, [4]SUNY Upstate Medical University, [5]University of Minnesota, [6]University of Nevada, Reno, [7]entro de Uretra Mexico, Hospital Angeles MOCEL
Presented By: Jonathan Nicholas Warner, MD

Introduction: Optimal surgical management of penile urethral strictures remains unclear. Herein, we report our multi-institutional series of patients undergoing a one-sided dorsal onlay buccal mucosal urethropalsty for penile urethral strictures accessed via a penoscrotal invagination technique.
Methods: We retrospectively reviewed consecutively treated penile urethral stricture patients who underwent a one-sided dorsal onlay buccal mucosal urethroplasty accessed via a penoscrotal incision and penile invagination across 7 institutions. This technique is a modification of the Kulkarni invagination technique to include penoscrotal rather than perineal incision for penile strictures. Thus, allowing for supine positioning, and less dissection to reach the stricture location. Minimum 4 months follow up was required for inclusion. Primary outcomes were stricture recurrence and complications.
Results: We identified 23 patients. Median age was 60 (20-74). Stricture etiology included trauma (1), lichen sclerosis (2), instrumentation (14), and 6 were idiopathic. Median stricture length was 5cm (1.5-10cm). Only 30% (7/23) patients had not previously received stricture treatment. Using the LSE nomogram, 15 were classified as 2b strictures and 9 as 2c. Post-operative complications occurred in 5 patients and included leaks (2), cellulits (1), penile edema (1), and sepsis (1). With median follow-up of 7 months, long-term (>30 day) complications included 1 fistula, 1 Peyronie's, and 3 (13%) stricture recurrences.
Conclusion: This modified Kulkarni technique for management of penile strictures is safe, feasible, and reproducible across multiple different institutions. This confers decreased incision-related morbidity with stricture outcomes comparable to more traditional techniques.
Funding: N/A