Optical Internal Urethrotomy Revisited: The Modified Way I Do it: Khanna's Technique

Introduction and Objective: Urethral strictures are the commonest cause of obstructed voiding in the young and frequently recur after initial treatment whether endoscopic or open urethroplasty. However the endoscopic operation, OIU has had a bad reputation by proponents of open surgery who have presented their data and papers without defining success in their presentations and publications. To review and assess the efficacy, safety and long-term results of our modified optical internal urethrotomy, we did this study.
Materials and Methods: There were 76 patients who underwent surgery by this technique, from 2007 onward. The procedure was done under GA/Spinal. Urethra was entered with 6/7.8 ureteroscope, and a guide wire left in the bladder. Urethra was dilated with ureteral dilators until 16f followed by Cook's amplatz urethral S-shaped dilators until 26F. This was followed by OIU with sache's knife and 16F silicone foley catheter left indwelling. If dilatation was not possible beyond 20F then elective OIU and repeat dilatation was done after 2 weeks. Only when this was not possible the patient was offered open urethroplasty. The patient was called for urethral calibration at 2, 4, 12 and 24 weeks and thereafter once a year.
Results: This was graded as good /improved/ and poor.
GOOD: patient aymptomatic, peak flow greater than 20ml/sec, easy calibration at all visits.
IMROVED: peak flow less than 15ml/sec, need for 2nd OIU.
POOR: voiding unsatisfactory, peak flow less than 10ml/s, ec failed calibration in follow-up.
There were 69 patients who had good results, 6 improved, and 1 poor. Patient satisfaction has been very high with average peak flow rate 32.52ml/sec in contrast to preop average peak flow rate of 7.09ml/sec. None lost to follow up and longest follow-up was 5 years.
Conclusion: We hope this technique of OIU will become the first modality of treatment in all passable urethral strictures where at least a guide wire can pass. We presume the urethra where a guide wire can pass and can be dilated to 26F, the spongiofibrosis across the stricture is minimal in these patients, and that's why the results are so gratifying. Urethroplasty is useful in patients where endoscopic dilatation is not feasible.