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physicians within the study and over the course of the study. Unfortunately, we were unable to obtain data in this study using the *International Classification of Diseases, Ninth Revision* codes to evaluate the rate of diagnosis of urethral stricture disease to compare this with the number of interventions performed during the study. We were also unable to obtain data on patients who were diagnosed within the VA system and subsequently had urethroplasty on a fee-for-service basis outside the VA system.

CONCLUSION

Although urethroplasty is still underused, there is a trend toward increased use of urethroplasty for male urethral stricture disease in the VA population. The majority of urethroplasties were performed at VA medical centers in locations near a residency program, and there was significant variability in the numbers of urethroplasties performed based on geographic location. We predict continued increases in utilization of urethroplasty for male urethral stricture disease as numbers of fellowship-trained reconstructive urologists increase. Further studies are warranted to determine if these results are representative of practice patterns in other patient populations during the same time.

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APPENDIX 1

Current procedural terminology codes for treatments of male urethral stricture disease

Type of Procedure	CPT Codes
Urethral dilation	53600, 53601, 53605, 53620, 53640, 53675
Visualized internal urethrotomy	52281, 52275, 52276, 53000, 53010, 53025
Urethroplasty	53400, 53405, 53410, 53415, 53420, 53425, 53431, 53450, 53460, 53505, 53510, 53515, 53520, 54324, 54326, 54328, 54344, 54348

CPT, current procedural terminology.

EDITORIAL COMMENT



The authors describe trends in management of urethral stricture disease in the Veterans Affairs (VA) system over the last 15 years. Over the study period, the authors report a nearly 3-fold decrease in the total number of urethral procedures, while urethroplasties more than doubled. These interrelated findings suggest an improvement in urethral stricture disease quality of care and more widespread education, adoption, and utilization of initial management of urethral stricture with urethroplasty. Although these data source lack information on the strictures themselves—etiology, length, and location, and thus the ability to more critically evaluate treatment decisions and outcomes, the outcomes are encouraging.

Furthermore, many patients had a single intervention, and as the authors point out, may have been referred out for recurrent or refractory stricture disease. In our university practice, we perform urethroplasties on VA-referred patients routinely. It is important to highlight that in this case a referral to a reconstructive specialist outside of the VA system represents an advance in the treatment of urethral stricture disease due to more widespread knowledge and acceptance of early referral for definitive management of recurrent or refractory urethral strictures.

Traumatic urethral and penile injuries have been well documented in the combat setting.¹⁻⁴ The complexity and breadth of genitourinary reconstruction entering the VA system is likely going to expand in the coming years due to changes in mechanisms, types, severity, and survivability of injuries sustained in war. In Operation Enduring Freedom and Operation Iraqi Freedom, the majority of genitourinary injuries were caused by improvised explosive devices that can cause both penetrating trauma from shrapnel and blunt injuries from the pressure wave caused by the blast at close proximity.^{1,2,4} Therefore, improved knowledge and adoption

of the most effective means to diagnose, treat, and manage urethral strictures and genitourinary reconstruction in the veteran population is paramount. We anticipate that the trend will continue as more fellowship-trained reconstructive urologists join the workforce in light of studies that continue to show improved patient outcomes and decreased cost of procedures performed at high-volume centers of excellence.

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REPLY



The authors wish to thank the editor for the insightful comments regarding our study. As they highlighted, there are several limitations to this data source, and it may not have captured some procedures performed outside of the Veterans Affairs system. Despite this, we feel that the results of the study are quite encouraging. Our data show a trend toward increased utilization of urethroplasty and a concomitant decrease in the total number of procedures for male urethral stricture disease over the course of the study.

As the number of reconstructive fellowships grows, we predict that there will be not only more fellowship-trained reconstructive urologists in the workforce but also a significant improvement in exposure to reconstructive techniques during residency training. With improved training in urologic reconstruction at the residency and fellowship level, we hope to see continued improvements in the management of male urethral stricture disease and subsequent outcomes in both the veteran and civilian populations.

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