Author’s response to reviews

Title: Outcome of buccal mucosa graft urethroplasty: a detailed analysis of success, morbidity and quality of life in a contemporary patient cohort at a referral center

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Author’s response to reviews:

Dear Professor Dr. Henderson,

Thank you very much for the critical review of our manuscript entitled “Outcome of buccal mucosa graft urethroplasty: a detailed analysis of success, morbidity and quality of life in a contemporary patient cohort at a referral center (BURO-D-17-00352)” and for offering us the opportunity to submit a revised version. We also would like to thank the reviewers for their helpful comments on our manuscript. According to the reviewers’ suggestions we have revised the manuscript. Below are our responses to the reviewers’ comments. All changes in the manuscript were highlighted in bold letters.

Respectfully yours,

Oliver Engel
(on-behalf of all co-authors)
Comment 1: The authors present a retrospective assessment of subjective outcomes following buccal graft urethroplasty. A major weakness of the study is that the PROM was not administered in the preoperative setting and that the outcomes are based solely on subjective responses.

We thank the reviewer for this comment. Indeed, it is a major limitation of the present study that there are no preoperative PROM data, which would allow comparing baseline values to postoperative findings. We have already addressed this fact as an important limitation of our study.

Answer: We would like to emphasize that PROM is an accepted and established instrument of outcome measure among various types of surgeries, including treatment of prostate cancer, bladder cancer and urethral reconstruction. In urethral reconstruction, specifically the USS-PROM that we have used in the present study has previously been validated by our study-group. Although we do not report on other outcome measures, e.g. uroflowmetry or residual urine, we feel that PROM is an accepted instrument for analyzing outcomes in patients following urethral reconstruction. In the original version of the manuscript, we have already pointed out that no data on other outcome measurements are available and that this fact represents a limitation of the present study. However, we focused on patient reported outcome, since it emphasizes the patients' perspective on outcomes of the surgical procedure. Therefore, utilization of the USS-PROM seems appropriate.

To address the reviewer's concern, we modified the discussion section of the revised manuscript as follows:

“This represents an important limitation of the present study, since a comparison of preoperative and postoperative voiding, erectile function, urinary continence and quality of life was not possible. Thus, there remains a risk of bias regarding the impact of urethroplasty on patient reported outcomes.”

“In addition, instrument-based outcome measure and comparison to baseline values allows objective evaluation of surgical results. Missing data on uroflowmetry, urethrography and urethrocystocopy following BMGU represents a limitation of the present study.”

“The present study did focus on success, morbidity and HRQoL of urethroplasty. Therefore, the utilization of USS-PROM is appropriate, since it represents a validated instrument allowing standardized patient-orientated outcome evaluation of success, voiding symptoms, quality of life and satisfaction.”
Comment 2: Of note the response rate was only 50%, which is acceptable, given a mailed questionnaire; however, I do not believe that you can make definitive statements about success when half of the stricture cohort was not assessed.

Answer: We agree with the reviewer that a response rate of almost 50% is acceptable, especially when considering that the follow-up ranged from 36 to 54 months and that a mailed questionnaire has been used. We also agree that it is not possible to draw definite conclusions regarding the patients who did not answer the questionnaire. This represents an important limitation of the present study. However, honest reporting of the response rate is mandatory, and the present response rate is corresponding to that of other studies on urethral reconstruction of our institution.

To address the reviewer's important remark, we included the following sentences to the discussion section of the revised manuscript:

“In addition, the response rate is limited and to draw conclusions regarding the patients who did not answer the questionnaire is not possible, which might represent a possible source of bias. However, the response rate of the present study is still in an acceptable range when considering the follow-up period and the fact that a mailed questionnaire has been used.”

Reviewer #2:

Comment 1: Thank you to the authors for collating their data and contribute to the body of literature on this area with QoL follow-up. Many are not contactable indicating most of them are probably happy!

Answer: We thank the reviewer for the positive evaluation of our manuscript. Please see also Comment 2, Reviewer 1, regarding the response rate and the patients who did not answer the questionnaire.

Comment 2: The question remain as to how best follow-up these patients. Do the authors do calibration procedures to document evidence of graft contracture at all and how this phenomenon correlate with patient's symptoms or absence of symptoms. If you do calibration, then how many patients have for example less than 14 fr urethra but are asymptomatic? Would you agree that esp. in longer grafts that calibration to identify a narrowing luminal diameter may be important to identify who is at risk of failure even if asymptomatic? These patients can then be monitored more closely to avoid risk of chronic sequelae of obstruction. A comment or two in the discussion regarding the above may benefit the readership.
Answer: We agree with the reviewer that there are many possibilities of follow-up in patients treated with urethroplasty. In the present study, we have used PROM, which represents a patient-orientated follow-up strategy. In addition, various instrument-based follow-up modalities are available, including uroflowmetry, residual urine and urethral calibration. At our institution, we do not regularly perform urethral calibration at follow-up. We agree with the reviewer that urethral calibration gives detailed information on the wideness of the urethra and early identification of stricture recurrence. However, as already pointed out in the original version of the manuscript, stricture recurrences have to narrow the urethra to a caliber <10F to result in a relevant decrease of urinary flow rates. In addition, it has to be emphasized that urethral calibration represents an invasive procedure.

To address the reviewer's point, we included the following sentences to the discussion section of the revised manuscript:

“Moreover, the present study did not comprise instrument-based outcome measure, i.e. urethral calibration, uroflowmetry, urethrography and urethrocystoscopy.“

“In addition, instrument-based outcome measure and comparison to baseline values allows objective evaluation of surgical results. Missing data on urethral calibration, uroflowmetry, urethrography and urethrocystoscopy following BMGU represents a limitation of the present study.”

“Urethral calibration can identify narrowing of the urethral diameter and may detect stricture recurrence early following urethroplasty.”

“Finally, urethral calibration, uroflowmetry, urethrography and urethrocystoscopy may not allow assessing adequately the morbidity of BMGU, which was a secondary endpoint of the present study.“

Comment 3: Well done on this paper!

Answer: We thank the reviewer for acknowledging our work.