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EDITORIAL COMMENTS

Britton and colleagues report on a large, single-institution experience, describing the natural history, risk factors, and impact of vesicourethral anastomotic stenosis (VUAS) on urinary control after radical prostatectomy (RP).¹ VUAS can be a difficult condition to manage, especially in recurrent cases when radiation is involved. Fortunately, we see fewer of them with the rise of robotic-assisted prostatectomy.² Time will tell if focal therapy or ablative therapies will cause more intraprostatic stenoses, which can be problematic.

This study addresses a critical gap in our understanding of VUAS by investigating trends over a

27-year period covering the open and robotic RP eras. The study analyzes risk factors for VUAS formation, describes management strategies, and evaluates recurrence patterns among individuals who develop VUAS. The use of a prospectively maintained institutional registry, spanning 2 eras of RP, contributes to the study's strength. The study also evaluates VUAS rates among high-volume surgeons, which improves our knowledge of the variability in treating VUAS among surgeons. The study's identification of predictors of VUAS formation reaffirms findings from previous work. The authors also provide essential

insights into the impact of VUAS on urinary control that have important implications for patient counseling and surgical technique modifications.

Especially in the setting of previous radiation, VUAS treatment can result in profound urinary leakage. We start with a gentle dilation with a balloon, which in our experience works for most and results in less leakage. Like the authors, we favor a robotic bladder neck reconstruction over aggressive endoscopic

management in most scenarios, as the results are durable and severe incontinence is less likely.³

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I congratulate the authors for this analysis of their large, prospectively managed database to improve understanding of this terribly vexing problem.¹ The overall rate for vesicourethral anastomotic stricture (VUAS) was 4.8%, with a median time to diagnosis of 3.4 months. In addition to the previously described risk factors, including patient age, BMI, urine leak, hematoma, need for transfusion, and surgeon volume, the burning questions for many readers likely relate to differences between the open vs robotic assisted techniques. While only a small number were included in the robotic analysis, we do find that it may offer potential protection from VUAS. However, technology alone (deployment of the robot) may not have changed outcomes as much as surgeon experience and evolution in the understanding of anatomy and technique. In 1987 we were still learning the basics of how to do this operation safely, and that basic knowledge evolution continues today. As an example, when the nerve-sparing technique was introduced originally in the 1980s, electrocautery was not used, and sharp

dissection preferentially dominated.² While this may have increased blood loss, it potentially decreased collateral damage and therefore improvements in erectile function and continence rates.³

The protection against VUAS from adjuvant radiotherapy is super interesting. Selection bias likely contributes to this finding; candidates for adjuvant therapy with a VUAS may not be offered radiation for fear of making things worse. Unfortunately, this cannot be answered completely with these data, and we all must use caution in that it is highly unlikely giving prophylactic radiation to patients after radical prostatectomy in order to prevent VUAS alone is definitely not logical.

I'm confident that the rates of VUAS and other side effects of radical prostatectomy will likely continue to decrease with time as we continue on our surgical learning curve journey.

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The authors determined risk factors, natural history, and treatment outcomes of vesicourethral anastomotic stenosis (VUAS) using a large database of approximately 18,000 patients undergoing radical prostatectomy (RP) over a 25-year period.¹ Of the

cohort, 4.8% developed VUAS at a median of 3.4 months. It is comforting to note that the authors found similar risk factors to other studies,² including age, BMI, urine leak, hematoma (or transfusions), and surgeon and surgical technique. While less than