CONCLUSIONS: Sparing the bulbospongiose muscle during urethroplasty does not seem to have a significant impact on patient reported EF or PVD compared with non-bulbospongiosus sparing urethroplasty at early follow-up.

### Source of Funding: None

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### MP52-08

**EXCISION AND PRIMARY ANASTOMOSIS VS. DORSAL BUCCAL GRAFTING FOR BULBAR URETHRAL STRICTURES: COMPARISON OF OUTCOMES AND QUALITY OF LIFE**

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**INTRODUCTION AND OBJECTIVES:** Excision and primary anastomosis (EPA) with urethral transection has historically been favored as the procedure of choice for short bulbar urethral strictures due to excellent success rates. However, buccal graft onlay repair without transection is gaining favor because of potential long-term sexual complications that may result from EPA. We aim to compare short and long-term urinary and sexual outcomes of both procedures.

**METHODS:** A retrospective analysis was performed of all EPA and dorsal buccal (DB) urethroplasties performed for bulbar urethral strictures at our institution between 1998 and 2015. Exclusion criteria included prior urethroplasty, simultaneous reconstruction of a separate part of the urethra, need for a 2nd buccal graft harvest, hypospadias or lichen sclerosis. Our protocol includes cystoscopy 4 months after surgery to ensure a technical success and subsequent annual symptom, flow rate, and post-void residual assessment. All patients included in the study who were contacted during the month prior to abstract submission completed validated questionnaires to assess voiding, erectile, and ejaculatory function and other urethroplasty specific outcomes including glans sensitivity and engorgement.

**RESULTS:** After exclusion criteria were applied, a total of 130 (EPA) and 38 (DB) patients were included in the study. Technical success at 4 months, success at last evaluation, length of stricture and length of follow-up for EPA vs DB was 100% vs. 97.4% (NS), 99.2% vs. 94.7% (p=0.07), 1.7cm vs. 3.95cm (p<0.0001) and 42.3 vs. 39.8 months respectively. Thirty-one EPA and twenty-one DB patients responded to the survey. Of these, ejaculatory bother and post-void dribbling were significantly worse in the DB group. Six patients in the EPA group complained of a pulling sensation or curvature during erection compared to one in the DB group (p=0.21, the average stricture length was 1.4 cm in this group). DB grafting was associated with worse pot-void dribbling and ejaculatory bother. There were otherwise no significant differences in patient reported outcome measures related to quality of life, urinary function, erectile function, sexual activity, or penile sensitivity between groups. No patients complained of a cold glans.

**CONCLUSIONS:** EPA and DB grafting are both highly successful techniques for strictures isolated to the bulbar urethra with low sexual complications. Our data does not suggest that EPA for short bulbar strictures should be avoided in favor of DB due to a concern of an increased risk of sexual side effects with EPA.

**Source of Funding:** None

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### MP52-09

**STRUCTURE LENGTH, PATIENT COMORBIDITY, INFECTIOUS ETIOLOGY AND OBESITY INFLUENCES STRICTURE RECURRANCE AFTER BULBAR URETHROPLASTY: MULTIVARIATE ANALYSIS OF BULBAR URETHROPLASTY OUTCOMES**

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**INTRODUCTION AND OBJECTIVES:** Bulbar urethral strictures are the most common form of urethral stricture. Although urethroplasty is the most effective treatment, some patients develop stricture recurrence. We examine possible risk factors for stricture recurrence after bulbar urethroplasty.

**METHODS:** 596 patients undergoing isolated bulbar urethroplasty from Aug 2003 to June 2015 with complete follow-up were included in the analysis. Urethroplasty failure was defined as a recurrent stricture <16Fr identified on cystoscopy during follow-up. Potential risk factors examined were patient age, stricture etiology, stricture length, diabetes, smoking, obesity, charlson comorbidity index, number of previous endoscopic treatments, previous urethroplasty, and type of urethroplasty. Multivariable binary logistic regression was used to evaluate potential risk factors and determine associations.

**RESULTS:** Mean patient age was 44.4 years old. Overall there was a 93.5% stricture free rate with a mean follow-up of 63 months. Average stricture length was 3.9cm. Stricture etiology was most commonly idiopathic (59.4%). 88.1% (525) of patients had failed prior endoscopic treatment while 10.7% (64) failed previous urethroplasty. Of the 596 urethroplasties performed 40.3% (240) were reconstructed using buccal mucosa as an onlay technique, 2.2% (13) were flaps, 28.5% (170) were augmented anastomosis, 27.7% (165) were anastomatic urethroplasties, and 1.3% (8) used combined tissue techniques with successes of 93.8%, 77.0%, 91.8%, 97.0%, and 75%, respectively. On multivariate analysis increasing stricture length (p=0.003; OR 1.3; 1.1-1.4), increased patient comorbidity (p=0.018; OR 2.8; 1.1-6.5), obesity (p=0.0025; OR 2.7; 1.1-6.6) and infectious strictures (p=0.025; OR 4.3; 1.2-15.5) increased the likelihood of stricture recurrence. Previous urethroplasty (p=0.19), previous endoscopic procedures (p=0.19), type of urethroplasty (p=0.88), and individual comorbidities such as diabetes (p=0.88), smoking (p=0.76) and patient age (p=0.86) did not affect the rate of stricture recurrence.

**CONCLUSIONS:** Although bulbar urethroplasty has a very good (93.5%) stricture free rate, patients with increased stricture length, increased overall comorbidity, obesity and strictures of infectious etiology are at increased risk for bulbar urethroplasty failure.

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### MP52-10

**ANTIMICROBIAL PRACTICE PATTERNS FOR URETHROPLASTY AMONG GU RECONSTRUCTION EXPERTS: A CALL FOR STANDARDIZATION**

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**INTRODUCTION AND OBJECTIVES:** Improper use of antimicrobials is a global concern and growing health care crisis. The AUA suggests that for perioperative antimicrobial prophylaxis, a single dose of IV Cephalexin is recommended. We sought to evaluate the current antimicrobial administration practice patterns for urethroplasty among genitourinary (GU) reconstruction experts.

**METHODS:** A 27-question survey was designed to assess pre-, peri-, and postoperative antimicrobial administration practice patterns and was administered to 40 international members of the Society of Genitourinary Reconstructive Surgeons (GURS) who commonly perform urethroplasty.

**RESULTS:** The response rate was 85% (n=34). 30% of respondents indicated they have been practicing for 5-9 years, 21% for 10-14 years, and 21% for > 25 years. One third of reconstruction