Two methods in bladder neck stenosis treatment efficiency: Holmium YAG laser and cold blade incision

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Abstract
Aim: In this study, we aimed to compare the efficacy of Holmium YAG laser (Ho YAG) and cold knife incision in the literature.
Material and Methods: Bladder neck stenosis was retrospectively screened in our hospital between January 2018 and January 2019. Recurrence time was defined as the maximum flow rate below 15 ml/s and/or when it became symptomatic. The patients were divided into two groups. The first group consisted of 14 patients with bladder neck stenosis who underwent cold knife procedure. The second group consisted of 17 patients with bladder neck stenosis who underwent Holmium laser.
Results: In the group where laser ablation was applied due to bladder neck stenosis, the postoperative 6th month maximum flow rate was significantly higher (p = 0.01), while post voiding residual (PVR) values were significantly lower (p = 0.029). When the groups were compared in terms of flow rate and PVR, there was no significant difference in terms of urine flow rate and PVR at 3 months, respectively. Nevertheless, the flow rate and PVR amount at 6 months were statistically significant in favor of the laser ablation group.
Discussion: The use of holmium laser for bladder neck stenosis is promising in first-line treatment protocols with minimally invasive treatment modality, high success rates, low recurrence, and complication rates.

Keywords
Bladder neck; Stenosis; Holmium laser; Cold blade; Treatment

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Introduction
Benign Prostate Hyperplasia (BPH) is a histological diagnosis associated with lower urinary tract symptoms which incidence increases with age [1]. 25-30% of these files need treatment [2]. Medical treatments applied generally require improvement in patient symptoms until surgical treatment.

Transurethral Resection of the Prostate (TURP) is the gold standard treatment method for BPH treatment, with a success rate close to 90% [3]. Common complications of the procedure include bleeding, infection, retrograde injection, urethral stricture, and incontinence [4]. Another complication observed at the same time after TURP procedure is bladder neck stenosis (BNS) and its incidence varies between 0-4.9% [5-7]. Although we have limited knowledge about BNS, which starts to appear 4-6 weeks after TURP and is considered as late complication, factors that play an etiologic role, insufficient surgical technique, small adenoma, excessive resection, and large resection lobes are accused [8-10]. The lack of clear advice by the current guidelines and the recurrence potential of the disease cause problems in treatment. [10,11]. Some later definitions of bladder neck stenosis have been introduced by Marion and Bodian [12,13]. In the treatment, it is aimed to open the bladder neck to reduce urethral resistance. Transurethral resection can be done for this. However, it can trigger infection and recurrent scar formation.

In this study, we aimed to compare the effectiveness of Ho YAG laser and cold knife incision in our patients with BNS and to find it in the literature.

Material and Methods
Pre-study was approved by the local ethics committee. The patients were retrospectively screened in the category of countries diagnosed with bladder neck stenosis between January 2018 and January 2019. Patient consent was not obtained because it was a retrospective study. Patients who had TURP operation due to BPH were examined. Patients with urinary tract infections, who had undergone urological intervention, had undergone transvesical prostatectomy and those who had surgery for prostate cancer were excluded. Demographic documents and prostate volumes were reached in preparative countries. Intraoperative procedure time, post-operative, and post-operative transurethral (TU) probe duration, 3rd month and 6th month were included for uroflowmetric maximum flow rate and post voiding residü (PVR) recordings. The times when the maximum flow rate was below 15ml/s and/or became symptomatic were described as the recurrence time. The times of hospitalization were reached for 3rd month and 6th month. Complication, factors that play an etiological role, insufficient surgical technique, small adenoma, excessive resection, and large resection lobes are accused [5-8,10]. The lack of clear advice by the current guidelines and the recurrence potential of the disease cause problems in treatment. [10,11]. Some later definitions of bladder neck stenosis have been introduced by Marion and Bodian [12,13]. In the treatment, it is aimed to open the bladder neck to reduce urethral resistance. Transurethral resection can be done for this. However, it can trigger infection and recurrent scar formation.

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Statistics Method
Data were analyzed with SPSS 25.0 version (SPSS®, IL, USA) software. The compliance of the data with the normal distribution curve was evaluated with the Shapiro-Wilk test, the Mann-Whitney U test was used for the comparison of two groups with non-normal distribution, whereas the Wilcoxon test was used for the comparison of paired and non-normal distributed data. Nominal categorical data were assessed with the Chi-square test. P <0.05 was considered significant.

Results
The mean age of all countries was 68.6 ± 1.26 (51-79) years, and Body Mass Index (BMI) was 26.06 ± 0.49 (21-34). There was no difference in age, BMI, American Society of Anesthesiologists (ASA) score, comorbid disease history, hospitalization time, prostate volume, relationship rate, preop urine flow rate, post-op 3rd- month max urine flow rates, preop pvr, postop (Tables 1.2).

Laser ablation options in the group at the postop 6th month max. PVR value was found to be significantly lower (p = 0.029). When the groups were compared in terms of flow rate and PVR, there was no significant difference in terms of urine flow rate and PVR at 3 months, respectively. Nevertheless, the flow rate and PVR amount at 6 months were statistically significant in favor of the laser ablation group. (p <0.001) (Table 3).

Table 1. Comparison of demographic characteristics between groups

| Cold Blade | Laser | p |
|------------|-------|---|
| Number of patients n | 14 | 17 | 0.922 |
| Age (years) | 68.6 ± 7.6 | 68.7 ± 6.8 | 0.860 |
| BMI m/kg | 26.43 ± 3.1 | 25.7 ± 2.4 | 0.421 |
| ASA score 1/2 | 7/7 | 6/11 | 0.409 |
| Comorbid disease history | 6/8 (71.4%) | 9/8 (47%) | 0.576 |

Table 2. Comparision of operation data between groups

| Cold Blade | Laser | p |
|------------|-------|---|
| Hospitalization Time | 1.14 ± 0.3 | 1.12 ± 0.3 | 0.922 |
| Prostate V. mL±SD (mean rank) | 73.1 ± 37.5 (16.4) | 70.7 ± 36.1 (15.6) | 0.799 |
| Complication no/yes | 10 (71.4%) / 4 (28.6%) | 12 (70.6%) / 5 (29.4%) | 0.959 |
| Preop Q maks mL/s±SD (mean rank) | 7.86 ± 2.6 (15.04) | 7.82 ± 2.3 (16.79) | 0.797 |
| Post op 3. month Q maks mL/s±SD (mean rank) | 26 ± 3.9 (16.54) | 25.76 ± 3.1 (15.5) | 0.769 |
| Postop 6. month Q maks mL/s±SD (mean rank) | 16.57 ± 4.7 (10.29) | 22.59 ± 4.4 (20.71) | .001 |
| Postop PVRmL±SD (mean rank) | 129.2 ± 57.1 (15.7) | 130.1 ± 48.4 (16.1) | 0.922 |
| 3 month PVRmL±SD (mean rank) | 11.7 ± 10.8 (15.4) | 13.4 ± 13.6 (14.6) | 0.769 |
| 6 month PVRmL±SD (mean rank) | 59.3 ± 26.7 (19.8) | 40.8 ± 22.5 (12.1) | 0.029 |

Cold Blade Laser p

Cold Blade Laser p

Karl-Storz (Tuttlingen, Germany) brand internal urethrotome was used. The stenosis in the bladder neck was cut until the fibrotic tissue ended. In the other group, with 21 French cystoscopy sets (Hamburg, Germany) Olympus brand, 562 mm HoYAG (Quanta, Milan, Italy) laserablation mode, 10 Hz and 2 J energy was ablated. TU was placed at the end. Surgical procedures were performed under spinal anesthesia.
Table 3. Comparison of Q max and PVR values within the same surgery group

|                | Preop | 3. month | 6. month | p       |
|----------------|-------|----------|----------|---------|
| **Q max**      |       |          |          |         |
| Cold Blade     | 7.36±2.6 | 26±3.9  | 16.57±4.7| <0.001  |
| Laser          | 7.82±2.3 | 25.76±3  | 22.59±4.4| <0.001  |
| **PVR**        |       |          |          |         |
| Cold Blade     | 129.2±57.1(15.7) | 11.7±10.8 (15.4) | 59.3±26.7 (19.4)  | <0.001  |
| Laser          | 130.1±48.4(16.1) | 13.4±15.4(16.4) | 40.8±22.5(12.7) | <0.001  |

β: wilcoxon, Q maks: maximum current velocity, PVR: post voiding residual

Discussion

Bladder neck stenosis, which is a complication observed after BPH surgery, occurs within the first 2 years after surgery. In BNS etiology, surgical procedures, prostate weight, history of diabetes, smoking and cardiovascular diseases are accused. Numerous methods are described in the literature for BNS treatment. There are various techniques such as urethral dilation, bladder neck incision, cytotoxic agent injection after incision, open reconstruction, urethral stents [15,16]. Urethral dilation is used as the first-line treatment modality in non-complete stenoses, but it has high recurrence rates. Bladder neck incision and / or resection can be performed by cystoscopy and endoscopic method in patients who do not want spark plug dilatation and / or recurrent bladder neck stenosis after spark plug replacement [17-19]. The cold-knife incision or cytotoxic agent injection described to reduce recurrence rates have potentially serious side effects that may result in anaphylaxis, extravasation, and bladder necrosis, or even cystectomy [14-20]. In our study, in the group where we applied Ho-YAG laserablation, only 2 patients at the end of the 6th month, and in the group of patients who underwent cold knife incision, the clinical recurrence was seen in 6 patients. In the European Urology Guideline, the post-TURP BNS development rates were cooperated as 12.3% in the prostate volume below 80 g. At a rechargeable small prostate volume (less than 20 g), this ratio is determined to be higher (16%) [22]. BNS can be a difficult process to manage among urologists due to its frequent repetition potential. There is a need for more frequent treatment in BNS and patients become symptomatic in a shorter time. In our study group, clinically recurrence was observed in only 2 rooms in which HoYAG laserablation was performed, and minimal fibrotic bands observed with flexible cystoscopy under office conditions were opened and their clinical relief was provided. In the cold knife incision group, 6 observed clinical recurrences were resistant to the need for surgery. We believe that the Ho YAG laser with fibrotic colors delays almost complete ablation, or is therapeutic.

Mundy et al. They reported repairing the bladder neck with open surgical methods. They succeeded in 21 out of 23 patients with this method, but pointed out the necessity of using arterial urinary sphincters [23]. Wessells et al. have described primer excision of the bladder neck and urethroplasty with primer anastomosis and penile faciolo cutaneous flap or rectus phlebia [24]. Ink probability has been reported to be high. For this reason, necessity of the last stage artificial sphincter should be considered. In the bladder neck mentioned above, the evaluation of urinary incontinence may develop in the areas where the spark plug, endoscopic incision, endoscopic excision and substance injection in the incision areas remaining in the clinical trial phase. In this case, it is recommended to wait at least 3 months for intervention in incontinence and to observe the steady state of the situation [25].

In our study, there was no significant difference between the two groups in the duration of the TU catheter, the length of hospital stay and the complications. Planning of our study as a retrospective in a small patient room is considered as limitation.

Conclusions

The use of Ho-YAG laser in the treatment of bladder neck stenosis is promising in first-line treatment protocols with its minimally invasive treatment modality, high success rates, low recurrence and complication rates. However, more comprehensive prospective studies are needed to determine the effectiveness of treatment methods.

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