erectile dysfunction (ED), and the available studies have small sample sizes and heterogeneous populations. The heterogeneity among the studies could not be avoided completely, since many factors may contribute to ED, such as older age, hypertension, and diabetes. We did realize that there was heterogeneity in our meta-analysis.[1] Currently, a practical way to decrease the heterogeneity is to use subgroup analysis to reduce confounders. As such, we divided the studies into two subgroups according to different ED etiologies: ED (ED only) and ED associated with both PD and chronic pelvic pain syndrome to reduce the influence of heterogeneity.[1]

In our meta-analysis, we intentionally included all etiologies of ED to determine whether LI-ESWT affects all ED, not just vasculogenic ED. Qiu et al and Li et al showed in animal studies that LI-ESWT increases vascularity, increases the number of progenitor cells in the tissue, and promotes nerve regeneration.[2,3] In the correspondence, Zhao simplified the mechanism of LI-ESWT as being exclusively vasculogenic, which we have established as inaccurate.

Zhao comments that the significant improvement in the minimal clinically important difference (MCID) is much more related to the improvement of LI-ESWT effect on ED, rather than simple improvement of the International Index of Erectile Function (IIEF). However, anchor-based MCIDs were estimated using data from 17 randomized, double-blind, placebo-controlled, parallel-group clinical trials of the phosphodiesterase type 5 inhibitor (PDE5-I) tadalafil for 3345 patients treated for 12 weeks.[4] Moreover, MCIDs varied significantly according to baseline ED severity (mild: 2; moderate: 5; severe: 7), and results need to be replicated in studies using other PDE5-Is or in nonpharmacologic intervention studies. Another potential limitation for MCID is the selection of the clinical anchor for the analyses (ie, IIEF Q7). Anchor-based approaches to defining MCIDs should ideally use patient ratings of change administered at different periods of time or on exit from a clinical trial. Actually, the IIEF we applied was recommended by the International Consultation on Sexual Medicine in 2004 and 2010 as the gold standard self-report questionnaire for measuring erectile function (EF) in clinical trials and observational studies, and has already been accepted and recommended by regulatory agencies worldwide for approval of erectile dysfunction (ED) therapies. A recent PubMed search indicated more than1400 citations of the IIEF since its development in 1996. Multiple validation studies and systematic reviews of the IIEF have been published supporting its use in both clinical and research settings.[5] Consequently, we applied IIEF for our meta-analysis.

Based on the above, despite of those limitations mentioned above, the major aim of this meta-analysis was to evaluate the currently available clinical trials of LI-ESWT for ED to determine whether or not LI-ESWT improves penile function, to stimulate more research, and to encourage scientists and clinicians to design high-quality clinical trials that will help identify the real benefits of LI-ESWT and the ideal patient population for treatment.

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Guizhong Li, M.D. and Libo Man, M.D.
Department of Urology, Beijing Jishuitan Hospital, Beijing, China
E-mail: lee_gz99@sohu.com (G. Li).

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"Re: Direct Vision Internal Urethrotomy for Short Anterior Urethral Strictures and Beyond: Success Rates, Predictors of Treatment Failure, and Recurrence Management"

Dear Editor,

I have read the articles of Kluth et al named "*Direct Vision Internal Urethrotomy for Short Anterior Urethral Strictures and Beyond: Success Rates, Predictors of Treatment Failure and Recurrence Management*" with interest.[1] In the discussion part of the article, publications of Zehri et al were referenced.[2] It is stated in the article that the success rate after internal urethrotomy is given as 37% in writing of Zehri et al titled "*Predictors of recurrence of urethral stricture disease following optical Urethrotomy*." However, in abstract section of original article of Zehri et al, it is said: "For a mean follow up of 8.9+/-11 months, the overall recurrence rate was

I have no commercial relationship that could create any conflict of interest.
I have reviewed the final version of the letter and approve it for publication.

37%, with mean time to recurrence of 4.5 months." This means 37% is not a success rate, it is the rate of repeat (unsuccess). This rate is given in the results section of the same article as "The median duration between optical urethrotomy and recurrence was 4.5 months and recurrence rate was 34%." I am of the opinion that this information should be corrected in this valuable article of Kluth et al.

Sincerely

References

1. Kluth LA, Ernst L, Vetterlein MW, et al. Direct vision internal urethrotomy for short anterior urethral strictures and beyond: success rates, predictors of treatment failure, and recurrence management. *Urology*. 2017;106:210–215.
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Hüseyin Aydemir, M.D.
Department of Urology, Sakarya University, Education and Research Hospital, Sakarya, Turkey
E-mail: husaydemir@yahoo.com (H. Aydemir).

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Reply: Letter-to-the-editor: Direct Vision Internal Urethrotomy for Short Anterior Urethral Strictures and Beyond: Success Rates, Predictors of Treatment Failure and Recurrence Management (Urology2018;XXX:XX-XX)

Dear Editor,

we would like to thank the author of the letter to the editor for her or his correct notion that the recurrence rate of 37% as reported publication by Zehri et al[1] was falsely referenced as success rate in our article,[2] and we would like to apologize for this erratum. However, the respective paragraph simply aims to roughly put the findings from our study into perspective of the available literature. Importantly, we did not draw any conclusions related to the erroneously assumed low success rate of 37%, and thus, we do believe that misleading or confusion due to this erratum is somehow negligible. Again, we apologize for this corrigendum.

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Clemens M. Rosenbaum, M.D., Malte W. Vetterlein, M.D., and Luis A. Kluth, M.D.
Department of Urology, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
Department of Urology, University Medical Center Frankfurt a.M., Frankfurt, Germany
E-mail: rosenbaumclemens@gmail.com (C.M. Rosenbaum).

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Re: Huang et al.: The Application of Suctioning Flexible Ureteroscopy With Intelligent Pressure Control in Treating Upper Urinary Tract Calculi on Patients With a Solitary Kidney (Urology 2018;111:44-47)

TO THE EDITOR:

We read this article with great interest and would like to congratulate the authors for the innovation of a new ureteral access sheath (UAS)—11.5/15Fr with a pressure-sensing tip and irrigation and suctioning platform for use in RIRS. The authors have shown a 92.5% success rate with low operative time and low complication rate with this new device in the management of upper urinary tract calculi in a solitary kidney.

In performing RIRS, the tip of UAS is kept in upper ureter rather than pelvis to allow for deflection of the flexible ureteroscope. Thus, if the novel access sheath is placed in the upper ureter, it is unclear how pelvic pressures can be measured by the pressure-sensing channel. Furthermore, if the tip of the suctioning channel is in the upper ureter instead of pelvis, then it would be ineffective in reducing the pelvic pressure, as negative pressure in that location would cause the ureter to collapse rather than effectively removing fluid from the pelvis.

One of the benefits mentioned by the authors is reduced operative time. We would like to know how the operative time was defined (lasing time or entire procedure time). We are curious to know how many times the alarm was activated during the procedure due to raised pelvic pressures following blockage by gravel. How much time was taken to troubleshoot this problem and whether