Re: Boomerang Technique, The Buccal Mucosal Grafting Harvesting model for long urethral Stricture Urethroplasty: A case series

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We read with great interest the recent case series by Hosseini et al detailing the new "Boomerang Technique" for harvesting buccal mucosa for substitution urethroplasty.[1] The authors describe a novel technique in five patients for harvesting buccal mucosa in a "Boomerang" shape thus facilitating a longer graft take from a single cheek with no apparent complications recorded.

The authors allude to the increasingly wide use of buccal graft mucosa since first described[2] in patch urethroplasty and its versatility regarding oral recovery.

In our reconstructive unit we routinely harvest buccal graft mucosa for substitution urethroplasty. Nasal intubation is used but unlike Hosseini et al we employ McKesson mouth props mouth and a tongue retractor to facilitate graft harvest following local anaesthetic infiltration. Postoperatively, all patients are discharged on a five day course of oral benzydamine hydrochloride and are permitted fluids only for the first postoperative night.

Specific to this small series the mean graft size was 9.8 cm. Although all grafts donor sites were closed the authors do not mention if any patient was discharged with any oral preparations. Separately, although no oral complications have been reported to date the follow up period is limited. Additionally, in this series no specific questionnaires have been used to assess the long term outcomes of oral graft harvest.

Soave et al have previously employed the use of validated pain questionnaires in a series of 135 patients to assess the long term impacts of graft harvest on oral pain and discomfort and have illustrated the length of time between graft take and subsequent pain development.[3] Similar to Wood et al[4] they also illustrated that non closure of buccal graft site is also feasible. Rourke at al have demonstrated the use of questionnaires for 6 months postoperatively to assess complications and overall results favoured non closure of the oral wound.[5]

The authors are to be commended for describing a new technique for buccal graft harvest; an obvious advantage is the longer graft take that can be taken from a single cheek which is useful in long BXO strictures and potentially avoids the morbidity associated with bilateral mouth grafts, however, follow up is limited and the series small.

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