



A PROSPECTIVE, COHORT STUDY OF EFFICACY OF *TRAIVRUTTAM TAIL - UTTAR BASTI* IN STRICTURE URETHRA

*¹Dr. Maheshkumar N. Chaudhari and ²Dr. Mrudula M. Chaudhari

¹Professor & HOD (Shalya-Tantra Dept.), Chaitanya Ayurveda College & Hospital, Bhusaval- 425201, Jalgaon (Maharashtra) (India).

²BAMS, MA (Sanskrit), Nilvasu Hospital, Municipal Park, Bhusaval-425201, Dist.- Jalgaon (Maharashtra) (India).



*Corresponding Author: Dr. Maheshkumar N. Chaudhari

Professor & HOD (Shalya-Tantra Dept.), Chaitanya Ayurveda College & Hospital, Bhusaval- 425201, Jalgaon (Maharashtra) (India).

Article Received on 05/04/2024

Article Revised on 26/04/2024

Article Accepted on 16/05/2024

ABSTARCT

Till today there is no solid solution for stricture urethra except surgical intervention. The most common presentation includes obstructive voiding symptoms, urinary retention, or urinary tract infections. Obstructive voiding symptoms are characterized by a decreased force of stream, incomplete emptying of the bladder, urinary terminal dribbling (post-void dribbling), straining to void and urinary intermittency. These symptoms are progressive in many patients. There is no medical therapy to treat urethral stricture, Surgical treatment of urethral stricture is indicated when the patient has severe voiding symptoms, bladder calculi, increased post-void residual, urinary tract infection, or when conservative management fails. When the urethral lining forms a scar and the hole becomes narrow, making it difficult for urine to pass through, we call it a urethral stricture. A urethral stricture can cause a very slow urinary stream or make it difficult to completely empty bladder. Anterior urethral injury are thought to most often result from a blunt force blow to the perineum, producing a crushing effect on the tissues of the urethra. Ayurveda have a non invasive solid solution to deal with this notorious urethral stricture i.e. *Uttar basti*. *Uttar basti* means intra urethral drug administration. *Uttar basti* cleans the entire urinary system genital organs. It improves the circulation, opens the channels of the system and removes all the toxicity. It restores the normal functioning of the urinary system and genital region. It also helps in providing nourishment in the specific area. It is a ray of hope for those wishing a treatment without any surgical intervention of urinary and genital system. *Uttara Basti* is considered a treatment of choice for genital and urinary system. It benefits by pacifying the vitiated *apana vayu* (type of *vata dosha*).

KEYWORDS: Stricture Urethra, *Traivruttam Tail*, *Uttar Basti*.

INTRODUCTION

Traivruttam Tail – An Ayurvedic Medicated Oil (Specially advocated for Stricture Urethra by Achary Sushruta).

Uttar Basti = (Intra Urethral Drug Administration) - *Uttar basti* is a part of an Ayurvedic treatment. Drug used for *Uttar-basti* usually in the form of medicated oil or *ghee*. Administration of drugs through *uttara marga* (openings in the anterior part of the body) is called '*Uttar Basti*'. The *Uttar basti* have excellent qualities to cure & care of reproductive and urinary organs, so it is called '*Uttar Basti*'. These medicines should be retained for specific time & then should be expelled out through urination. This would be the new for modern world.

Stricture Urethra = *Mutrotsang* (According to Ayurveda terminology).

”बस्तौ वाऽप्यथवा नाले मणौ वा यस्य देहिनः ।

मूत्रं प्रवृत्तं सज्जेत सरक्तं वा प्रवाहतः ॥ 15 ॥

स्रवेच्छनैरल्पमल्पं सरुजं वाऽथ नीरुजम् ।

विगुणानिलजो व्याधिः समूत्रोत्सङ्गसंज्ञितः॥” 16 ॥

सु. उ. 15-16 / 58^[1]

Urethral Stricture (*Mutrotsang*)

While urinating, a man's urine, despite being released, gets stuck in the bladder, urethra or comes out with blood. Perhaps it comes out gradually, in small quantities with or without pain, this condition caused by vitiated *Vata*, is called '*Mutrotsang*' (Urethral Stricture).

“कषायकल्कसर्पीषि भक्ष्यान् लेहान् पयांसि च ।

क्षारमद्यासवस्वेदान् बस्तींश्चोत्तरसंज्ञितान् ॥ 27 ॥

विदुष्यान्मतिमांस्तत्र विधिं चाश्मरिनाशनम् ।

मूत्रोदावर्तयोगांश्च कात्सर्न्येनात्र प्रयोजयेत् ॥” 28 ॥

सु. उ. 27-28 / 58^[2]

General treatment of Stoppage of Urine

A wise *Vaidya* (doctor), in all types of stoppage of urine (there are 12 types of urinary disorders, stricture urethra is one of them, according to *Achary Sushruta*), food like *Kashaya* (herbal decoction), *Kalk* (herbal drug's paste), *Ghrit*, *Avaleh* and milk and alkali, *Madya*, honey, *Asava*, *Upanahadik Sweda*, **Uttar Basti** and *Chakraat Sneha-virechana* and prescribe lithotriptic drugs.

Dhalhanacharya more cleared, that vitiated *Vaat* is the cause of all types of urinary disorders. **Basti** (Urinary Bladder) is the reside of **Apan Vaat** & tail is best mitigative agent for *Vaat*.

General treatment sequence for urinary disorders.

“अत ऊर्ध्वं प्रवक्ष्यामि मूत्रदोषे क्रमं हितम् ॥ 49 ॥

स्नेहस्वेदोपपन्नानां हितं तेषु विरेचनम् ।

ततः संशुद्धदेहानां हिताश्चोत्तरस्तयः ॥” 50 ॥

सु. उ. 49-50 / 58^[3]

Now after this, the general treatment sequence beneficial for urinary disorders is described. First of all, the urinary defect should be lubricated in the form of *Snehapana* and *Snehabhyanaga* and then sweated. Afterwards, purgation should be done with laxative medicines. In this way, after their body gets purified, it is beneficial to give them **Uttara-basti**.

Traumatic urinary disorders

“मूत्रवाहिषु शल्येन क्षतेष्वभिहितेषु च ।

स्रोतःसु मूत्राघातस्तु जायते भूश्वेदनः ॥

वातबस्तेस्तु तुल्यानि तस्य लिङ्गानि लक्षयेत् ॥” 8 ॥

सु. उ. 15-16 / 59^[4]

Extremely painful Urinary Tract disease occurs when the urinary vasculature gets damaged by internal or external force or due to trauma. In this, symptoms similar to the aforesaid *Vatabasti* arise.

Medicines for Stricture Urethra - *Traivrutam Tailam*.

“श्वदंष्ट्राऽश्मभिर्दौ कुम्भी हपुष्पां कण्टकारिकाम् ।

बलां शतावरी रासना वरुणं गिरिकर्णिकाम् ॥17॥

तथा विदारिगन्धादिं संहृत्य त्रैवृतं पचेत् ।

तैलं घृतं वा तपेयं तेन वाऽप्यनुवासनम् ॥

दद्यादुत्तरबस्तिन्च वातकृच्छ्रोपशान्तये ॥” 18 ।

सु. उ. 17-18 / 58^[5]

Gokharu, *Pashanbhed*, *Jal parni*, *Kantkari*, *Bala*, *Shatavari*, *Rasna*, *Varun Bark*, *Aparajita*, *Vidari Gandhadi gan*, collect all these in equal quantities, i.e. 4 *pal* (16 *tola* = 160 gm) and grind on the stone with water and make *kalk* (paste). Then, take 4 times water of this *kalk* (1 *Prastha* = 64 *Tolas* = 640 ml), **triple oil**, fat and marrow, sesame oil or oil fat and marrow mixed in equal proportion from these three and oil, then add 4 times water (4 *Prastha* = 256 *tola* = 2560 ml) After cooking, the residual, when it cools down, filter it and fill it in a glass bottle. This oil is called as '**Trivruttam Tail**' & should be increased from 6 *mashas* to 2 *tola* and mixed with lukewarm water or milk and used for drinking,

providing *anu-vasan basti* and for **uttar basti** to calm / mitigate the urinary disorders caused by vitiated *Vaat*. In this way, we can also make **Trivruttam Ghrit**.

Keep both oil and *ghrit* separate. Let whoever has the capacity to use it. Oil should be used in *vata*-predominant and *kapha*-predominant urinary tract infections and ghee should be used in *pitta*--predominant urinary tract infections. By drinking, *ghee* or oil will spread throughout the body along with the blood and will provide relief from the defects and by giving *Anuvasana Basti*, it will destroy the dryness of the rectum and colon etc., and by giving **Uttar Basti** in the urinary system, it will give relief from the *Vaata* etc. defects and by giving **Uttar Basti** in the urinary tract, the urinary tract and colonic defects will be destroyed, will help in curing urinary stoppage. Therefore, use this oil or *ghee* in three ways: *Paan* (drink), *Anuvasan Basti* and *Uttar Basti*.

In this study, we are giving only *Trivruttam* oil **Uttara Basti** in Stricture Urethra patients through *Uttar basti*.

I applied this *Trivruttam* oil in my patients since last 15 years of practice of endo-Urology & got tremendous result. Why *Maharshi Sushruta* said only oil & *ghee*? Because of cow's ghee is more compatible for human body. Oil & *Ghee* has – Soothing, healing & generates new normal cells with bacteriostatic properties naturally and it's lubrication persists for long period & oleate internally the strotasas (system) like urethra, bladder continuously. Because the tissue of this part are very meticulous & in endo- urological procedures foley's rubber & various types of catheters as well as D.J. stents are continuously frictioning the local tissue & mucous membrane which causes trauma --- bleeding--infection--fibrosis--narrowing of the lumen – & finally - - stricture or stenosis formation will take place.^[6] The initial injuries are often ignored by the patient and urethral injury manifests years later as a stricture. The stricture results from scarring induced by ischemia at the site of the injury. Treatments include: dilation – enlarging the stricture with gradual stretching. urethrotomy – cutting the stricture with a laser or knife through a scope. Open surgery – surgical removal of the stricture with reconnection and reconstruction, possibly with grafts (urethroplasty).

It is also not uncommon to encounter strictures from iatrogenic causes including prior instrumentation of the urethra with scopes or urethral catheters.

The patient evaluated and deemed medically stable for the selected procedure. Urine culture done prior & after the *Uttar-basti*. Urethral stricture thoroughly evaluated with radiographic and/or endoscopic techniques.

When the urethral lining forms a scar and the hole becomes narrow, making it difficult for urine to pass through, we call it a urethral stricture.

The most common causes of urethral stricture appear to be chronic inflammation or injury. Scar tissue can gradually form from: An injury to penis or scrotum or a straddle injury to the scrotum or perineum. An infection, most often sexually transmitted infections like chlamydia. Putting a small tube called a catheter into the bladder to drain urine is often the first step for treating urine blockage. Antibiotics treat an infection. Self-catheterization might be a choice for those diagnosed with a short stricture.^[7]

The urethra is divided into two segments anterior and posterior. The anterior urethra (from distal to proximal) includes the meatus, fossa navicularis, penile (or pendulous) urethra, and bulbar urethra. The posterior urethra (from distal to proximal) includes the membranous urethra and the prostatic urethra.

The urethra lies within the corpus spongiosum, beginning at the level of the bulbous urethra and extending distally through the length of the penile urethra. The bulbar urethra begins at the root of the penis and ends at the urogenital diaphragm. The penile urethra has a more central position within the corpus spongiosum in contrast to the bulbous urethra, which is more dorsally positioned. The membranous urethra involves the segment extending from the urogenital diaphragm to the verumontanum. The prostatic urethra extends proximally from the verumontanum to the bladder neck.

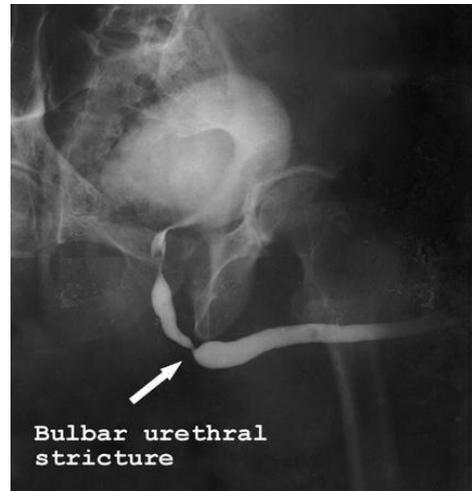
Urethral strictures can result from inflammatory, ischemic, or traumatic processes. These processes lead to scar tissue formation; the scar tissue contracts and reduces the caliber of the urethral lumen, causing resistance to the antegrade flow of urine. Many cases are idiopathic, but patients may have a history of genitourinary tract infection or trauma, including iatrogenic trauma.^[8]

The term urethral stricture generally refers to the anterior urethra. These cases are secondary to scarring in the spongy erectile tissue of the corpus spongiosum. A posterior urethral stricture is due to a fibrotic process that narrows the bladder neck and usually results from a distraction injury secondary to trauma or surgery, such as radical prostatectomy.^[9] The focus of this article is anterior urethral stricture.

Urethral dilation

Urethral dilation is very common practice in urethral stricture. Recurrence of the urethral stricture is the most common complication. Dilation of a urethral stricture is appropriate for patients with isolated epithelial strictures without scarring of the corpus spongiosum. Although rare, dilations can lead to urethral trauma caused by passage of the instrument through the urothelium into the corpus spongiosum or perispongial tissues. This risk can be minimized with careful technique and appropriate selection of patients for dilation.

Urethral strictures may be asymptomatic. Clinical manifestations include obstructive voiding symptoms, urinary retention, and urinary tract infection. Retrograde urethrography is the main diagnostic method for finding anterior urethra strictures and determining their length.^[9]



Many techniques are available for the treatment of urethral stricture, including dilation, urethrotomy and open reconstruction. No single technique can be applied successfully to every situation; each technique has advantages and disadvantages.^[10,11,12] Establishing effective drainage of the urinary bladder can be challenging, and a thorough understanding of urethral anatomy and urologic technology is essential.

The most common causes of urethral stricture are traumatic or iatrogenic. Inflammatory or infectious, malignant, and congenital etiologies are less common. Approximately 30% of urethral strictures are idiopathic. Iatrogenic urethral trauma usually results from improper or prolonged catheterization and accounts for 32% of strictures.^[13]

Prognosis

The outcomes of urethral reconstruction for lichen sclerosus (LS) urethral strictures are poor, with reported stricture recurrence rates ranging from 20% to 50%.^[14] Dilation and/or direct vision internal urethrotomy (DVIU) results are poor, with success rates ranging from 0%-20%.^[15]

A prospective randomized comparison of internal urethrotomy (DVIU) and urethral dilation for male urethral strictures found no significant difference in efficacy between the two procedures when used as initial treatment.^[16]

Excision with primary anastomosis (EPA) repair for anterior urethral strictures is considered to be the "gold standard" and was the first type of surgical repair of described.

Free graft repair consists of harvesting tissue from elsewhere in the body (usually the buccal mucosa of the mouth) and using that tissue to augment the strictured segment of urethra. These procedures have an overall success rate of 84.3%. Mundy's analysis demonstrated a 95% success rate with graft reconstructions when the follow-up was limited to 1 year. Longer follow-up showed deterioration over time.^[17]

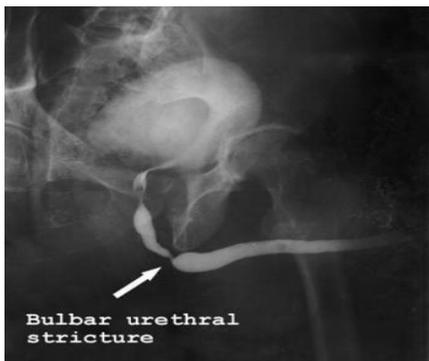
Approach Considerations by *Trivruttam tail Uttar basti*

The diagnosis of urethral strictures is based on a suggestive history, findings on physical examination, and

radiographic or endoscopic visualization. The entire urethra, both proximal and distal to the strictured area, evaluated endoscopically and/or radiographically prior to *Trivruttam tail Uttar basti*.

Imaging Studies

Radiographic evaluation of the urethra with contrast studies is best achieved by retrograde urethrogram (RUG), or antegrade cystourethrogram if the patient has an existing suprapubic catheter. USG, etc.



RUG demonstrating demonstrating bulbar urethral stricture.



RUG demonstrating complete obliteration of the bulbous urethra.



Retrograde urethrogram demonstrating pan-urethral stricture disease.

Diagnostic Procedures

Endoscopic evaluation conducted by flexible or rigid cystourethroscopy. Flexible cystourethroscopy performed with little discomfort to the patient using only local anesthesia, such as 2% lidocaine jelly intraurethrally.

Surgical Treatment for stricture urethra

Like Urethral dilation, Internal urethrotomy, Permanent urethral stents, Open Reconstruction, Buccal mucosal graft, Pedicle skin flaps, etc. are being done now a days.

AIMS AND OBJECTS

To study the efficacy of *Trivruttam Tail (oil) Uttar basti* in males stricture Urethra.

Parameters – (Investigations done before & after 30th day of *Uttar basti* started),

- 1) Clinical evaluation (Daily on OPD basis),
- 2) Retrograde Urethrogram,
- 3) All necessary blood & urine (routine & c/s) tests,
- 4) USG – Abd. & Pelvis

Inclusive criteria

- 1) Age - 51 to 60 year,
- 2) Sex – Male patients only,
- 3) Fresh cases of stricture urethra \leq 2 cm in length,
- 4) Post DVIU patient who is on CIC.

Exclusive criteria

- 1) Patient with DM, Hypertension, Thyroid, cardiac insufficiency or medically unfit
- 2) Acute & chronic renal diseases,
- 3) Other uro-genital disorders,
- 4) Any Endo / open urological surgery done before,
- 5) Catheterized patients.

MATERIAL AND METHODOLOGY**Material**

- *Trivruttam Tail* (oil) (Manufactured according to *Achary Sushruta*)
- Sterile gloves, 50 ml syringe.

Methods

- Duly consented, total 30 patients has taken according to inclusive criteria for this study.
- Warm *Trivruttam Tail* 40 ml is used.
- Before procedure, ask patient for complete urination as he can,
- This procedure of *Uttar Basti* should be performed in OT only,
- Followed all aseptic precautions,

- Properly sterilized *Trivruttam Tail* (oil) used,
- Then proper painting & draping should be done,
- Slowly pushing of Warm *Trivruttam Tail* directly in urethra by 50 ml syringe.
- Daily *Uttar basti* given consecutively for 7 days to every patient.
- Assessment according to parameters was done, before & on 30th day of the *Uttar basti*,
- Patient observed for his first post *Uttar Basti urination*, *haematuria*, *dysuria*, etc.

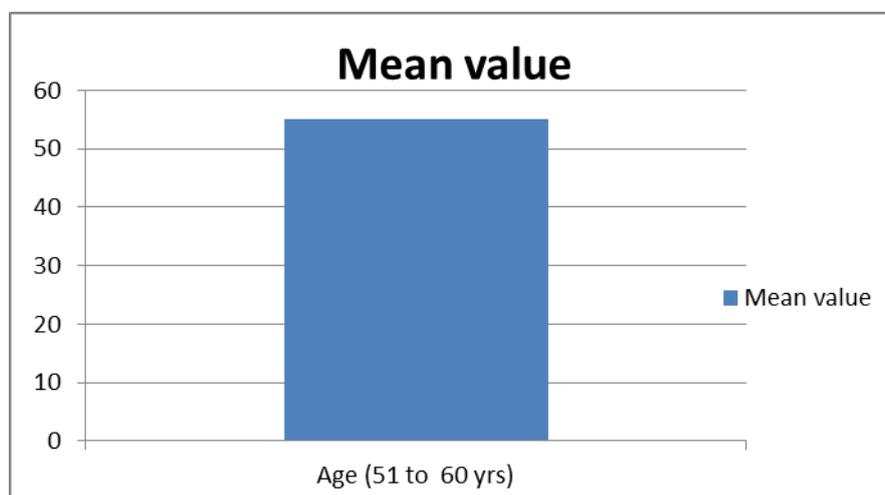
Clinical Trial

Clinical study carried out at Chaitanya Ayurveda College & Hospital, Sakegaon- Bhusaval & Nilvasu Hospital, Bhusaval-425201 Dist.- Jalgaon (Maharashtra) India.

Data Analysis

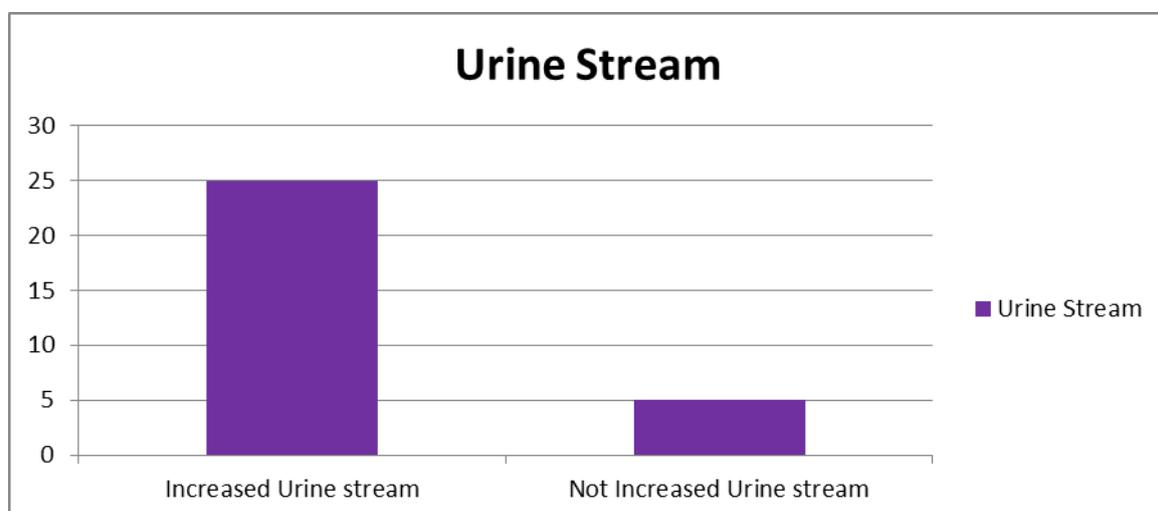
- 1) **Age** - Total 30 patients was assessed.

	Mean value
Age (51 to 60 yrs)	55 yr.



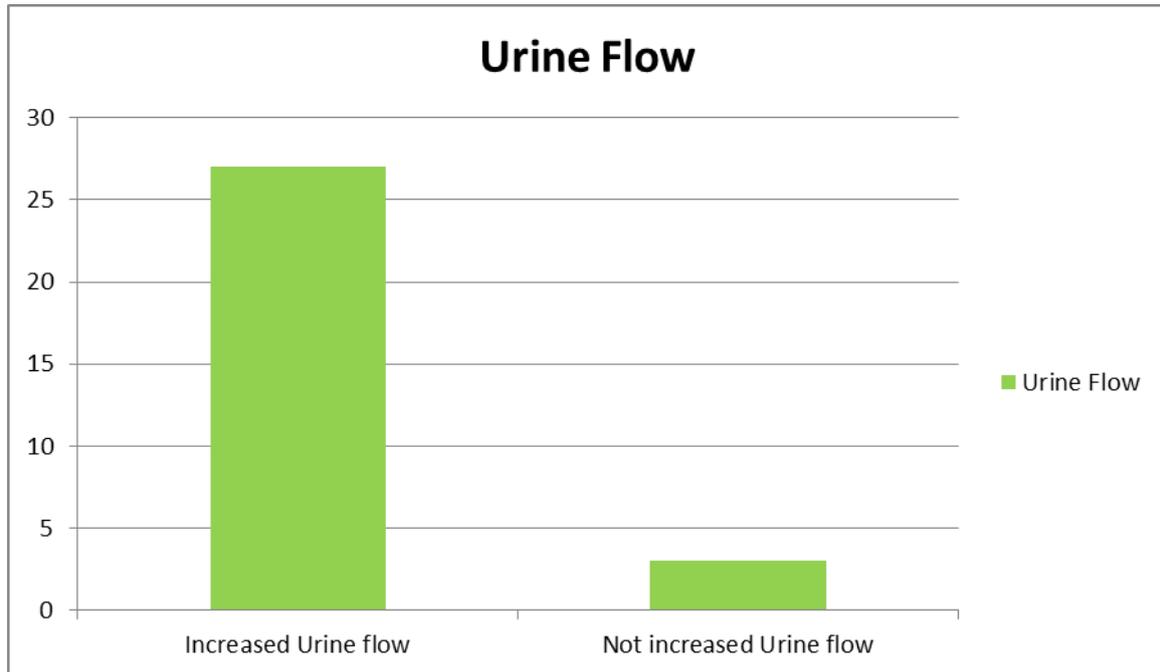
- 2) **Urine Stream** – (Post *Uttar-Basti* procedure-Urethrogram)

Total no. of Patients	Increased	Not increased	Result in %
30	25	5	83.33 %

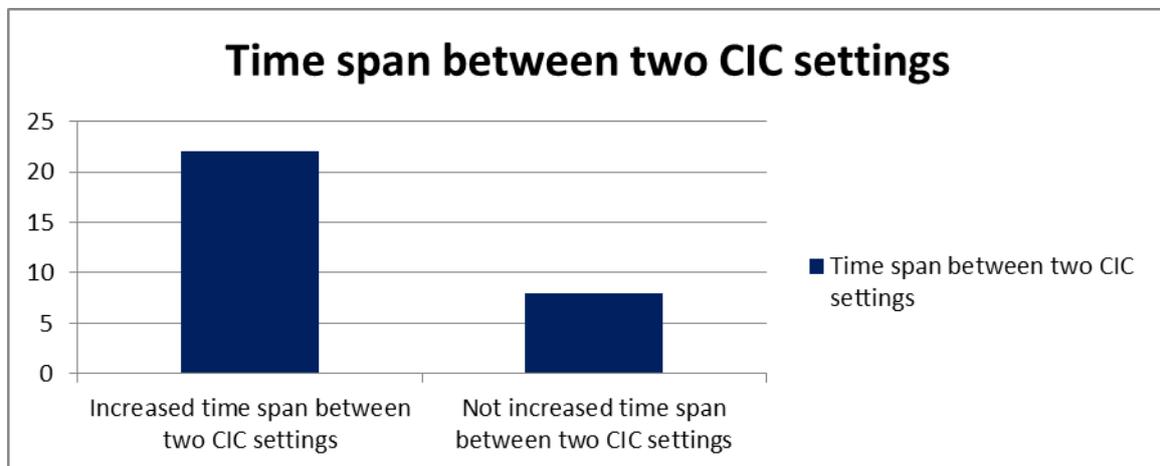


3) Urine Flow – (Post *Uttar-Basti* Uroflowmetry test)

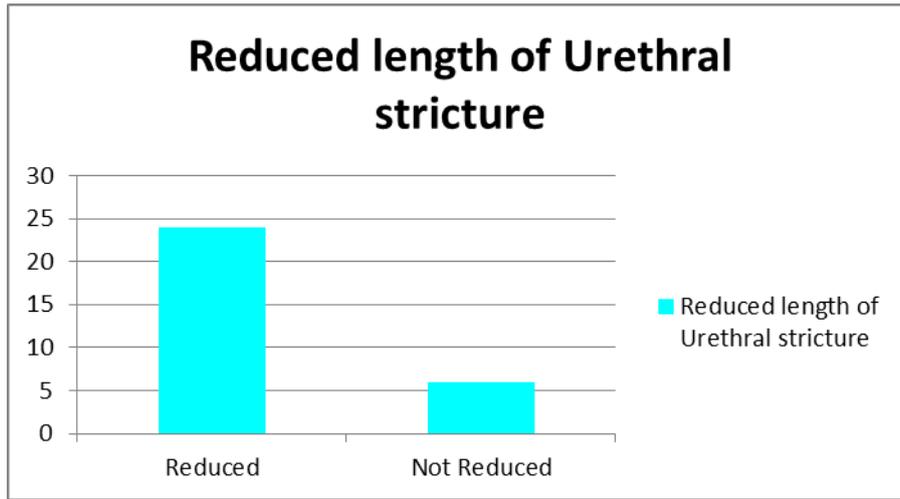
Total no. of Patients	Increased	Not increased	Result in %
30	27	3	90 %

4) Time span between two CIC settings – (Post *Uttar-Basti* procedure)

Total no. of Patients	Increased	Not increased	Result in %
30	22	8	73.33 %

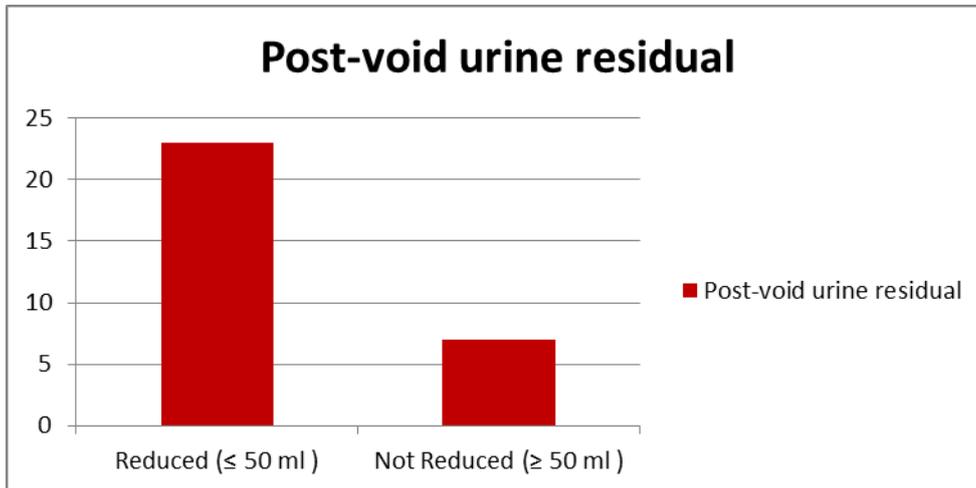
5) Reduced length of Urethral stricture – (Post *Uttar-Basti* RGU)

Total no. of Patients	Reduced	Not Reduced	Result in %
30	24	6	80 %



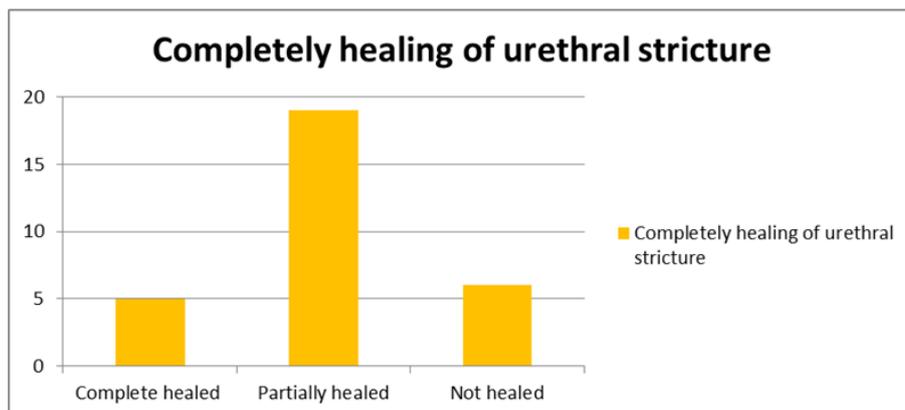
6) Post-void urine residual (≤ 50 ml)- (Assessment criteria – USG)

Total no. of Patients	Reduced ≤ 50 ml	Not Reduced \geq than 50 ml	Result in %
30	23	7	76.66 %



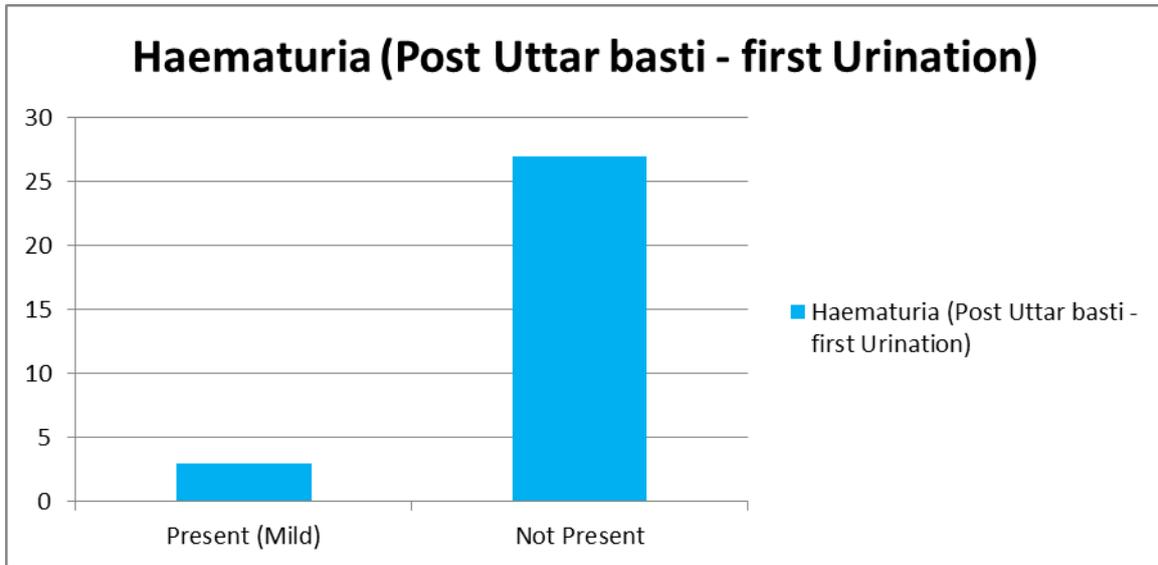
7) Completely healing of urethral stricture- (Post *Uttar-Basti* procedure RGU done)

		Result in %
Complete Healed	5	16.66 %
Partially Healed	19	63.33 %
Not Healed	6	20 %
Total no. of Patients	30	

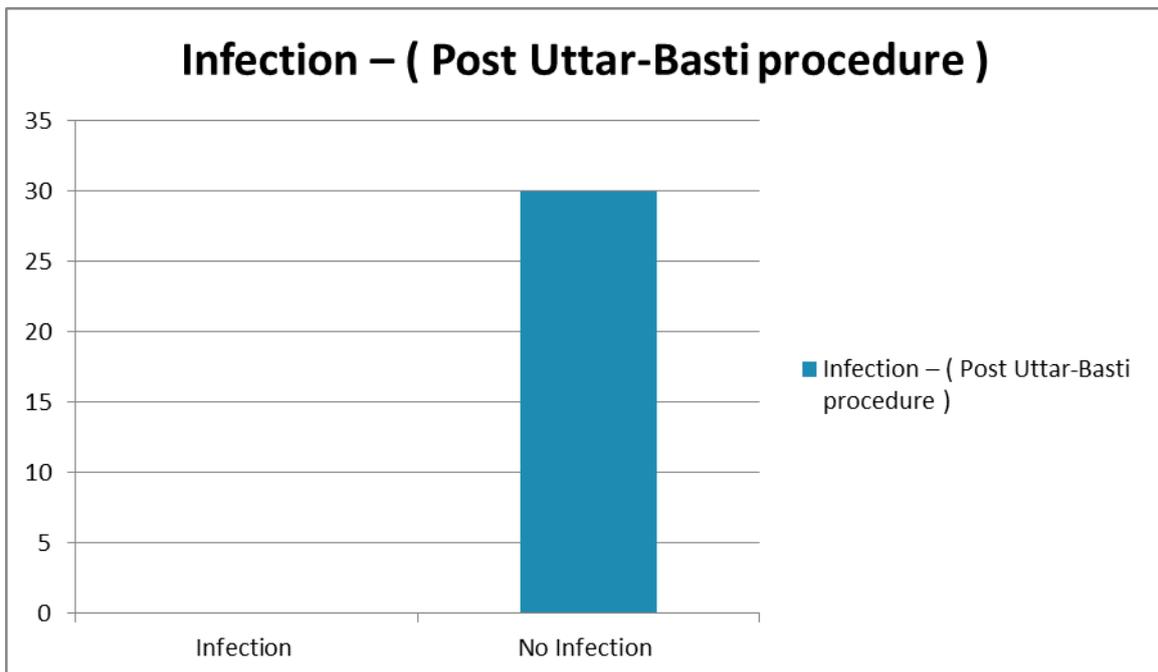


8) **Haematuria** – (Post *Uttar-Basti* procedure- first urination)

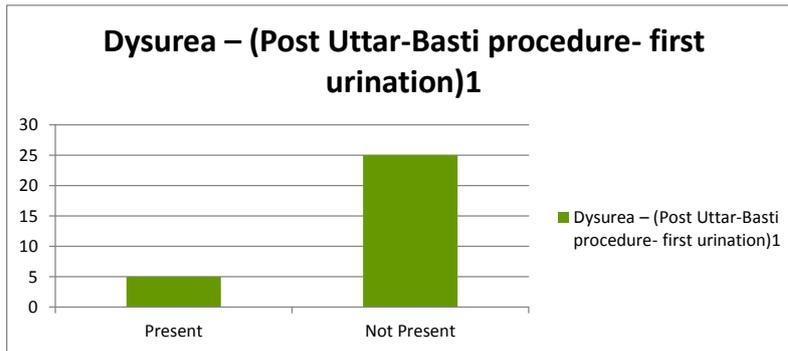
Total no. of Patients	Not Present	Present (Mild)	Result in %
30	27	3	90 %

9) **Infection** – (Post *Uttar-Basti* procedure)

Total no. of Patients	Infection	No Infection	Result in %
30	0	30	100 %

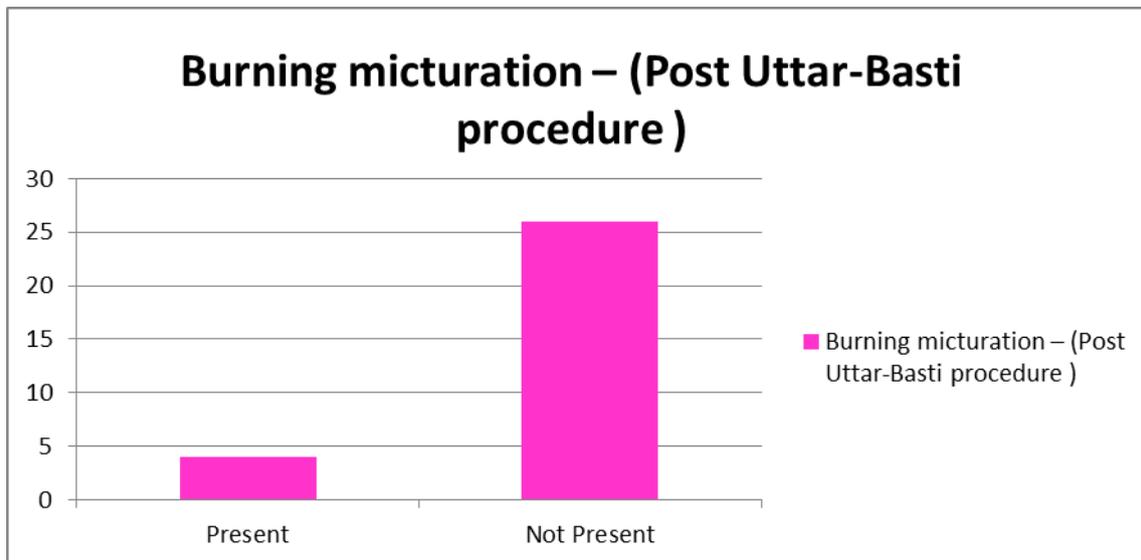
10) **Dysurea** – (Post *Uttar-Basti* procedure- first urination)

Total no. of Patients	Present	Not Present	Result in %
30	5	25	83.33 %



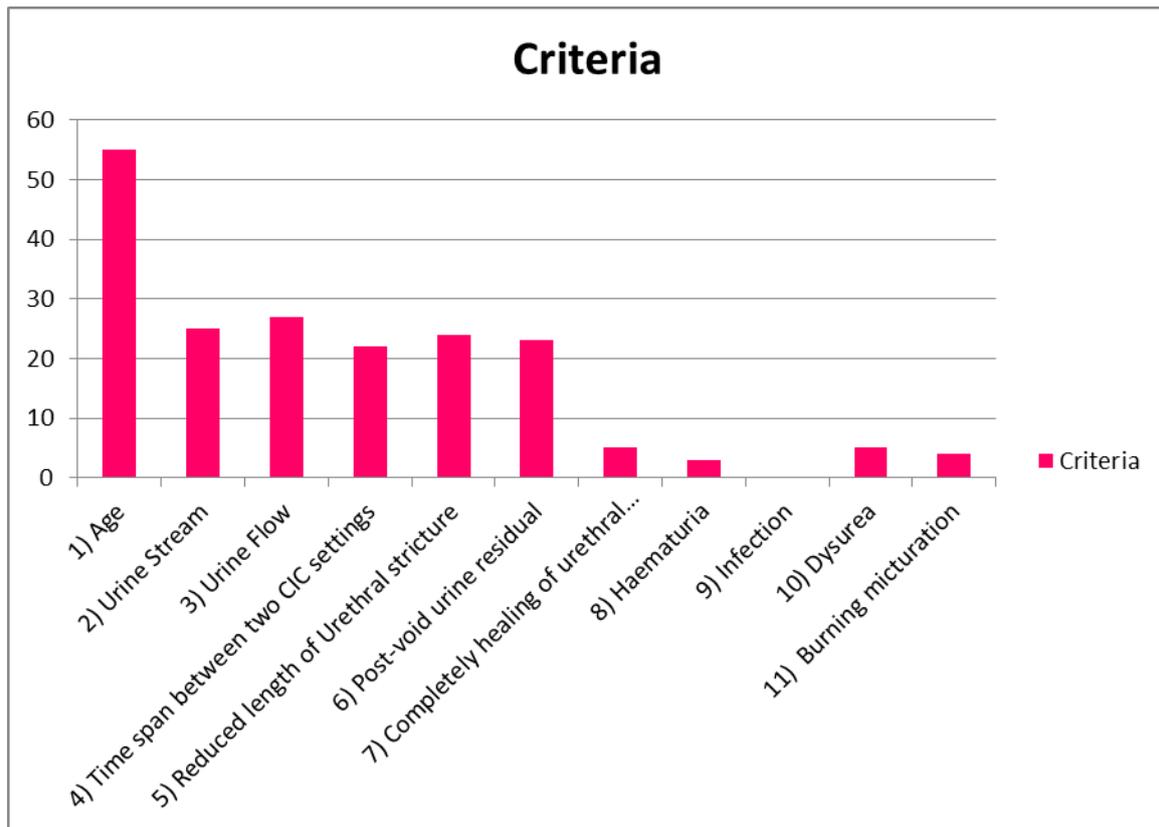
11) Burning micturation – (Post Uttar-Basti procedure)

Total no. of Patients	Present	Not Present	Result in %
30	4	26	86.66 %



12) Master Table

	Criteria		Result in %
1	Age	Mean Value – 55	-
2	Urine Stream	25	83.33 %
3	Urine Flow	27	90 %
4	Time span between two CIC settings	22	73.33 %
5	Reduced length of Urethral stricture	24	80 %
6	Post-void urine residual	23	76.66 %
7	Completely healing of urethral stricture	5	16.66 %
8	Haematuria	3	90 %
9	Infection	0	100 %
10	Dysurea	5	83.33 %
11	Burning micturation	4	86.66 %



RESULT

- Age wise selection of patients according to inclusive criteria done,
- Urine stream is increased in 83.33 % of the patients,
- Urine flow is increased in 90.00 % of patients,
- Time span between two CIC settings increased in 73.33 % of patients,
- Length of urethral stricture is reduced in 80 % of patients,
- Post void urine residual decreased ≤ 50 ml in 76.66 % of patients,
- Complete healing of urethral stricture in 16.66 %, partial healing in 63.33 % & no healing in 20 % of patients, but they need more settings of *Traivruttam tail – Uttar basti*,
- Haematuria was present only in 10 % of patients in their post procedure first urination,
- Infection (Post Procedure) not found in single patient,
- Dysurea was present only in 16.66 % of patients in their post procedure first urination,
- Burning micturition was present only in 13.33 % of patients in their post procedure first urination.

OBSERVATION

Certainly patients are get benefitted & less suffered symptomatically from *Traivruttam tail - Uttar Basti*. Oleation of *Traivruttam tail* is persists for long time, which is definitely helpful for patient to tolerate catheters & dilators. In every post procedures symptoms like haematuria, urethral stricture, dysurea & burning micturition was found minimally. No infection was found in a single patient. No any complications were

found of *Trivruttam Tail –Uttar basti* during the entire study except mild dysuria during post procedure first urination. The results of *Uttar basti* is depends on irrespective of site, size, and extent of the stricture. Rarely, in some patients, the flow & stream of urine gets compromised, after some time (a few months to years) of the *Uttar-basti* procedure & they may require additional settings of *Uttar-basti*. This *Trivruttam Tail* stops the fibrosis process of scar of urethra & promote epithelization in the urethral strictured area. Further studies are needed to confirm this data & recurrence evaluation but recurrence of urethral stricture after *Uttar-basti* course has rarely seen.

Finally we can say that there is more relief by giving *Traivruttam Tail - Uttar Basti* in Stricture Urethra. This *Uttar Basti* procedure may prove a very promising treatment for LUTS as well as urethral stricture.

DISCUSSION

Success depends on the epithelialization process, before wound contraction, significantly increases the urethral lumen caliber. Complications include recurrence of stricture, which is the most common complication; bleeding; and extravasation of irrigation fluid into perispongial tissues, thus increasing the fibrotic response. Longer periods & unnecessary catheterization have been shown to increase failure rates. So we didn't put catheter after *Uttar basti*.

Warm *Trivruttam Tail* 40 ml is used because warmness penetrates the fibrosed scar of urethral stricture & make

it loose & helps to start epithelization process in urethra. This *Uttar basti* procedure is non-invasive with minimal handling, no pain procedure. It doesn't require anaesthesia, no need of Urethral catheterization, OPD basis procedure. No need of Hospitalization, rest required, less chances of recurrence.

Precautions to be taken during & after the treatment of *Uttar-basti*

- ✓ Drink a lot of water to keep urine clean,
- ✓ The urge of urine should neither be ignored nor be forced,
- ✓ Avoid any kind of sexual activity during & at least for three months after *Uttar-basti*
- ✓ Avoid unnecessary catheterization or instrumentation in the urethra. For the patient of CIC, may allowed as per requirement.
- ✓ Avoid spicy, Sour tasted, fast, junk & unhygienic food during the course of *Uttar-Basti*.

Results of *Uttar-basti* treatment may vary from patient to patient & assessed clinically and radiologically by comparison between pre and post-treatment investigations like Urethrogram, Uro-flowmetry & USG. These investigations should be done- before & after completion of the treatment. (Generally on 1st & 30th day of the treatment).

This proves that, *Uttar - basti* procedure will set as '**Gold Standard**' treatment for urethral stricture.

CONCLUSION

The proposed *Uttar-basti* technique is simple, safe, non-invasive and inexpensive procedure for the treatment of Stricture Urethra.

Traivruttam Tail (Oil) *Uttar- Basti* have a great significance in the treatment of Stricture Urethra.

Data Availability

Data are available from the corresponding author.

ACKNOWLEDGEMENT

The authors are highly acknowledges Chaitanya Ayurveda College and Hospital, Bhusaval, Maharashtra for the infrastructure provided for this work. The authors also thank to Dr. Manik B. Patil, Principal of this institute for his their guidance and support.

Disclaimer

The Institutes, where this study was performed, belong to a charitable organization engaged in health and education services in the region. The medications used in this study are common classical Ayurvedic recipes (open access); these are not branded/ proprietary medicines of any company.

Conflicts of Interest

The authors declare that they have no conflicts of interest & none source of funding.

Patient consent

Written permission for publication of this case study has been obtained from the patient.

Patient's perspective

Patient was satisfied with the given treatment.

Credit author statement-

Conceptualization: Dr. Maheshkumar N. Chaudhari
Methodology: Dr. Maheshkumar N. Chaudhari
Investigation: Dr. Maheshkumar N. Chaudhari
Writing - Original Draft: Dr. Mrudula M. Chaudhari
Review & Editing: Dr. Maheshkumar N. Chaudhari
Guarantee: Dr. Maheshkumar N. Chaudhari

Sources of Funding- This case report received no funding.

Declaration of competing interest-

The authors declare that they have no competing interests.

Declaration of generative AI in scientific writing-

No generative AI was used for scientific writing.

Author Disclosure Statement

No competing financial interest exist.

Funding Information

No funding was received for this study.

REFERENCES

1. Sushruta Samhita – Ayurveda Tatva Sandipika – Hindi Vyakhya – Part- II, by Kaviraj Dr. Ambikadatta Shastri, Chaukhambha Sanskrit Sansthan, Varanasi, 11th edition 1997, Adhyay-58, Shlok no.- 15-16, Page no. 425.
2. Sushruta Samhita – Ayurveda Tatva Sandipika – Hindi Vyakhya – Part- II, by Kaviraj Dr. Ambikadatta Shastri, Chaukhambha Sanskrit Sansthan, Varanasi, 11th edition 1997, Adhyay-58, Shlok no.- 27 - 28, Page no. 427.
3. Sushruta Samhita – Ayurveda Tatva Sandipika – Hindi Vyakhya – Part- II, by Kaviraj Dr. Ambikadatta Shastri, Chaukhambha Sanskrit Sansthan, Varanasi, 11th edition 1997, Adhyay-58, Shlok no.- 49 - 50, Page no. 429.
4. Sushruta Samhita – Ayurveda Tatva Sandipika – Hindi Vyakhya – Part- II, by Kaviraj Dr. Ambikadatta Shastri, Chaukhambha Sanskrit Sansthan, Varanasi, 11th edition 1997, Adhyay-59, Shlok no.- 8, Page no. 433.
5. Sushruta Samhita – Ayurveda Tatva Sandipika – Hindi Vyakhya – Part- II, by Kaviraj Dr. Ambikadatta Shastri, Chaukhambha Sanskrit Sansthan, Varanasi, 11th edition 1997, Adhyay-59, Shlok no.- 17 - 18, Page no. 434.
6. Dr. Maheshkumar N. Chaudhari - Management of Benign Enlargement of Prostate (BEP) by *Dashmool tail Uttar-Basti* – A clinical review study. European

Journal of Pharmaceutical and Medical Research,
Volume-IX, Issue- - 12, February 2022 Page No.
226-233 www.ejpmr.com

7. https://www.google.com/search?q=stricture+urethra&sca_esv=88efb82a0fd29766&sca_upv=1&rlz=1C1CHBD_enIN1067IN1069&sxsr=ACQVn0-
8. <https://emedicine.medscape.com/article/450903-overview?form=fpf#a12>
9. Parker DC, Simhan J. Management of complications after surgical outlet reduction for benign prostatic obstruction. *Can J Urol*, 2015 Oct; 22(5 Suppl 1): 88-92. [QxMD MEDLINE Link].
10. Al Taweel W, Seyam R. Visual Internal Urethrotomy for Adult Male Urethral Stricture Has Poor Long-Term Results. *Adv Urol*, 2015; 2015: 656459. [QxMD MEDLINE Link].
11. Odoemene CA, Okere P. One-stage Anastomotic Urethroplasty for Traumatic Urethral Strictures, January 2004-January 2013. *Niger J Surg*. 2015 Jul-Dec. 21(2): 124-9. [QxMD MEDLINE Link].
12. Liu JS, Hofer MD, Oberlin DT, Milose J, Flury SC, Morey AF, et al. Practice Patterns in the Treatment of Urethral Stricture Among American Urologists: A Paradigm Change?. *Urology*, 2015 Oct. 86(4): 830-4. [QxMD MEDLINE Link].
13. Davis NF, Quinlan MR, Bhatt NR, Browne C, MacCraith E, Manecksha R, et al. Incidence, Cost, Complications and Clinical Outcomes of Iatrogenic Urethral Catheterization Injuries: A Prospective Multi-Institutional Study. *J Urol*, 2016 Nov; 196(5): 1473-1477. [QxMD MEDLINE Link].
14. Hofer MD, Zhao LC, Morey AF, Scott JF, Chang AJ, Brandes SB, et al. Outcomes after urethroplasty for radiotherapy induced bulbomembranous urethral stricture disease. *J Urol*, 2014 May; 191(5): 1307-12. [QxMD MEDLINE Link].
15. Steenkamp JW, Heyns CF, de Kock ML. Internal urethrotomy versus dilation as treatment for male urethral strictures: a prospective, randomized comparison. *J Urol*, 1997 Jan; 157(1): 98-101. [QxMD MEDLINE Link].
16. Milroy E, Allen A. Long-term results of urolume urethral stent for recurrent urethral strictures. *J Urol*, 1996 Mar. 155(3): 904-8. [QxMD MEDLINE Link].
17. Mundy AR. Management of urethral strictures. *Postgrad Med J.*, Aug 2006; 82(970): 489-9. [QxMD MEDLINE Link].