

**MANAGEMENT OF POST TURP URETHRAL STRICTURE WITH YASTIMADHU
TAILA UTTARA BASTI – A CASE STUDY****Dr. Kulkarni Vedant Mangesh^{1*}, Dr. Manjunath S. Naregal², Dr. Shankar S.³**¹3rd Year PG Scholar, Department of Shalya Tantra, SDM Institute of Ayurveda and Hospital, Bengaluru, India.²Assistant Professor, Department of Shalya Tantra, SDM Institute of Ayurveda and Hospital, Bengaluru, India.³Professor, HOD Department of Shalya Tantra, SDM Institute of Ayurveda and Hospital, Bengaluru, India.***Corresponding Author: Dr. Kulkarni Vedant Mangesh**

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DOI: <https://doi.org/10.5281/zenodo.23830021>**How to cite this Article:** Dr. Kulkarni Vedant Mangesh^{1*}, Dr. Manjunath S. Naregal², Dr. Shankar S.³. (2026). Management of Post Turp Urethral Stricture With Yastimadhu Taila Uttara Basti - A Case Study. World Journal of Pharmaceutical and Medical Research, 12(11), 355–360.

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Article Received on 01/10/2026

Article Revised on 22/10/2026

Article Published on 01/11/2026

ABSTRACT

Introduction: Despite recent innovations Transurethral Resection of Prostate (TURP) is considered as Gold Standard procedure in treatment of Benign Prostate Hyperplasia (BPH) since decades. Post-TURP urethral stricture (PTS) is one of the well-documented delayed complications following TURP. The global incidence rate of PTS ranges between 2.2% - 9.8%, in India the rate is between 4.3% - 11%. In Ayurveda the symptoms of stricture can be co related to mutrasangha type of mutraghata. Acharya Sushruta has explained use of Uttar Basti in treatment of Mutraghata. **Material & Method:** A Male patient with h/o TURP 2 months back presented to OPD with Lower Urinary Tract Symptoms (LUTS) details of which a furnished in paper. **Treatment:** Patient was Treated with Uttarbasti with Yastimadhu Taila for 7 days. **Results:** Clinically Significant result were observed with reduction in IPSS score by 14 points. **Discussion:** Urinary Bladder is sthana for Apana Vayu and there is vata kapha dushti in case of mutrasangha Yastimadhu taila due to its Kapha & vatahara property is useful in this condition.

KEYWORDS: Post TURP Stricture, Urethral Stricture, BPH, Mutraghata, Uttara Basti.**INTRODUCTION**

Benign prostatic hyperplasia (BPH) is a ubiquitous health condition affecting aging men worldwide. While transurethral resection of the prostate (TURP) remains the definitive surgical reference standard for lower urinary tract obstruction secondary to BPH, post-TURP urethral stricture (PTS) continues to pose a persistent clinical dilemma.^[1,2] The reported prevalence of post-TURP urethral strictures and bladder neck contractures ranges between 2.2%–9% globally and 4.4%–11% in India.^[2,3] Stricture formation following electrosurgery is primarily driven by thermal mucosal trauma, stray electrical currents, mucosal ischemia from large instrument sheaths, and subsequent fibroblastic proliferation during wound healing.^[3,4]

Conventional urological management of PTS relies on repeated mechanical urethral dilatation, direct vision internal urethrotomy (DVIU), or complex reconstructive urethroplasty.^[4,5] However, repeat dilatations and

urethrotomies frequently induce secondary micro-trauma, precipitating a recurrent cycle of spongiofibrosis and resticture formation, with recurrence rates exceeding 50% within two years.^[5]

In Ayurveda, conditions presenting with urinary retention, hesitancy, and flow obstruction are categorized under Mutraghata, specifically corresponding to Mutrasangha.^[6,7] According to Sushruta Samhita, Mutrasangha arises due to vitiated Vata Dosha (Viguna Anila or Vimargagami Vata) obstructing the urinary passages.^[6,8] Classical management guidelines promulgated by Acharya Sushruta advocate for both systemic interventions (Kashaya, Kalka, Kshara, Snehana, Swedana) and local targeted therapies, paramount among which is Uttara Basti—the instillation of medicated oils or decoctions directly into the lower genitourinary tract.^[6,9]

Uttara Basti functions not merely as a mechanical instillate, but as a specialized, organ-targeted lipid-based drug delivery system.^[9,10] Yastimadhu Taila, possesses marked Vata-Pitta Shamaka, Vrana Ropana, Sothahara, and Mridukara characteristics.^[10,11]

This case report documents the clinical management, procedural methodology, and therapeutic outcomes of a post-TURP bulbar-penile urethral stricture treated with Yastimadhu Taila Uttara Basti.

Patient Information

A 68-year-old male presented to the outpatient department of Shalya Tantra complaining of progressive voiding difficulty for one month. His symptoms included a markedly weak urinary stream, a sensation of incomplete bladder emptying, severe urinary urgency, post-micturition dribbling, increased daytime frequency, and distressing nocturia. Additionally, over the preceding two weeks, the patient experienced upper gastrointestinal distress, including heartburn, abdominal bloating, sour belching, and chronic constipation.

The patient was a known case of essential hypertension and type 2 diabetes mellitus, both managed on regular oral hypoglycaemic and antihypertensive medications. He had a history of symptomatic BPH, for which he underwent an uneventful bipolar TURP at a tertiary care urology centre approximately two and a half months prior (August 12, 2025).

Following surgery, the patient failed to achieve satisfactory symptomatic relief. By mid-September 2025, his voiding parameters deteriorated significantly, characterized by severe straining and pronounced dribbling. On September 26, 2025, he underwent diagnostic cystoscopy and mechanical urethral dilatation at the operating hospital. Although transient symptomatic improvement was achieved, severe LUTS relapsed within two weeks (October 10, 2025). Seeking non-surgical alternative care, the patient reported to our hospital on October 25, 2025, and was admitted for inpatient Ayurvedic evaluation and management.

Clinical Findings & Diagnostic Assessment

Physical Examination

On general examination, the patient was conscious, oriented, and hemodynamically stable (Blood Pressure: 130/80 mmHg, Pulse Rate: 74 beats/min).

Systemic physical examination revealed no pallor, icterus, cyanosis, clubbing, lymphadenopathy, or peripheral pedal oedema.

Examination of the cardiovascular and respiratory systems was within normal limits.

Per-abdominal examination showed a soft, non-tender abdomen with a resonant percussion note and no palpable suprapubic bladder distension.

Local examination of the external genitalia revealed circumcised anatomy with a normal external urethral meatus devoid of erythema, discharge, or palpable periurethral induration. The patient reported a daytime voiding frequency of 9 to 12 times and a night time frequency of 4 times.

Diagnostic Evaluation and Baseline Scoring

At the time of admission, the baseline severity of lower urinary tract symptoms was quantified using the validated International Prostate Symptom Score (IPSS). The patient recorded a baseline total IPSS score of 31 out of 35, categorizing his condition as severe LUTS (Table 1).

Diagnostic Exploratory Procedure

On Day 1 of intervention, under full aseptic precautions, local exploration of the urethral lumen was performed using a sterile 6 French (FG) feeding tube lubricated with 2% lignocaine gel. Mechanical obstruction was encountered at 5 cm distal to the external urethral meatus. Gentle advancement caused the feeding tube to kink at 5 cm and 16 cm positions.

The procedure elicited localized burning pain, and a few drops of blood were observed on the gauze piece, confirming a narrow, friable, strictured segment within the urethra.

Timeline of Events

August 12, 2025: Patient underwent bipolar TURP for BPH at a conventional medical facility.

August 27, 2025: Persistent post-operative voiding dysfunction; minimal relief from pre-surgical LUTS.

September 26, 2025: Mechanical urethral dilatation and diagnostic cystoscopy performed.

October 10, 2025: Rapid relapse of severe obstructive urinary symptoms.

October 25, 2025: Admitted to our institution; baseline IPSS recorded as 31/35.

October 26, 2025 (Day 1): Diagnostic Uttara Basti attempt; 6FG tube obstruction noted at 5 cm with minor mucosal haemorrhage.

October 27 – 31, 2025 (Days 2–6): Daily Uttara Basti with Yastimadhu Taila administered in escalating doses (5 mL to 17 mL); bleeding resolved immediately on Day 2.

November 1, 2025 (Day 7): Smooth negotiation of 6FG feeding tube up to 22 cm; 20 mL Yastimadhu Taila instilled. Patient discharged on oral medications.

November 15, 2025: Follow-up visit 1; maintained stable urinary stream, no recurrent bleeding.

December 12, 2025: Follow-up visit 2; symptom relief maintained without relapse.

December 29, 2025: Reassessment of IPSS score (reduced to 14/35); patient telephonic feedback recorded. Scheduled for second sitting of Uttara Basti.

January 7, 2026: Patient tragically expired in a road traffic accident while traveling from his hometown.

Therapeutic Intervention

The treatment plan comprised a 7-day course of local intraurethral Uttara Basti coupled with systemic oral Ayurvedic medications.

Procedure: Uttara Basti Materials Required

Sterile feeding tube (6FG), Povidone-iodine solution IP 10% (Betadine), Sterile latex surgical gloves and drapes, Sterile hypodermic syringes (10 mL and 2 mL), Lignocaine Hydrochloride Gel 2% (Xylocaine), Luke-

warm sterile Yastimadhu Taila, Sterile gauze sponges and gallipots.

Purva karma

The procedure was conducted in an operation theatre under strict aseptic conditions. The patient was instructed to void urine prior to the procedure. He was placed in a comfortable supine position with legs slightly abducted. The penile shaft, glans, and perineal region were scrubbed with 10% povidone-iodine solution and draped with sterile towels. Approximately 3–5 mL of 2% lignocaine jelly was instilled intraurethrally using a sterile syringe and retained for 3 to 5 minutes for local anaesthesia and mucosal lubrication.

Pradhan Karma

Day 1: Attempted catheterization with a 6FG feeding tube encountered stricture resistance at 5 cm, resulting in tube bending and minor mucosal contact bleeding. Intraurethral instillation of warm Yastimadhu Taila was initiated directly via the meatus.

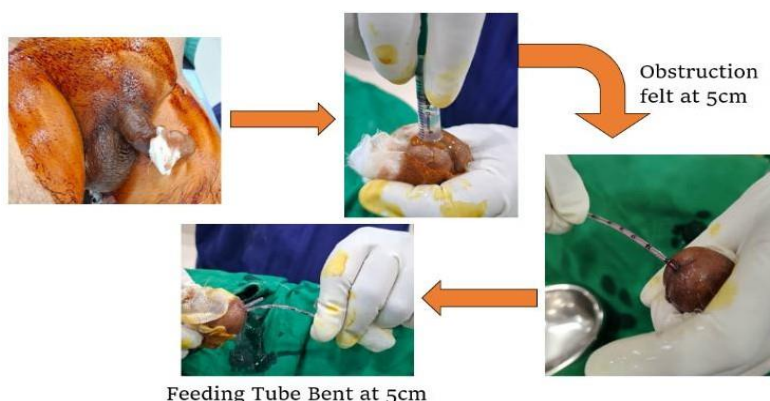


Fig 1: Procedure on Day 1.

Days 2 to 6 (Arohana Matra): Yastimadhu Taila was instilled directly into the urethral meatus under gentle, controlled manual hydrostatic pressure using a syringe fitted with a soft nozzle adapter. The volume of oil was escalated daily as tolerated:

Day 2: 5 mL (mucosal bleeding ceased entirely)

Day 3: 7.5 mL

Day 4: 10 mL

Day 5: 15 mL

Day 6: 17 mL



Fig 2: Day 2 to Day 6.

Following instillation, gentle penile compression at the meatus was maintained, and the patient remained in a supine position for 45 minutes to facilitate gravitational pooling, mucosal contact, and lipid absorption across the strictured segment. Transient, mild burning discomfort was noted only during active instillation.

Day 7: Under identical aseptic conditions, a 6FG sterile feeding tube was gently introduced. The tube negotiated past the previously obstructed 5 cm segment smoothly and advanced without resistance up to 22 cm into the proximal urethra/bladder neck. A full therapeutic dose of 20 mL warm Yastimadhu Taila was successfully instilled through the lumen of the feeding tube.



Day 7

- FG 6 Feeding tube passed easily up to 22cm
- Uttar basti done with 20 ml Yastimadhu taila through feeding tube

Fig. 3: Day 7 of Procedure.

Paschat Karma

The patient was observed for 30 minutes post-procedure for any adverse events, such as acute urinary retention, severe dysuria, or haematuria. Vital signs remained stable throughout.

Shaman Aushadhis (Oral Medications)

Chandraprabha Vati: 1 tablet (500 mg) thrice daily after meals with lukewarm water.

Varunadi Kashaya: 15 mL thrice daily before meals, diluted with 45 mL warm water, combined with 1 pinch of Yava Kshara.

Tab Anuloma DS: 1 tablet at bedtime after meals (Vata Anulomana, laxative to prevent straining during defecation).

Sukumara Ghrita: 1 teaspoonful (~5 mL) twice daily, administered immediately before and after breakfast

(prescribed at discharge to heal upper GI mucosal irritation, heartburn, belching, and chronic constipation).

Outcomes and Follow-up

The patient exhibited steady clinical recovery throughout the 7-day inpatient procedure and subsequent outpatient follow-up period:

Resolution of Haemorrhage and Irritation: Local mucosal micro-haemorrhage and mechanical friability encountered on Day 1 were completely resolved by Day 2 following the initial instillation of Yastimadhu Taila.

Restoration of Luminal Patency: On Day 7, complete anatomical patency for a 6FG catheter was re-established up to 22 cm, confirming significant dissolution or softening of the stricture ring.

Table 1: Baseline and Post-Treatment IPSS Sub-Scores.

IPSS Symptom Parameter	Baseline Score (25 Oct 2025)	Post-Treatment Score (29 Dec 2025)
Incomplete Emptying	5 (Almost always)	1 (Less than 1 time in 5)
Frequency	4 (More than half the time)	2 (Less than half the time)
Intermittency	5 (Almost always)	1 (Less than 1 time in 5)
Urgency	4 (More than half the time)	3 (About half the time)
Weak Stream	5 (Almost always)	1 (Less than 1 time in 5)
Straining	4 (More than half the time)	2 (Less than half the time)
Nocturia	4 (4 times per night)	4 (4 times per night)
Total IPSS Score	31 / 35 (Severe)	14 / 35 (Moderate)

Objective IPSS Reduction: Reassessment of the IPSS on December 29, 2025 (2 months post-discharge) demonstrated a marked decrease in total score from 31 (severe symptoms) to 14 (moderate symptoms), representing a 54.8% reduction in overall symptom severity.

Marked Improvement: Incomplete emptying score dropped from 5 to 1; Intermittency dropped from 5 to 1; Weak stream dropped from 5 to 1.

Moderate Improvement: Daytime frequency reduced from 4 to 2; Straining reduced from 4 to 2.

Refractory Parameters: Urgency showed marginal change (4 to 3), while Nocturia remained unchanged at 4 times per night. This refractory behaviour likely reflects persistent post-obstructive detrusor muscle instability or age-related nocturnal polyuria rather than mechanical urethral obstruction.

Gastrointestinal Symptoms: Upper GI distress (heartburn, sour belching, bloating) and chronic constipation were resolved following the addition of Sukumara Ghrita and Anuloma DS.

Long-Term Status: The patient remained symptomatically stable through December 2025 without

signs of resticturing or voiding deterioration. A second sitting of Uttara Basti was planned for early January 2026. However, on January 7, 2026, the patient unfortunately succumbed to fatal injuries sustained in a road traffic accident while traveling from his native town.

DISCUSSION

Post-TURP urethral stricture represents a secondary iatrogenic pathology arising from thermal energy dispersion, mucosal deep burns, and circumferential ischemic scarring within the prostatic urethral junction or bulbo-membranous urethra.^[2,3] Mechanical dilatation or visual urethrotomy temporarily tears the scar ring; however, subsequent secondary healing via myofibroblast activity frequently leads to recurrent dense spongiofibrosis.^[4,5]

Samprapti Vighatana

In Ayurvedic literature, Mutrasangha is detailed as a condition where Viguna Vata (particularly Apana Vata) lodges in the Bastimukha.^[6,7] The thermal surgical trauma from TURP acts as an Agantukjanya Vrana, leading to localized Pitta-Rakta aggravation coupled with severe Vata vitiation.^[7,8] This results in Sankocha (constriction/narrowing) and Kharatva (roughness/induration) of the urethral passage (Mutramarga), manifesting as severe outflow obstruction.^[6,8]

Yastimadhu Taila Uttara Basti achieves therapeutic breakdown of this disease process through its specific properties:

Yastimadhu (*Glycyrrhiza glabra*): Possesses Madhura Rasa, Guru-Snigdha Guna, Sheeta Virya, and Madhura Vipaka. It acts as a potent Vata-Pitta Shamaka, Vrana Ropana, Vrana Shothahara, and Sothahara agent.^[11,12]

Tila Taila (Sesame Oil base): Possesses Vyavayi, Vikasi, Sukshma, and Vata-hara attributes, allowing deep cellular tissue penetration (Srotogami) to soften indurated fibrotic tissues.^[9,10]

By administering Yastimadhu Taila via Uttara Basti, the Snigdha and Sheeta properties directly counteract the Ruksha, Khara, and hyper-inflammatory attributes of the strictured scar tissue.^[10,11]

Biomolecular and Pharmacological Mechanisms

The therapeutic efficacy of Yastimadhu Taila Uttara Basti observed in this case can be explained through modern bio-pharmacological and biomechanical mechanisms:

Anti-Inflammatory Cascade: Licorice roots contain rich concentrations of triterpenoid saponins (glycyrrhizin, 18 β -glycyrrhetic acid) and active flavonoids (glabridin, liquiritigenin, isoliquiritigenin).^[12,13] Glycyrrhizin and its metabolite 18 β -glycyrrhetic acid are documented inhibitors of nuclear factor kappa B (NF- κ B), cyclooxygenase-2 (COX-2), and inducible nitric oxide

synthase (iNOS).^[12,14] By blunting NF- κ B transcription, Yastimadhu suppresses downstream expression of pro-inflammatory cytokines, including TNF- α , IL-1 β , and IL-6, thereby arresting persistent mucosal inflammation and contact bleeding.^[13,14]

Anti-Fibrotic Signaling and Matrix Remodeling:

Urethral stricture pathogenesis is driven by Transforming Growth Factor-beta 1 (TGF- β 1), which triggers fibroblast trans-differentiation into α -smooth muscle actin (α -SMA)-expressing myofibroblasts, causing excessive deposition of dense, disorganized Collagen Type I and Type III (spongiofibrosis).^[1,15] Phytochemical studies demonstrate that glabridin and isoliquiritigenin downregulate TGF- β 1-induced Smad2/3 phosphorylation, effectively inhibiting myofibroblast proliferation and extracellular matrix accumulation.^[13,15] Furthermore, Yastimadhu compounds modulate the ratio of Matrix Metalloproteinases (MMPs) to Tissue Inhibitors of Metalloproteinases (TIMPs), promoting enzymatic degradation and softening of established fibrous scar tissue.^[14,15]

Lipid-Mediated Trans-Epithelial Delivery: Sesame oil (Tila Taila) serves as an ideal lipophilic vehicle rich in unsaturated fatty acids (linoleic and oleic acids) and natural lipophilic antioxidants (sesamin, sesamol).^[10,11] The lipid vehicle readily diffuses across the urothelial mucosal barrier into the underlying tunica spongiosa, delivering lipophilic triterpenoids directly to the site of fibrotic injury.^[10,16]

Hydrostatic Lubrication and Mechanical Dilation:

Administering oil via Uttara Basti under gentle manual pressure generates hydraulic pressure within the urethral lumen.^[9,10] Retaining 15–20 mL of oil for 45 minutes exerts a continuous radial outward hydrostatic force across the narrowed segment. This atraumatic radial pressure distends the stricture without causing the shearing micro-lacerations typical of rigid metal or sound dilators, allowing the catheter to pass smoothly by Day 7.^[10,17] Additionally, the oil coats the urethral urothelium, forming a hydrophobic barrier that shields healing tissue from the irritating, acidic, and hyperosmolar properties of excreted urine.^[9,16]

Role of Shaman Aushadhis

The oral medications played an important supportive role in this recovery:

Chandraprabha Vati provided systemic anti-inflammatory, urinary antiseptic, and mild diuretic effects, reducing bladder neck hyper-excitability.^[11,18]

Varunadi Kashaya supplemented with Yava Kshara exerted potent Chedana (scraping/fibrolytic) and lithontriptic actions, aiding in the breakdown of dense mucosal deposits and improving detrusor contractility.^[7,18]

Tab Anuloma DS and Sukumara Ghrita successfully addressed the patient's co-existing constipation and upper GI distress. By ensuring smooth bowel movements (Anulomana), these agents prevented increased intra-abdominal pressure during defecation, which can otherwise exacerbate pelvic floor muscle strain and urinary outflow resistance.^[11,18]

Patient Perspective

During a routine follow-up telephonic assessment conducted on December 29, 2025, the patient shared the following feedback regarding his recovery:

"I feel very relieved of my symptoms and my urine flow has improved immensely. Looking back at how much I suffered after my prostate surgery and urethral dilatation, I feel I should have opted for Ayurveda in the beginning itself instead of undergoing surgery."

Informed Consent

Written informed consent was explicitly obtained from the patient on November 30, 2025. The consent authorized the clinical team to record, utilize, and publish his anonymized medical history, diagnostic findings, procedural photographs, and symptom scores for academic and scientific publication purposes.

CONCLUSION

This case demonstrates that intraurethral Uttara Basti using Yastimadhu Taila, combined with targeted oral Ayurvedic pharmacotherapy, effectively managed a post-TURP urethral stricture. The intervention successfully restored urethral patency, prevented post-dilatation restenosis, and led to a clinically meaningful reduction in IPSS score from 31 to 14.

Uttara Basti functions as an organ-specific drug delivery route that combines gentle hydrostatic mechanical dilatation with anti-inflammatory, anti-fibrotic, and tissue-softening pharmacological actions. Given its safety profile, cost-effectiveness, and non-invasive nature, Yastimadhu Taila Uttara Basti represents a promising therapeutic alternative or adjunctive option for post-surgical urethral strictures. Controlled, prospective clinical trials with larger sample sizes and long-term radiological follow-up (e.g., retrograde urethrography and uroflowmetry) are warranted to establish standardized clinical protocols.

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