

Urological Commentary on Ketamine-Associated Uropathy

To the Editor: I read with interest the review by Andrade¹ on ketamine-associated uropathy in therapeutic and nontherapeutic settings. From a urological standpoint, the article raises important considerations but also highlights key gaps that deserve clarification.

The high prevalence of lower urinary tract symptoms and upper tract involvement among recreational users—reported at up to 77% and 30%, respectively—reflects findings from urological cohort studies and systematic reviews.^{2–5} However, these estimates are largely drawn from heavy-use populations referred for specialist care and may overstate risk among individuals receiving structured therapeutic treatment. Nevertheless, the assumption that prescribed ketamine carries negligible urological risk is not fully supported by the evidence. Emerging data from psychiatric cohorts and several documented cases indicate that ketamine-induced cystitis can occur even with supervised medical dosing.^{6–9} The absence of robust evidence does not justify definitive reassurance.

Mechanistically, Andrade highlights urothelial toxicity, inflammation, and fibrosis, which are well established in urological research.⁸ What warrants emphasis is that once fibrosis and bladder contraction occur, recovery is often incomplete even with abstinence. Centers in high-prevalence regions report progression to upper tract deterioration and the need for surgical reconstruction despite cessation.⁴ This underscores the importance of early detection rather than reactive management.

Monitoring recommendations in psychiatric practice remain variable. From a urological perspective, structured surveillance—routine symptom review, urinalysis, and low thresholds for imaging—is overdue for patients receiving long-term ketamine therapy.^{3,8,10–12} This applies particularly to frequent-dose regimens, where cumulative exposure may be substantial. Relying solely on hydration advice or passive symptom reporting risks missing reversible stages of urothelial injury.

A further point insufficiently emphasized in the review is the necessity of multidisciplinary care. The British Association of Urological Surgeons highlights abstinence as the cornerstone of management, but relapse and inconsistent follow-up remain significant challenges for both recreational and therapeutic users.² Effective care requires coordinated involvement of urology, psychiatry, and addiction medicine—an approach not yet standardized across services.

In summary, while Andrade offers a timely synthesis, the urological literature suggests that ketamine-associated uropathy poses a low but meaningful risk even in therapeutic settings. Preventing irreversible bladder damage requires earlier surveillance, clear referral pathways, and closer collaboration between specialties. Prospective longitudinal studies are now essential to define true incidence, identify early markers of urothelial injury, and develop evidence-based monitoring protocols.

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Asem Abdelrahman, MBChB, MRCS

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Author Affiliations: Department of Urology, St George's University Hospitals, London, United Kingdom.

Corresponding Author: Asem Abdelrahman, MBChB, MRCS, St George's University Hospitals, Urology, Blackshaw Rd, London, SW17 0RE United Kingdom (asem.abdelrahman@nhs.net).

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