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Letter to the Editor

Deepithelized glans reconfiguration: A kaleidoscopic view considering the protopathic sensibility of the glans penis

We read the recent article by Alshammari et al. [1] with great interest and would like to congratulate the authors for presenting their new technique. However, there are certain issues that need to be highlighted. First, the authors have re-emphasized our previous work [2] and have mentioned that the penile urethra actually terminates at the mid glans level, and not the tip of the glans. However, they have failed to replicate and follow one of the major conclusions of that paper, i.e. glans wings are separated by the septum glandis and the frenulum. A complete glans wrap all around the urethra is non-anatomical and is counterproductive [3]. Second, we have strong reservations regarding this technique, which appears to be more of a glans reduction rather than reconfiguration. It is believed that the cosmesis will be unfavorable in long term due to loss of glanular tissue on the ventral aspect. It can lead to varying degrees of glanular tilt (in a resting state or during erection) which dissolves the purpose of this new technique. We will be eager to look at the long-term results and not just a maximum follow-up of 12 months. Third, the deepithelization of the glans comes with a cost. Although the authors have highlighted a strategy of careful deepithelization superficial to the spongiosum, it is impossible to prevent the loss of sensory corpuscles. The genital end bulbs, which are predominant in the corona glandis and frenulum will suffer a major loss while performing this technique [4]. Finally, this technique described by the authors has similarities with the original description of the glans approximation procedure (GAP) procedure by Zaontz et al. [5]. Both have utilized the principle of partial deepithelization of the glans penis.

We would also like to bring to your attention the following classification of the glans penis which we feel is very important in glans and glanular-urethral reconstruction. As per the classification, the glans is divided into 4 regions: 1-the apex with the fossa navicularis at the center and the expanded cone of corpus spongiosum surrounding it, 2-the dorsal part of the glans at the level of termination of corpora cavernosa, 3-the corona glandis, and 4-the frenulum and its point of reflection onto the ventral surface of the glans [4]. The addition of the distal ligament of the dorsal side and the septum glandis around the meatus and between the glans wings ventrally complete this classification [2].

It is also noteworthy that the embryological development of the glans lasts 6—12 months after birth. This stage of development is usually intervened by the healthcare providers, in particular by us, the surgeons. We believe that the non-retractable foreskin in the newborn and the release of the foreskin due to the dissolution of "glandar lamella" or "glandopreputial lamella" play a crucial role in the normal development of the glans epithelium and its unique sensorineural features [4,6]. It must also be mentioned that this process is important for the development of the frenulum and/or the frenular triangle, which is the most sensitive and erogenous part of the penis during sexual intercourse. Therefore, in order to achieve optimal functional results (in terms of sexual satisfaction), it is imperative that these regions of the glans penis and the foreskin should undergo a reconstruction that resembles the normal anatomy [3]. Thus, it is high time to start scrutinizing the newer procedures and techniques such that they don't impair the protopathic sensibility of the glans penis.

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