



Letter to the Editor

Surgical process variables for the classification of hypospadias



I read the article published by the Western Pediatric Urology Consortium (WPUC) network on identifying variability in surgical practices and instruments used for hypospadias repair [1]. Despite the authors' efforts, I think it is not possible to use this study to understand what variables can be reliably measured for future surgical outcomes in hypospadias. There are mainly two types of variables to measure in surgical research studies: patient outcomes and surgical process. In fact, almost all "variables" in this study are patient, surgeon and procedure-related confounding variables and/or contributing factors (such as patient classification as distal TIP and proximal hypospadias, level of expertise of practicing fellow surgeons, operative templates, tissues used, suture types and catheter selection, etc.), making it difficult to draw valid conclusions. Obviously, the variables and/or factors studied in this work cannot be correlated with the surgical outcomes. It is also interesting that the authors of WPUC classified the patients as having TIP and proximal hypospadias repairs. Unless it is a naïve approach, it needs to be discussed in detail. A hypospadias repair technique that violates the established anatomical facts cannot be used as the background to a scientific study attempting to identify the variables of hypospadias surgery. As I have mentioned in my previous reports, with glans dissection (ignoring the "septum glandis"), uniform tubularization of the neourethra (ignoring the "fossa navicularis"), and with the deep midline glans incision (ignoring and harming the "distal ligament") TIPU is the biggest delusion in pediatric urology [2–5].

A clear understanding of the normal anatomy of the penis and the structural malformation in hypospadias is essential for anatomical reconstruction in hypospadias surgery. An operative note (template or traditional dictation) is an important source of surgical communication used for research and quality assurance. Operative notes should

include standard established anatomical landmarks and tissue specifications to describe the details of a reconstruction. In hypospadias, patient-specific anatomical variables should be fully defined and standardization of the surgical procedure is required. There is no surgery other than hypospadias that has more than 300 different types of repair techniques and more than 20 so-called repair modifications described by a single surgeon. Worse, in addition to using misnomers for the terminology (e.g., corporotomy instead of tunicotomy), some anatomical features and structures of the penis/urethra (e.g., septum glandis, fossa navicularis, distal ligament, tunica albuginea) have been overlooked or consistently denied in hypospadias surgery [2,3]. However, for the standardization of hypospadias surgery, these anatomical structures to be reconstructed must be recognized and set as solid anatomical landmarks. Consequently, these anatomical landmarks can be used as variables to classify hypospadias and create an operative note template to facilitate surgical communication for the hypospadias surgical process. I believe that the surgical process for hypospadias should guide two distinct concepts of surgical repair reserved for the glanular and penile urethra, since the glanular urethra differs from the penile urethra in that it forms a fossa with a specific shape, with different boundaries, attachments, and elasticity [2–6].

Source of funding

None

Conflicts of interest

None.

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DOI of original article: <https://doi.org/10.1016/j.jpuro.2022.12.001>.

<https://doi.org/10.1016/j.jpuro.2023.01.020>

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25 January 2023

Available online 23 February 2023