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Letter to the Editor

Change the game, not the players

Dear Editor,

I read with great interest the study on the results of pediatric surgery registrars performing supervised hypospadias surgery [1]. The authors' statement in the introduction to their article does not match the results of their study. In a sense, they come to the conclusion that hypospadias repair is not a technically demanding operation and is not a complex procedure, but gives variable results both in the hands of experienced surgeons and in the hands of registrars. I can understand the wish of a registrar to be involved more in hypospadias surgery for faster acquisition of surgical skills. But I can't understand why a registrar should necessarily learn skills that have no impact on results. Therefore, I think that the only acceptable and logical conclusion of this study may be the fact that there is something wrong with the hypospadias repair concepts used by the authors.

While the authors emphasize the importance of case volume in maintaining high standards of operative performance, they do not explain the learning curve (LC) for acquiring hypospadias repair skills. Measurement of surgical LC requires standardization of variables, methods, and statistical analysis [2]. However, in the authors' study, patient demographics and operative information were limited by meatal location and chordee degree, surgery type (TIP and staged repair), and operative time. Cases were classified as favourable anatomy, such as adequate penile size, large glans, and a deep urethral groove, which were supposed to be operated on by the registrars. These are confounding variables that cannot be used to assess the competency or expertise of a trainee or consultant. Complication rates between registrars and consultants were determined in a retrospective data collection, and the exact registrar versus consultant involvement in each procedure was not determined. Frankly, there is no standardization of the method selection of the correct variables in this study.

In this article, the results of urethral reconstructions show that something is conceptually wrong. As with all hypospadias repairs, the methods used by the authors do not include reconstruction of the *navicular fossa* and *septum glandis*.

It is important to understand that repairing hypospadias is not simply a matter of creating a water-tight, uniform tube through (!) the glans [3–6]. If the surgical repair is contrary to normal anatomy, the surgeon's experience and/or year of training will have no bearing on achieving a normally functioning urethra. I know how eager surgical trainees are to operate and expand their practice. But since in science "it is important not to stop questioning," I think it is primarily the trainees who have to deal with the functional anatomy of the urethra and ask questions before increasing their caseloads. I believe that hypospadias surgery is a technically demanding and complex operation that also requires detailed anatomical knowledge.

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None.

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