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Letter to the Editor

Traditional misconceptions in hypospadias surgery – Letter to the editor regarding "Two–stage repair for primary hypospadias: Functional and cosmetic outcomes in 145 cases with a followup period of over five years"

In this article, the authors analyze urinary and sexual functions, postoperative complications, and cosmetic results in patients who have undergone two-stage primary hypospadias repair [1]. The misconception of relying on tradition is widespread in medicine, can be taught by the experts, and if one is not careful, can be very convincing. This also leads to the acceptance of complications, and there is no other surgical specialty that accepts postoperative complications as readily as hypospadias surgery. Traditional misconceptions and evidence-based anatomical facts in hypospadias surgery:

1. The male urethra is not a straight, uniform tube, as reconstructed in all hypospadias repair techniques. It has the "fossa navicularis", which forms the glanular urethra with specific functional properties. The glans is not an anterior extension or expansion of the corpus spongiosum, which gradually terminates at the mid-glanular level. A faulty development of the fossa navicularis indicates a malformation of the glans itself, manifesting as grooves of varying depth on the glans [2–5].
2. The glans tissue does not completely enclose the navicular fossa, but is separated by the "septum glandis" along the ventral midline. Although there is no "glans fusion", this has unfortunately been routinely achieved for decades during hypospadias surgery by dissecting the wings of the glans [6].
3. The "septum glandis" is the fibroelastic tissue, which covers the fossa navicularis. As a fibroelastic partition, the septum glandis provides the elasticity and adaptive configuration of the glanular urethra during micturition and ejaculation. Together with the frenulum the septum glandis forms the ventral wall of the glanular urethra [2–5].
4. The "distal ligament" contributes significantly to the flexibility and rigidity of the glans, particularly during sexual intercourse. A deep midline incision of the glans is equivalent to a direct visual internal urethrotomy, corresponding exactly to the position of the distal ligament, which has reportedly led to erectile dysfunction in patients following hypospadias repair. Apparently, grafting glans would have far more detrimental consequences [2,7].

It is interesting how persistently these anatomical details are ignored in hypospadias surgery. As a member of the same institution as the authors, I have taught these anatomical details in several live surgical workshops and published numerous articles on hypospadias. From the perspective of upholding tradition, I find the stance of those authors who cling to these misconceptions deeply troubling. In addition, the common statement "there is still no consensus on the ideal approach to primary correction of hypospadias" should not serve as an excuse in hypospadias studies. In light of the findings of scientific studies, it is time to finally overcome such misconceptions and conclusions.

Conflict of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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