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Letters to the Editor

The management of hypospadias: its relevance to surgical training in the principles and practice of plastic surgery

Sir

David Elliot's essay on hypospadias (*British Journal of Plastic Surgery*, **40**, 227) was excellent. Someone needed to write on the subject, particularly, because in an age when plastic surgeons have succeeded in transferring large quantities of tissue with resultant anatomical and functional improvements, they have failed to make a viable tube of skin of no more than 2 to 4 cm in length with assured success. This is even more astonishing when one realises that this tube is not asked to perform any motor function as in a bowel transfer, for example, to reconstruct an excised oesophagus.

Although, generally, plastic surgeons have admitted to their failures in this area, the other specialists who deal with the condition, like the paediatric surgeon, the paediatric urologist and the urologists, always appear to present a front which conveys a very high rate of success and that too with one-stage surgery. Their immediate complications, like fistulae, always or almost always are small and consequently close by themselves or can be successfully closed by a small out-patient procedure. I am unable to confirm this from my experience both in my practice and at the teaching hospital where I work. The rate of complications in one-stage hypospadias repair in average hands in my clinical environment is frightfully high. Also a major breakdown in a one-stage hypospadias operation is extremely difficult to unravel and mend. The task of carrying a tubed axial pattern flap, tagged on to a random pattern flap, through a 90° turn and of anastomosing it with success to a hole situated in an area of embryological bankruptcy, surrounded by a fresh raw area made to release chordee, is a surgical exercise flying in the face of all rules of healing and subsequent normal growth as I know them. I am aware that some centres in the USA have high rates of immediate success with this procedure. But let us wait; like the crazes for the hula hoop and the holy men from India, this too may pass away.

The words "embryological bankruptcy" might intrude on the sensibilities of lovers of English, but the retroposed meatus is indeed located in an area which has failed to thrive *in utero*. While studies of vascularity of the distal prepucial skin might have improved our ability to use it more efficiently, nobody has paid attention to the quality of tissue around the abnormal proximal opening. This is where trouble occurs most frequently.

In passing, I have one small objection to Mr Elliot's comparison of healing following circumcision to that in hypospadias. The success in ablative or excisional surgery in a normally developed penis cannot be compared to reconstructive surgery of a defectively developed organ just because penile skin is common to both surgical efforts. However, there might be one similarity—there are perhaps far too many circumcisions in normal penes and reconstructions in minor and non-disabling hypospadias cases.

If there is one specialty in which results are subject to close scrutiny, it is plastic surgery. Our results are on the surface for everyone to see and criticise. David Elliot's critique of our results in a hidden part is further evidence that we are not afraid. Fear, however, is faintly discernible in Tagliacotian's article which appears in the same issue of the Journal. Are we to be swamped out of the race for survival by regional specialists and aggressive general surgeons in peripheral hospitals? The answer to that question lies in analysing the thoughts of other specialties and the way they have viewed our activities for the last two decades. There is a view in my hospital that my Unit is infiltrating in all surgical areas and consequently has a long waiting list. On one hand they allege that we dabble in everything and on the other they complain that we do not share our skills unless the concerned doctor completely switches his or her loyalties to us. Plastic surgeons are the peculiar recipients of both love and hate, need and rejection. It is against this background that the "other surgeons" have now entered a psychological phase of "let us show the **!!. . . " (expletives omitted).

Irrespective of whether they get their unjust vengeance, we too must realise that we have remained generalists for too long. In my Unit I am trying to convince my senior registrars to branch out. I can see at least five sub-specialties within our discipline—hand, cranio-maxillo-facial surgery, microsurgery, head, neck and oncological reconstruction, and aesthetics. Even leaving all this behind there will be enough for a generalist who can include urogenital work in his pursuits. A general surgeon with three years' plastic surgical training branching out into a small sub-speciality—you cannot have anything better than that! For this plan to succeed, the present incumbents of senior resident positions in Plastic Units must get going. Let us keep the flag flying!

Yours faithfully,

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