

Response to Snodgrass and Bush

We sincerely appreciate the comments made by Warren Snodgrass and Nicol Bush regarding our paper. First of all, we need to clarify that of our population of 130 patients only 66 have already reached pubertal development (55 in the preputial flap group and 11 in the staged repair). The aim of the published paper, as already clearly stated in our discussion, was limited to a retrospective analysis of the potential risk of development of megalourethra and fistula in this population. We fully agree that there is indeed a potential large amount of very important data retained in these series which may help to better understand some of the still unresolved questions on long-term outcome of hypospadias repair. Unfortunately we will need a few more years of follow-up before we will be able to fulfill these requests. Regarding the multiple questions mentioned we will try to provide some specific answers.

Severe curvature and definition of 'proximal hypospadias':

The definition of proximal hypospadias in our series should not be strictly interpreted in the usual manner, reserving this definition only to a perineal and/or scrotal location of the meatus, but including also patients with proximal penile hypospadias and, more widely, patients in whom it was not possible to preserve the urethral plate. Thus applying the concept of proximal hypospadias more extensively though less accurately, but certainly none of these patients had a distal or sub-coronal hypospadias. This may therefore explain the reduced number of corporoplasties reported in our series. Moreover, it is our attitude to adopt a less aggressive surgical approach in very small children for the curvature correction, avoiding any ventral lengthening because of potential concerns about the long-term outcome.

Cosmetic and functional results:

Once again, the purpose of this work was not to provide a detailed report of the outcome in terms of follow-up strategies and assessment methods; the fact of not losing

patients to follow-up results from a very strict post-operative protocol. Patients are seen immediately post-operatively, 1 year after surgery and usually at pre-school age (5 years) and at pubertal development. Only in the more recent years we have systematically started the process of a standardized protocol including uroflow and pre and post-micturition US assessment for residual urine.

Indeed, we are accustomed, and we are requested by families, to check our patients consistently over time. Living in a country where families tend not to move frequently (as may happen more commonly in North America), it is therefore much easier not to lose contact with them.

Finally we agree that much more information could be obtained from the series of patients preliminarily presented and it is our intention, supported by these positive comments made by our colleagues, to provide more specific papers in the future.

Best regards

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