



Fig. 35.1. Algorithm for primary hypospadias repair

formity rather than making the hypospadiac deformity suit the repair he prefers. We do not believe that one should use a technique that shortens an already short penis just because it has a lower complication rate. By the same reasoning, one should not shorten the penis dorsally to correct the ventral chordee and, lastly, one should not leave a raw surface if a fully epithelialised neourethra can be achieved.

For glanular hypospadias with mobile meatus or cleft glans, we prefer to use the MAGPI or the GAP technique. For distal hypospadias, we prefer to use the Y-V glanuloplasty modified Mathieu approach. We do not leave a stent inside the urethra. A temporary compression dressing is applied for 6 h, then the wound is left exposed. This has proven very satisfactory to children and parents. We have adopted the lateral-based flap for proximal hypospadias. Two-stage repair is advisable for perineal hypospadias to avoid the use of hair-bearing areas of skin. We believe that not leaving a stent inside the urethra or a dressing on the penis has improved our results dramatically. Figure 35.1 summarises our recommendations for primary hypospadias repair.

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