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# Hypospadias dilemmas: A round table

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## Introduction

At each step in the assessment and management of hypospadias arise questions and dilemmas that the four authors of this round table would like to list and explain from their point of view. From evaluation of hypospadias severity, preoperative biological assessment, preoperative hormonal stimulation, choice of urethroplasty to the postoperative evaluation, many divergences exist. Yet there is need to find a consensual approach to this congenital anomaly in pediatric urological practice. Warren Snodgrass, Antonio Macedo and Pierre Mouriquand developed this dialogue following their panel discussion at the World Congress of Pediatric Urology. Piet Hoebeke was asked to referee their comments to highlight areas of agreement and dispute.

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## Anatomy and classification

**Question 1: What criteria do you find relevant to evaluate the severity of hypospadias?**

PM: Severity follows the anatomy of hypospadias, which could be defined as a development halt that leads to an insufficient development of the genital tubercle essentially marked by a ventral triangular defect [1]. Its summit is formed by the proximal division of the corpus spongiosum, the lateral sides by the two atretic pillars of spongiosum, and the base by the widely open glans. The more proximally the spongiosum divides, the more severe the hypospadias is. The position of the urethral meatus does not seem to be a solid enough parameter to define this severity as, quite often, the urethra sitting proximal to the ectopic meatus is poorly developed and may need to be refashioned. All tissues sitting inside this triangle are under-developed, hypoplastic or dysplastic, although there is no histological consensus to define these concepts. As well as the level of division of the spongiosum, the size of the glans is a relevant criterion, the


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