

while others were cured by dilatation; this indicates that the ultimate success rate without another operation was 92.4%. We had a patient with dehiscence glanuloplasty that underwent a successful second redo tubularized incised plate urethroplasty re-operation and responded satisfactorily

For prevention of fistula, when possible, the neo-urethra was covered with a blanket of tunica vaginalis (Figure 4) or some other buffering vascularized layer as an alternative flap for multilayer coverage of the urethroplasty. Therefore, the incidence of fistula was only one case that could be due to meatal stricture. Meatal stenosis is the most reported form of complication and usually responds to dilatation. Although uroflowmetry was not performed, meatal stenosis was evaluated clinically. Based on the opinion of Duckett et al.⁽⁵⁾, flowmetry is a good objective measure of caliber, but observation of a good full stream is subsequently more revealing in follow-up. Ideally one should have both⁽⁵⁾.

In conclusion, using the TIP urethroplasty as described by Snodgrass et al. is a suitable method for treating the re-operative cases. It can also be used successfully in patients who do not have a healthy skin flap and for circumcised patients when there is a complete lack of foreskin.

Group2:

In the management of fistula of more proximal hypospadias failed repair, the same principles of excision of the fistula tract, tension free closure and a second layer covering help decreasing the incidence of complications specially dehiscence and fistula after the redo-repair

Bracka⁽¹⁰⁾ reported his experience with 600 patients with primary and secondary hypospadias repairs, he concluded that the second layer largely decrease the incidence of fistula from 63% without a second layer to only 5.4% with the use of dartos flap as a second covering layer While Massimo Catti et al⁽¹¹⁾ described the incidence of fistula in redo hypospadias repair was as high as 20% and this was more common with free graft use like buccal mucosal graft than grafts with a pedicle.

In the second group series seven [7] patients had fistula as a complication of prior proximal hypospadias repair two of them developed fistula postoperatively making the fistula rate as high as 28.5%. Although the patients' sample is small (seven patients only) this high failure rate can be explained by several reasons like the early experience of the surgeon and the type of suture material used which is vicryl 4/0 while ideally it is 6/0 or 7/0 vicryl as described by Massimo Catti⁽¹¹⁾



Figure 1