

COMMENT

Comment On: A novel circumcision technique for adult phimosis combining three techniques: a retrospective comparative study

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INTRODUCTION

Today different surgical techniques are available for the treatment of the **phimosis**, but none of them represent the "gold standard." The traditional *forceps-guided technique*, the *dorsal slit technique*, and the *inner ring-outer ring (sleeve) techniques* are the most commonly used. However, in the recent years, many devices have also been introduced in daily clinical practice, allowing for automatized "mechanical" circumcision procedures [1].

Regarding the present study, the authors report the results obtained from a series of patients who underwent circumcision using a modified technique: this modification essentially combines three already standardized techniques.

The authors argue that this technical variant, which requires detailed intra-operative measurements, allows to perform a procedure with a low risk of complications and favorable aesthetic and functional outcomes [2].

OPERATIVE TIME CONSIDERATIONS

The authors state that using this modified technique resulted in comparable operative times to those required for the classic *dorsal slit technique* used in the control group.

From our point of view, it seems unlikely that a standard technique like *dorsal slit* would require a surgical time similar to that of the authors' proposed as a triple-technique approach; this is clearly due to the fact that the "modified" technique needs more surgical steps, which naturally extend the operative time.

Assuming that the operative times are really comparable, surgical time seems too long (36 minutes) using the purposed technique, exceeding the average time reported in the literature, as the mean operative time is 24 minutes (12 minutes shorter) using standardized procedures. Moreover, some studies report significantly shorter times, such as in the study by Güler et al., where the authors report a mean operative time of approximately 15 minutes [3]. Table 1.

At a time of crisis in public healthcare systems, optimizing cost-effectiveness in managing benign diseases like phimosis is a priority: minimizing operative time, maintaining high standards of care, remains a fundamental goal.

The long surgical time reported by the authors are probably due to the various intraoperative measurements required by the technique, as well as additional steps (maybe not entirely

necessary) that are not usually included in the single standardized techniques.

TECHNICAL CONSIDERATIONS

A second key point concerns the step involving the forceps-guided technique. It's clearly visible that the surgeon clamps the preputial skin using a large and coarse instrument before excising the excess tissue above the clamp (Fig. 1).

This maneuver causes an evident trauma to the underlying skin, tissue which is then used to perform the final sub-coronal suture.

It's important to emphasize that in the forceps-guided technique, the clamp should be used only to guide the surgeon during incision line; therefore, the skin incision (not mucosal incision) should be made below the clamp rather than above it. Furthermore the ideal clamp should resemble the classic Mogen clamp, with a sort of "gap" between the jaws and, most importantly, atraumatic edges at the center, maintaining the skin integrity and ensuring the glans remains outside the surgical field [3].

As widely described in plastic surgery literature, traumatized tissues may experience impaired healing. Mechanical pressure can lead to pathological processes such as ischemia, chronic inflammation, proliferation, regeneration, degeneration, and necrosis. In physiological conditions, intrinsic mechanical forces, generated by epidermal, dermal, and subcutaneous components, maintain skin tropism; however, the application of extrinsic forces can disrupt this microenvironment, leading to tissue damage. Moreover prolonged exposure to high-intensity pressure can cause irreversible tissue ischemia and prolonged inflammation during wound healing [4, 5].

This situation may negatively impact the final coronal suture line, leading to postoperative complications such as dyschromic healing tissue, asymmetric suture line, abnormal scarring tissue till trapped penis.

To minimize these risks, we recommend performing the incision below the clamp rather than above it.

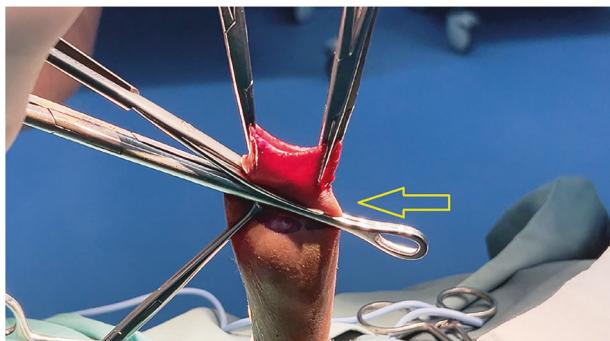
FOLLOW-UP AND OUTCOME ASSESSMENT

A third important aspect to consider is that the study only describes short-term surgical outcomes (7 days postoperatively).

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Table 1. surgical time and adverse events of different standard procedures.

Authors	Surgical technique Minutes (SD)	Mild adverse events	Moderate adverse events
Güler 2022 [3]	15.4 (2.5)	/	8.4
Huo 2015 [6]	22.6 (4.6)	/	/
Jin 2015 [7]	24.2 (3.2)	12.4	18.4
Kanyago 2013 [8]	23.2 (5.5)	13.0	18.2
Li 2010 [9]	25.6 (8.3)	/	/
Li 2014 [10]	30.8 (4.0)	/	/
Lv 2014 [11]	21.4 (5.8)	14.3	6.6
Miao 2015 [12]	28.3 (4.2)	/	/
Millard 2013 [13]	22.5 (6.6)	13.9	16.7
Pang 2015 [14]	31.2 (3.9)	/	/
Ren 2014 [15]	30.4 (4.7)	/	/
Sokal 2014 [16]	20.3 (4.8)	12.0	6.0
Wang 2014 [17]	23.6 (4.4)	/	/
Millard 2014 [18]	/	12.7	19.4
Shenje 2016 [19]	/	5.3	5.6

**Fig. 1 Circumcision technique purposed from the Authors.** The clamp roughly compresses the skin of the foreskin.

It's important to bear in mind that wound healing is a slow process, and long-term outcomes should also be evaluated.

Nevertheless, the authors report a complication rate of 2.6% in patients who underwent circumcision using the modified technique, compared to an 11% complication rate in those who underwent the standard dorsal slit technique; this suggests a significant lower complication rate than reported in the current literature and this is surprising. Table 1.

However, in the Materials and Methods section, the authors do not specify the follow-up duration for all patients (this information is only briefly mentioned in the results table) nor the methods used to assess aesthetic and functional outcomes, whether subjective or objective.

To our knowledge, no validated questionnaires were used, relying solely on patients' subjective evaluations. To ensure objective data collection and minimize potential bias, we recommend to use validated assessment tools such as the VAS Scale or the PGI-I; without these tools, the results—and consequently conclusions—could be affected by an unbridgeable bias.

CONCLUSIONS

It's clear that combining three well-established and standardized surgical techniques, refined over decades, is likely to get satisfactory results.

The extended operative time, despite a lower complication rate, suggests that this technical modification may be useful.

Attention to technical details and meticulous surgical steps can make a significant difference in this type of procedures, which is often considered "surgical routine" but can sometimes present unexpected challenges for the surgeons.

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AUTHOR CONTRIBUTIONS

AZ: Conceptualization (lead); Supervision (equal); Writing – original draft (supporting); Writing – review and editing (equal); MP and MF: Supervision (equal); writing – review and editing (equal) AUTHORS.

COMPETING INTERESTS

The authors declare no competing interests.