The Classification and Surgical Treatment of Adult Acquired Buried Penis Syndrome: A Call for Data and Collaboration

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> "We should credit [the sky] for what it is; for sheer size and perfection of function, it is far and away the grandest product of collaboration in all of nature."[1]
>
> —Lewis Thomas: *The Lives of a Cell: Notes of a Biology Watcher*

I read with great interest the stellar and lengthy commentary by Dr Gary Alter[2] that accompanied our paper, "The Surgical Treatment of Adult Acquired Buried Penis Syndrome: A New Classification System."[3] I appreciate the perspective and pioneering work of Dr Alter's years of experience treating (and publishing on) patients with this debilitating malady, one that affects a large and growing segment of the male demographic. These patients present with an often-embarrassing constellation of symptoms, including difficulty urinating, poor hygiene, low self-esteem, and complaints of sexual dysfunction. I also read with interest Dr Mark Solomon's letter addressing some concerns with our paper.[4] Our contribution was an attempt to standardize the "types" of buried penis patients that we see in our busy Plastic Surgery Unit in Madison, Wisconsin, and in doing so, we are able to offer a standardized set of operations for correction. We have found these categories exceedingly useful both as a communication tool between surgeon and patient and between collaborating services (urology and plastic surgery).[3] Although we understand that the Wisconsin Classification of Adult Acquired Buried Penis Syndrome is not a "one size fits all" categorization, it has proven exceedingly useful in our care of these patients, who are almost uniformly satisfied with their outcomes.

Specific to our methodology, Dr Solomon reports to have conducted "hundreds of cases" without performing a skin graft. Although I tip my hat to this approach, in our patient population early attempts at correcting the more severe forms of buried penis (types 3 or 4) with local skin flaps have proven overwhelmingly unsatisfactory with a high rate of recurrence. In fact, many of our patients present to our clinic having failed such interventions. Further, I disagree with the implication that we are violating the basic of principal of replacing "like with like." The penile skin is extremely thin and glabrous and so too is a very thin skin graft when taken above the level of the hair follicles (0.012 in). The skin of the surrounding thighs is nonglabrous tissue that is thick and fatty, and utilizing it to reconstruct the diseased skin of the penis is far from replacing "like with like."

Specific to surgical indications, one point that warrants discussion is the generalization asserted by Dr Solomon that most patients are seeking relief because they "universally have the desire to have intercourse." In our practice this is clearly not the case. Personal hygiene and "being able to urinate while standing up" are commonly the primary motivators for patients to seek therapy.[3] While sexual

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function is lower on the priority list, this begs the question: Does one beget the other?

I would also encourage collaboration in an attempt to solve and treat this vexing problem. As has become the ideal for other disciplines within plastic surgery (breast reconstruction, fat grafting),[5,6] multi-institutional collaboration has contributed to significant advancements. Also, there are abundant opportunities for collaboration between academic and private surgeons as each brings a unique perspective to often difficult and multi-dimensional problems. Such collaborations on a large group of patients could potentially lead to standardized patient-reported outcome instruments like the BREAST-Q, BODY-Q, and FACE-Q.[7-9]

We welcome further discussion on this topic, either pro or con, and even the proposition of another classification system to help guide surgical correction. Discourse of this nature is healthy and progressive and will ultimately push the field forwards. To have four separate contributions in the *Aesthetic Surgery Journal* on the mundane and often ignored condition of adult acquired buried penis is astounding because for "sheer size and perfection of function," these patients deserve this level of attention and discourse.

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