Declaration were followed. All patients were informed about the surgical procedure and realistic expectations were discussed with all the participants. Perioperative and postoperative risks, as well as potential complications of the procedure were discussed before the surgery. Written informed consent was obtained from all the patients. Patients were fully informed about our further scientific and publishing intentions, and gave us written informed consent. Surgery was performed by one surgeon (PW). None of the patients had any graft-related issues, increased risk of bleeding or any other heath problems compromising the use of STSG. Each patient was fully informed and educated about all current trends in partial glans resurfacing surgery. The realistic expectations were discussed as a part of the informed consent. Each patient made an independent decision, and opted for a less invasive approach regardless the paucity of data on Veriset use. We think that the encouraging moment was, the knowledge, that the surgeon can still perform redo sugery while using STSG.

In total we performed 6 procedures in 5 patients who underwent partial glans excision of the epithelium and subepithelium followed by coverage with novel haemostatic material – Veriset™.

After adequate general anesthesia induction, the patient was placed in a normal supine position. A tourniquet was placed around the base of the penis. The plane was developed to undermine the suspicious area with approximately 5 mm healthy margin and only few millimeters for benign and premalignat lesions respectively. Sharp dissection between the subepithelial layer and the corpus spongiosum was performed.

After complete excision, the defect was covered with novel tissue sealant Veriset™. Mild compression on the wet sponge for a minimum of 1–2 minutes was applicated, before releasing the tourniquet. Afterwards, a mild compressive bandage with fat gauze and Baneocin cream (combined antibacterial drug for topical application, which contains two antibiotics with bactericidal effect, neomycin and bacitracin) was applied after Foley catheter insertion (Ch 12). The catheter was removed after 3/5 days and patients were discharged on the third postoperative day.

On the very first day after the surgery, we had removed the bandage and after careful inspection of the glans applied a new bandage with a little bit less compression. On the excision site with the remaining parts of the Veriset material we applied a fat gauze with Baneocin. Consequently the Veriset material was completetly resorbed and fell off within 3–5 days. Each patient was followed on weekly intervals thereafter and carefully advised how to proceed with local wound management (application of vaseline mixed with Baneocin 3× daily, after local hygiene with aqua). Within a time frame of 6–8 weeks the excised glans area was completely epithelialized presumably from the healthy margins (Fig. 1, 2). In light of this, once the healing process was completed, there was no further wound care required.

RESULTS

The mean lesion size 14 mm (range 8–22 mm). All the lesions affected less than 1/3 of the whole glans surface. The mean follow-up was 10 weeks (range 8–24 weeks). All patients except one were free of primary local disease. In one case of well differentiated intraepithelial neoplasia (PeIN), the final histology confirmed (PeIN) crossing into squamous cell carcinoma (G1R+,3 mm). The patient underwent a second glans-preserving procedure followed with Veriset application. The frozen section as well as final histology demonstrated no evidence of PeIN nor SCC.

For the remaining cases the histology confirmed chronic balanoposthitis (2 pts) and verruca vulgaris (penile horn, 2 pts), what was in correlation with the primary preoperative biopsy result. In both patients with PeIN and one balanoposthitis case we performed circumcision in the same setting. All benign lesions were treated with various topical regimens previously, however without any success.