

vaginal coitus was not satisfactory. During the first 4 weeks the patient was advised to perform clean intermittent catheterization (2× per week) with Ch12 catheter in order to prevent onset of meatal stenosis. The final cosmetic appearance was considered very adequate (Fig. 3M).

The missing penile shaft skin can be replaced either with local vascularised scrotal flaps or skin grafting. Skin grafts can be harvested and prepared as full thickness or meshed. Current literature does not provide enough evidence with regard to graft superiority. STSG is currently a well established surgical technique, with good survival rates (6, 7). To date, there is no universal treatment algorithm defined, one of the reasons is the heterogenous patient population and rarity of the disease (8, 9).

In our patient, we were sceptical about scrotal skin grafting, in order not to compromise the overall

anatomy after previous scrotoplasty, Although the pedicled scrotal flaps has been widely established in pediatric and adult patient population with favourable outcomes (10, 11, 12). The relative disadvantage of the scrotal graft is the presence of hair follicles, which may require secondary multiple laser treatments.

## CONCLUSION

Surgical strategy of buried penis depends on the etiology and quality of affected and surrounding tissues, as well as overall anatomy of the external genitalia. The definitive treatment and surgical goal should repair voiding/sexual functioning and overall psychological well being of these individuals. STSG is a valid alternative for advanced cases in patients with already compromised scrotum.

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