Submitted: 24 January, 2026 Accepted: 14 April, 2026 Published: 30 June, 2026 DOI:10.22514/j.androl.2026.022

ORIGINAL RESEARCH

Evaluation of the ventral phalloplasty technique for adult penoscrotal web and scrotal laxity repair using the male genital self-image scale, Beck depression inventory, and International index of erectile function

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Abstract

Background: Ventral phalloplasty is a reconstructive procedure used to correct penoscrotal webbing and excessive scrotal laxity, both of which may negatively affect genital appearance, patient comfort, and sexual satisfaction. This study aimed to evaluate the effectiveness of ventral phalloplasty in the repair of adult penoscrotal webbing (PSW) and scrotal laxity by analyzing outcomes using Male Genital Self-Image Scale (MGSIS-7), Beck Depression Inventory (BDI), and International Index of Erectile Function (IIEF-15). **Methods**: Data from 54 patients diagnosed with PSW and scrotal laxity in our clinic between 2012 and 2022 who underwent repair using the ventral phalloplasty technique were retrospectively evaluated. Demographic variables, including age, operative time, web grade, body mass index (BMI), and postoperative complications, were recorded. In addition, each patient was assessed using the BDI, IIEF-15, and MGSIS-7 scales. **Results**: The mean age and operative time were 31.8 $\pm$ 5.57 years and 47.1 $\pm$ 4.82 minutes, respectively. Demographic variables such as age, operative duration, web grade, BMI, and postoperative complications were comparable across patients ($p > 0.05$). However, comparisons of BDI, IIEF-15, and MGSIS-7 scores revealed statistically significant differences ($p < 0.05$). **Conclusions**: Evaluation of the ventral phalloplasty technique in adults undergoing PSW and scrotal laxity repair, using MGSIS-7, BDI, and IIEF-15, demonstrated positive effects on both functional and aesthetic outcomes.

Keywords

Penoscrotal web; Scrotal laxity; Ventral phalloplasty; Genital self-image; Erectile dysfunction; Depression

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Evaluación de la técnica de faloplastia ventral en la corrección de la membrana penoscrotal y la laxitud escrotal en adultos mediante la escala de autoimagen genital masculina, el inventario de depresión de Beck y el índice internacional de función eréctil

Resumen

Antecedentes: La faloplastia ventral es una intervención reconstructiva que se utiliza para corregir la membrana penoscrotal y la laxitud escrotal excesiva, dos afecciones que pueden afectar negativamente al aspecto genital, al bienestar del paciente y a la satisfacción sexual. El objetivo de este estudio fue evaluar la eficacia de la faloplastia ventral en la reparación de la membrana penoscrotal (PSW) y la laxitud escrotal en adultos, mediante el análisis de los resultados utilizando Escala de Autoimagen Genital Masculina (MGSIS-7), Inventario de Depresión de Beck (BDI) y Índice Internacional de Función Eréctil (IIEF-15). **Métodos**: Se evaluaron retrospectivamente los datos 54 pacientes diagnosticados con PSW y laxitud escrotal en nuestra clínica entre 2012 y 2022, a los que se les practicó una reparación mediante la técnica de faloplastia ventral. Se registraron variables demográficas, como la edad, la duración de la intervención, el grado de la membrana, el índice de masa corporal (IMC) y las complicaciones posoperatorias. Además, se evaluó a cada paciente mediante las escalas BDI, IIEF-15 y MGSIS-7. **Resultados**: La edad media y la duración de la intervención fueron de 31.8 $\pm$ 5.57 años y 47.1 $\pm$ 4.82 minutos, respectivamente. Las variables demográficas, como la edad, la duración de la intervención, el grado de la membrana, el IMC y las complicaciones posoperatorias, fueron comparable entre los pacientes ($p > 0.05$). Sin embargo, las comparaciones de las puntuaciones del BDI, el IIEF-15 y el MGSIS-7 revelaron diferencias estadísticamente significativas ($p < 0.05$). **Conclusiones**: La evaluación de la técnica de faloplastia ventral en adultos sometidos a reparación de la membrana penoscrotal y laxitud escrotal mediante MGSIS-7, el BDI y el IIEF-15, demostró efectos positivos tanto en los resultados funcionales como en los estéticos.

Palabras Clave

Membrana penoscrotal; Laxitud escrotal; Faloplastia ventral; Autoimagen genital; Disfunción eréctil; Depresión

1. Introduction

The scrotum is a sac-like anatomical structure divided into two sections by the median raphe, which begins at the anus and extends through the perineum to reach the ventral surface of the penis. Owing to the greater length of the left spermatic cord, the left hemiscrotum generally hangs slightly lower than the right. The scrotal wall is notably elastic and consists of several layers, including rugated skin, the superficial (dartos) fascia, the external spermatic fascia, the cremaster muscle, and the internal spermatic fascia. Within this sac, the testes remain suspended, surrounded by the parietal and visceral layers of the tunica vaginalis and enclosed by the tunica albuginea [1].

PSW may present as a congenital anomaly but is more frequently acquired later in life, typically due to excessive excision of scrotal skin during circumcision. Research involving adult patients with PSW remains limited, largely because most published studies focus on children, in whom the condition is estimated to occur in about 4% of cases [2]. When PSW coexists with scrotal laxity, it may significantly impair sexual function as well as the psychological aspects of interpersonal interactions. Affected individuals may experience difficulties related to urination, sexual activity, and body perception [1, 3]. Although the inherent elasticity of the scrotum supports testicular positioning, excessive laxity or webbing may compromise tissue integrity, giving rise to both cosmetic and functional concerns [1]. Patients often report discomfort during movement or sexual intercourse, particularly when wearing loose clothing. Additionally, progressive scrotal laxity is commonly associated with the development of a persistent penoscrotal web.

For patients with pronounced discomfort or functional limitations due to PSW or scrotal laxity, surgical management is typically considered the first-line treatment option. The main indications for operative treatment include discomfort during routine activities, sexual dysfunction, recurrent infections, and significant emotional or psychological distress. Although surgery is widely preferred, some authors have explored the use of absorbable suspension sutures as a less invasive alternative approach [4]. The literature describes several operative techniques, ranging from tissue excision to reconstructive procedures, designed to restore both function and appearance, ultimately improving patient satisfaction and overall quality of life [1, 5].

This study aimed to assess the impact of the ventral phalloplasty technique on functional and cosmetic outcomes in adults undergoing repair of PSW and scrotal laxity, using validated instruments such as the MGSIS-7, BDI, and IIEF-15.

2. Methods

2.1 Study design

The severity of a webbed penis was assessed using the classification system proposed by El Koutby and El Gohary [2]. In this system, grade 1 represents a web extending to the proximal third of the penis; grade 2 involves the middle and distal thirds; and grade 3 represents an extensive web reaching the distal third. Psychological and sexual function were evaluated using three established measurement tools: the BDI, MGSIS-7, and IIEF-15 [6–9]. The MGSIS-7, consisting of seven psychometrically validated items, assesses how men perceive and feel about their genitalia. Each item is rated on a four-point

Likert scale, and total scores are calculated by summing all item responses, with higher scores reflecting a more favorable genital self-image. The Turkish adaptation of the scale was validated by Koçak *et al*. [9]. Sexual function was assessed using the IIEF-15, a widely used 15-item questionnaire that assesses erectile function, orgasmic response, sexual desire, intercourse satisfaction, and overall sexual health [7]. Depressive symptoms were assessed using the BDI, a 21-item self-report instrument designed to measure both the presence and severity of depression. Participants rate each item from 0 (no symptoms) to 3 (severe symptoms), and higher cumulative scores indicate more pronounced depressive symptoms [6].

A total of 54 patients were initially enrolled; however, as 9 individuals did not complete follow-up, the final analysis included 45 patients. Patient data were collected between January 2025 and June 2025, and the study duration was 6 months. These patients commonly reported discomfort during daily activities and sexual intercourse, along with a perceived reduction in penile length. Primary cases with grade 1, 2, and 3 PSW and scrotal laxity were included in the study. Exclusion criteria comprised patients who had undergone ventral phalloplasty due to penile or testicular prosthesis placement, those with penile curvature, individuals with a previous penoscrotal web procedure, cases with micropenis or penile torsion, patients with buried penis, and individuals with a history of scrotal surgery. Moreover, patients using medications or with a history of pelvic surgery that could impair erectile function were also excluded. All patients underwent surgical correction using the ventral phalloplasty technique. Demographic variables, including age, operative duration, web grade, BMI, and postoperative complications, were recorded for each patient. The psychometric scales used in the study were assessed prospectively before and after surgery. All data were analyzed retrospectively after study completion. In addition, all patients were assessed using the BDI, IIEF-15, and MGSIS-7 scales. Patients were followed up regularly for two years, and all operations were performed by the same surgeon.

2.2 Surgical technique

General anesthesia was administered to all patients. As prophylaxis, each patient received a third-generation cephalosporin antibiotic (50–100 mg/kg) prior to the operation. A detailed assessment under anesthesia was conducted before the surgical procedure. To clearly visualize the PSW and delineate the degree of scrotal laxity, the glans was gently grasped and elevated to maximal stretch length. The scrotum was then held along the median raphe and drawn caudally to allow evaluation of both webbing and laxity. At this stage, the area designated for excision was marked using an extended, bilaterally symmetrical V-shaped pattern that incorporated the segment of redundant scrotal tissue (Fig. 1a,b). This incision design was used in all patients to correct both PSW and scrotal laxity in a single operative session. The V-shaped extensions were positioned symmetrically on both sides to remove excess scrotal skin and were carried upward along the ventral penile shaft to the planned penoscrotal junction. During the procedure, excess scrotal skin was removed on both sides using a combination of blunt and sharp dissection, while taking care not to damage the tunica vaginalis. The dartos fascia was intentionally preserved to ensure adequate vascular supply and promote optimal wound healing (Fig. 1c). Closure of the incision was achieved with monofilament absorbable sutures along the median raphe (Fig. 1d,e). Through this technique, both aesthetic and functional concerns were successfully addressed. Correction of scrotal laxity and PSW yielded favorable cosmetic and functional outcomes for the patients (Fig. 1f).

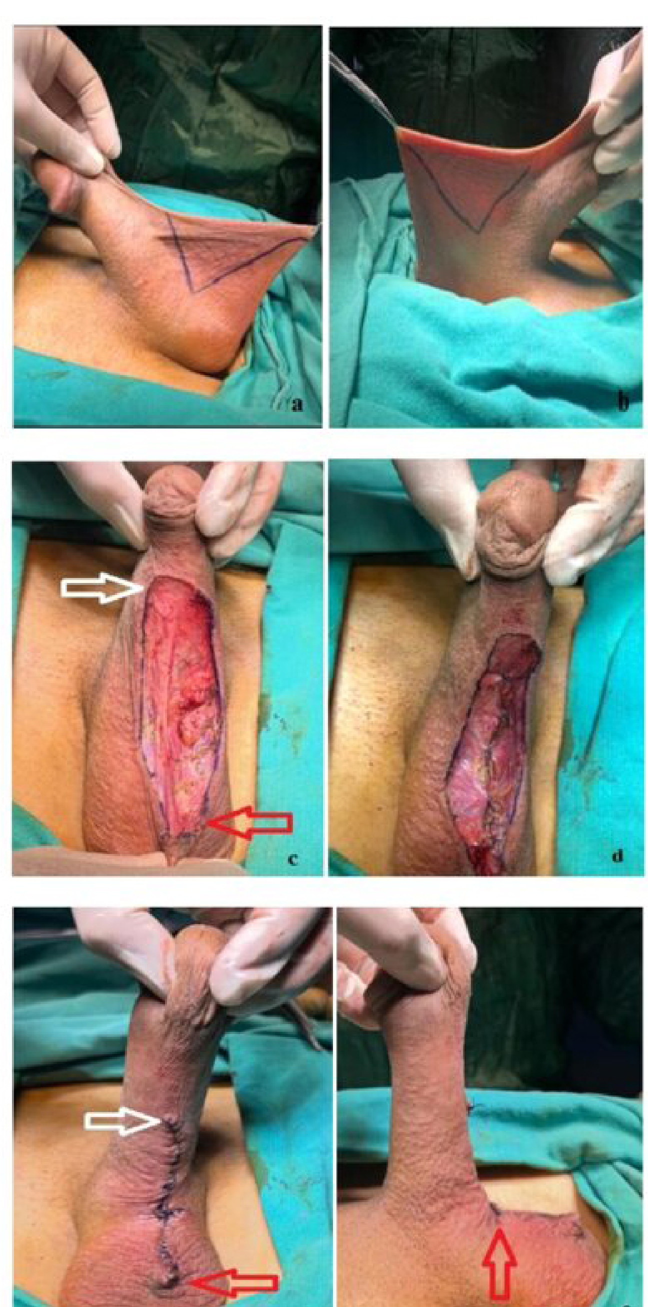

FIGURE 1. Steps of ventral phalloplasty surgery. (a,b) V-shaped mark on the tissue to be removed. (c) The appearance of tissue removed without damaging the tunica vaginalis and the underlying dartos fascia. (d,e) Image showing closure of skin and subcutaneous tissues with monofilament absorbable sutures. (f) Satisfactory cosmetic and functional finish.

2.3 Statistical analysis

Statistical analyses were performed using MedCalc version 20.009 (MedCalc, Ostend, Belgium). Normality was assessed using the Kolmogorov-Smirnov test and Q–Q plots for visual evaluation. Continuous variables were summarized as mean ± standard deviation (SD) when normally distributed and as median (minimum–maximum) when not normally distributed. Categorical variables were presented as counts and percentages. To compare preoperative values with postoperative measurements at 6, 12, and 24 months, repeated-measures Analysis of Variance (ANOVA) was used when normality assumptions were met. In cases where these assumptions were not met, the Friedman test was used as an alternative. *Post-hoc* multiple comparisons were conducted using Bonferroni adjustment. Significant temporal changes in scale scores were indicated by different letters in the tables. Furthermore, temporal trends were illustrated by plotting lines connecting the median values (with 95% confidence intervals) for each time point. To assess whether surgical outcomes were influenced by disease severity, a stratified analysis of measurement scores was conducted in patients with different severity levels (Grade 1, 2, and 3). Taking into account the variance and standard error for each web grade, data were selected homogeneously from each web grade. A stratified analysis was conducted by selecting an equal number of cases—4 cases from grade 1, 4 cases from grade 2, and 4 cases from grade 3—for each score. A p-value of < 0.05 was accepted as the threshold for statistical significance.

3. Results

The mean patient age was 31.8 ± 5.57 years, and the mean operative time was 47.1 ± 4.82 minutes. The cohort had a mean BMI of 24.0 kg/m^2. Postoperative assessment showed penile or scrotal edema in 5 patients (11.1%) and wound contracture in 3 patients (6.7%). Importantly, no patient experienced recurrence of the web. A comparison of demographic characteristics, including age, operative time, web severity, BMI, and postoperative complications, revealed no statistically significant differences among the groups ($p > 0.05$) (Table 1). Analysis of MGSIS-7 scores demonstrated significant improvements at 6, 12, and 24 months postoperatively ($p < 0.05$) (Table 2, Fig. 2). Similar statistically significant changes were detected in BDI scores at the same postoperative intervals ($p < 0.05$) (Table 2, Fig. 3). IIEF-15 scores likewise showed significant postoperative differences at 6, 12, and 24 months ($p < 0.05$) (Table 2, Fig. 4). To assess whether surgical outcomes were influenced by disease severity, a statistically significant difference was found in the stratified analysis of measurement scores among patients with different severity levels (Grade 1, 2, and 3) ($p < 0.05$) (Table 3).

During the early postoperative phase, 5 patients (11.1%) developed penile or scrotal edema, which resolved with conservative management, including warm baths and oral anti-inflammatory medications. In 3 (6.7%) patients, tension was observed at the dorsal penoscrotal junction after ventral skin closure, and a 3–4 mm longitudinal midline release incision was made to relieve this tension. No recurrent web was observed in any patient.

TABLE 1. Demographic features and clinical characteristics of the patients.

	Ventral Phalloplasty N = 45	
Age (yr), Mean ± SD	31.8	5.57
BMI (kg/m^2), Median (min–max)	24.0	(20–27)
Operation time (min), Mean ± SD	47.1	4.82
Penile or scrotal edema		
None	40	88.9
Present	5	11.1
Postoperative wound contracture		
None	42	93.3
Present	3	6.7
Degree of web		
Grade 1	4	8.9
Grade 2	15	33.3
Grade 3	26	57.8
Recurrence of the Web		
None	45	100.0
Present	0	0.0

SD: Standard deviation; BMI: Body mass index; min: minimum; max: maximum.

4. Discussion

Penoscrotal webbing and scrotal laxity, especially when accompanied by redundant scrotal tissue, can markedly affect a patient's quality of life, perceived penile length, and sexual satisfaction for both the patient and the partner. These problems may develop after procedures such as hydrocelectomy, orchiectomy, inguinal hernia repair, major weight loss, or other surgical interventions. Scrotal laxity is frequently associated with penoscrotal web formation, often resulting from excessive removal of foreskin during circumcision, which can cause upward traction of scrotal skin onto the penile shaft. When assessing an adult patient who experiences symptomatic or distressing scrotal laxity, it is crucial to obtain a comprehensive medical history and conduct a detailed examination of the scrotum and testes to accurately assess disease severity and determine the most appropriate treatment strategy [1]. In the present study, all patients underwent thorough clinical history-taking and physical examination, while secondary etiologies and individuals with marked obesity were excluded from the analysis.

A number of surgical approaches have been proposed to correct PSW and scrotal laxity. These include crescentic horizontal resections, inverted U-shaped incisions, and vertical ventral resections combined with horizontal approximation. Ventral phalloplasty-related techniques encompass penoscrotal Z-plasty, Y-V closure of the penoscrotal junction, and transverse skin excision supported by ventral suturing [1]. The bilaterally applied, symmetric, extended V-shaped incision,

TABLE 2. Comparison of scales over time.

	MGSIS-7 N = 45					BDI N = 45					IIEF-15 N = 45				
	Min	Max	Median	*F*	*p*-value	Min	Max	Median	*F*	*p*-value	Min	Max	Median	*F*	*p*-value
Pre-op	8	18	12^{a}			18	28	23^{a}			22	25	24^{a}		
Post-op (6th mon)	15	22	18^{b}	358.3	<0.001*	10	25	17^{b}	267.7	<0.001*	22	25	24^{b}	1104.9	<0.001*
Post-op (12th mon)	15	28	20^{c}			10	18	14^{c}			26	30	29^{c}		
Post-op (24th mon)	21	28	26^{d}			3	11	7^{d}			26	30	29^{d}		

**: Friedman test. There was a significant difference between time points with different letters ($p < 0.05$). Min: Minimum; Max: Maximum; MGSIS: Male Genital Self-Image Scale; BDI: Beck Depression Inventory; IIEF: International Index of Erectile Function.*

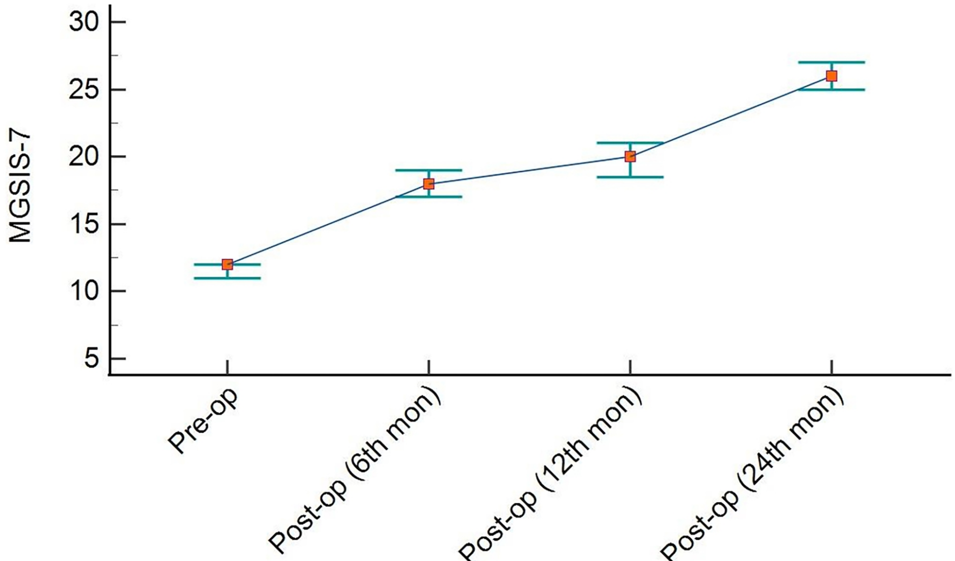

FIGURE 2. MGSIS-7 score of the groups (over time). MGSIS: Male Genital Self-Image Scale.

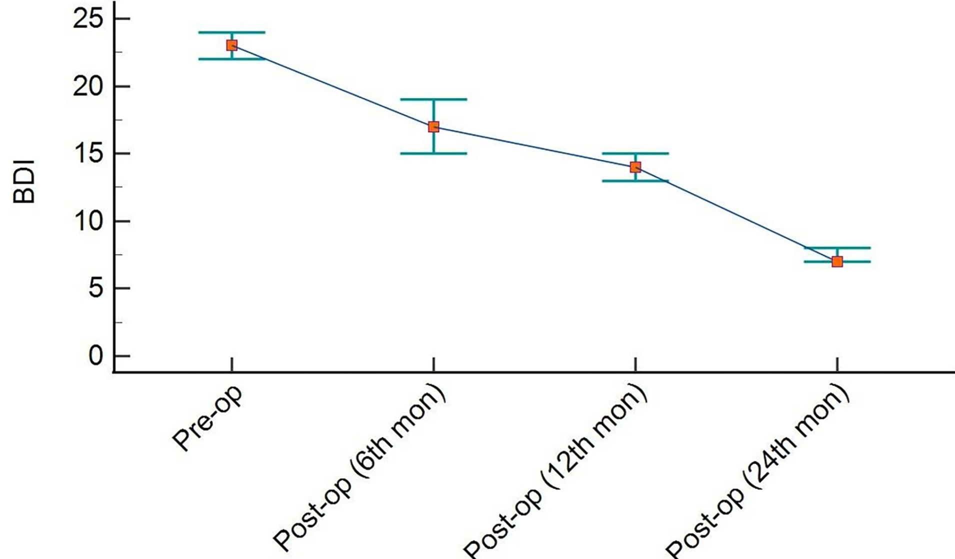

FIGURE 3. BDI score of the groups (over time). BDI: Beck Depression Inventory.

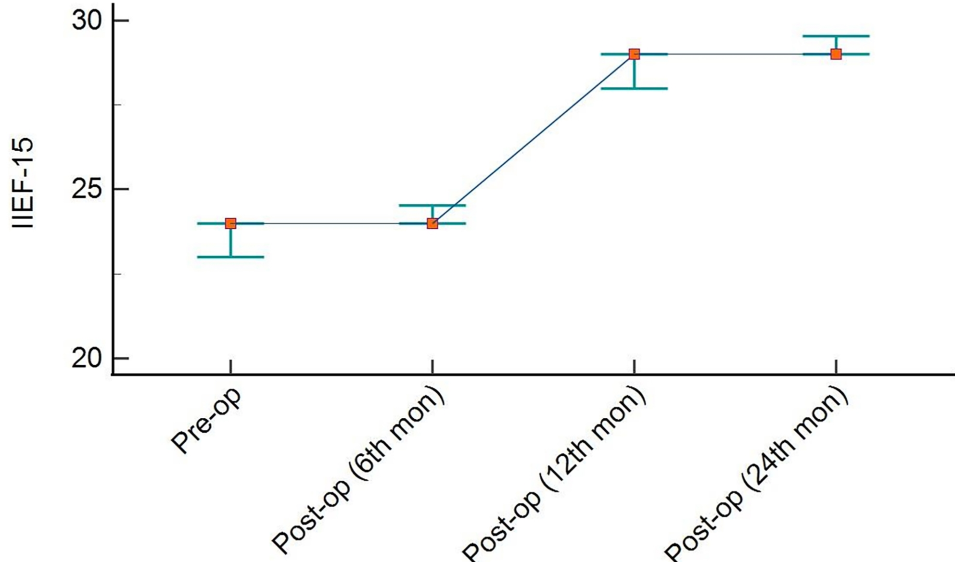

FIGURE 4. IIEF-15 score of the groups (over time). IIEF: International Index of Erectile Function.

TABLE 3. Comparison of scales over time (for stratified analysis across different levels).

	MGSIS-7 N = 12					BDI N = 12					IIEF-15 N = 12				
	Min	Max	Median	F	p-value	Min	Max	Median	F	p-value	Min	Max	Median	F	p-value
Pre-op	9	13	10^a			22	26	24^a			22	25	23.5^a		
Post-op (6th mon)	15	21	18^b	127.2	<0.001*	10	25	14^b	87.8	<0.001*	22	25	24^a	276.0	<0.001*
Post-op (12th mon)	15	25	20.5^c			10	17	14^c			26	30	29^b		
Post-op (24th mon)	23	27	25.5^d			5	10	7.5^d			26	30	29^b		

**: Friedman test. There was a significant difference between time points with different letters ($p < 0.05$). Min: Minimum; Max: Maximum; MGSIS: Male Genital Self-Image Scale; BDI: Beck Depression Inventory; IIEF: International Index of Erectile Function.*

designed to incorporate areas of lax scrotal tissue, is reported to have several advantages over vertical scrotal resection. This technique permits meticulous excision of redundant scrotal skin, contributing to improved scrotal contour and overall aesthetic outcomes [1, 10, 11]. In addition, the resultant longitudinal closure stabilizes the proximal penile skin, minimizes penile retraction, and enhances perceived penile length, ultimately improving patient satisfaction [10–12]. Indeed, studies have reported that 84% of patients (36/43) reported a subjective improvement in penile length after undergoing this procedure [1, 10, 11].

Thomas and Navia suggest that performing a vertical skin resection, placing the resultant scar along the median raphe, and considering the medial–lateral movements of the genital branch of the genitofemoral nerve and the ilioinguinal nerve help maintain scrotal sensitivity and provide a superior anatomical and aesthetic outcome [1]. Nevertheless, when significant scrotal laxity and PSW are present, a modified incision resembling a control mark may be preferable, as it enhances contour refinement while optimizing both cosmetic and functional outcomes [13]. In the present study, we utilized a symmetric, bilaterally extended V-shaped incision that included the area of scrotal laxity. The endpoint of the lax tissue was identified using a clamp, allowing for a more harmonious penile and scrotal contour. Moreover, patients experienced an increase in perceived penile length, which positively influenced overall patient satisfaction.

Genital self-image describes how individuals emotionally and psychologically perceive their own genitalia, especially in relation to sexual performance and satisfaction [14]. This perception may be shaped by several factors, including aesthetic concerns involving the genitals, circumcision status, BMI, body image satisfaction, emotional state, and conditions such as phimosis [15, 16]. Genital identity is also fundamental in influencing sexual orientation, as it relies heavily on one's perception of one's genital self [17]. Evidence suggests that maintaining a positive genital self-image is linked to better psychological well-being [18]. Nevertheless, research on men's genital self-perception remains relatively limited [8, 18]. When men perceive their genitals as adequate and

report no physical or emotional discomfort, this supports their overall quality of life [19]. It also reduces the likelihood of experiencing confidence-related problems during sexual intercourse [20]. While the penis is generally the genital structure of greatest concern, multiple studies have revealed that dissatisfaction among men most often centers on penile girth rather than other anatomical features [21, 22].

The MGSIS-7 is a straightforward and practical instrument for assessing genital self-image in men and offers clinicians valuable information across several dimensions [16]. A reduction in overall MGSIS-7 scores may give rise to feelings such as inadequacy in satisfying a partner, embarrassment, or humiliation [9]. Over time, these negative emotions may increase vulnerability to depression and anxiety, potentially contributing to sexual dysfunction. A man's comfort and confidence regarding his genital region also play a direct role in partner satisfaction. Individuals with a positive genital self-image tend to experience greater pleasure during sexual activity and achieve sexual satisfaction more readily [23]. In a study by Tal R *et al*. [24], the IIEF scale was used to assess the psychosocial outcomes of surgical correction in 32 patients with congenital penile deviation, and the findings were favorable. Likewise, Zachalski W *et al*. [25] reported a positive correlation between IIEF and BDI scores following treatment in 107 patients with congenital penile curvature. Sonbahar AE also utilized the MGSIS, IIEF, and BDI instruments in research exploring the relationship between male genital self-perception, sexual function, and depression and anxiety. The study found a moderate association between diminished genital self-image and increased susceptibility to depression and anxiety [8].

In this study, patients who underwent ventral phalloplasty were assessed in terms of depression, genital self-image, and sexual function using the MGSIS-7, IIEF-15, and BDI. The findings indicate that the technique has a positive impact on both functional outcomes and aesthetic concerns. However, the limited available literature restricted comprehensive comparisons with the existing studies. This work is the first to evaluate the functional and cosmetic effects of ventral phalloplasty using the MGSIS-7, IIEF-15, and BDI. This study may provide a foundation for future research.

Among the most significant limitations of this study are the following: female partners were not assessed; pre- and post-operative penile length was not measured; the study relied solely on patients' subjective perceptions of increased penile length; and the findings were not supported by objective quantitative data. In addition, this study evaluated only the outcomes of the ventral phalloplasty technique. The study lacks a control group and does not compare the technique with alternative surgical methods. This single-arm design is a limiting factor that reduces the reliability of the results. Moreover, the limited number of participants, the single-center and retrospective nature of the study, the need to compare a broader range of surgical approaches, potential reliability concerns associated with questionnaire-based assessments, and the relatively short follow-up period also limit the strength of the findings.

5. Conclusions

Ventral phalloplasty represents a safe and effective approach for correcting PSW and scrotal laxity, offering substantial improvements in patients' quality of life, genital appearance, and functional outcomes. Assessments using the MGSIS-7, BDI, and IIEF-15 indicate that the technique positively affects both functional and cosmetic outcomes. As awareness of PSW and scrotal laxity increases, there is an increasing need for additional studies with longer follow-up periods to broaden surgical options and support the development of standardized treatment protocols.

AVAILABILITY OF DATA AND MATERIALS

All relevant data are contained within this article.

AUTHOR CONTRIBUTIONS

KY, EK—Research concept and design; Data collection; statistical analysis; Data analysis and interpretation; administrative, technical, or financial support; critical review of the manuscript; consultation. KY—Preparation of the manuscript draft; Approval of the final manuscript. Both authors read and approved the final manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The study was approved by the Local Ethics Committee of Tokat Gaziosmanpaşa University Faculty of Medicine (Approval No: 25-MOBAEK-396, Date: 18 November 2025). The study was carried out in accordance with the ethical guidelines of the Declaration of Helsinki, and written informed consent was waived by the Ethics Committee. Patient images were included with signed informed consent.

ACKNOWLEDGMENT

Not applicable.

FUNDING

This research received no external funding.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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How to cite this article: Kenan Yalçın, Engin Kölükçü. Evaluation of the ventral phalloplasty technique for adult penoscrotal web and scrotal laxity repair using the male genital self-image scale, Beck depression inventory, and International index of erectile function. Revista Internacional de Andrología. 2026; 24(2): 83-90. doi: 10.22514/j.androl.2026.022.