Peer Review File
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Review Comments
Reviewer A

I believe that the effort made towards providing advice on the psychological aspects of penile implant surgery is commendable. While it is understandable that there is a scarcity of data available on this topic, the information provided can be quite beneficial for patients undergoing this procedure.

Comment 1: With regards to the paragraph on the relationship between the number of procedures and the likelihood of complications or revision surgery, it would be beneficial to include a reference to support the statement. This is important for maintaining academic rigor and credibility in the discussion. In light of this, I suggest a minor revision, I hope that this suggestion proves useful in improving the quality of your work.
Reply 1: Thank you for your comments. We have updated the manuscript with a reference to support the statement on surgeon volume and revision/complications.
Changes in the text 1: We have added a reference (now #34). Page 8, Line 192.

Reviewer B

This is a review paper looking at IPP implantation in patients who are "mentally complex." The authors note that patient psychological state can impact their overall experience and ability to cope with their operative and postoperative course.
Comment 2: The authors should define "mentally complex," and note where this term comes from
Reply 2: We agree this term is ambiguous. Per your suggestion below, we have now involved a reproductive psychiatrist in the manuscript. Dr. Betcher has offered multiplie changes to enhance the paper. Based on your suggestion and her comments, We have removed this term form the mansucript and changed the mansucript title.
Changes in text 2: “Mentally complex” verbiage removed from manuscript. Title updated to “Assessing Psychiatric Risk with a Focus on Optimizing Patient Satisfaction with Penile Prosthesis Placement – A Narrative Review”

Comment 3: The manuscript would be strengthened by having a mental health provider as a co-author
Reply 3: Thank you for your suggestion. Based on your suggestion, we have now included a psychiatrist with expertise in reproductive health to review the manuscript in the context of the target audice (urologists). We have updated the authorship to reflect this.

Comment 4: The authors note a focused physical exam will include a psychiatric exam, and they note that components that warrant further investigation include symptoms of multiple psychiatric disorders. However, the authors do not provide any practical details about how a urologist should assess for these conditions. If the authors just mean we should screen the patient's chart or ask them if they have certain diagnoses, then this is really part of the history-taking and not the physical exam.
Reply 4: This is a very helpful suggestion, we have re-arranged the history gathering section and made extensive changes to the manuscript.
Changes in the text 4: We have made extensive changes. "Components of a patient's psychiatric historythat may warrant further investigation include past or current symptoms of major depressive disorder, generalized anxiety disorder, obsessive compulsive disorder, adjustment disorder, borderline personality disorder, and body dysmorphic disorder.(15) Standardized objective screening questionnaires are useful screening tools. Examples include the Patient Health Questionnaire- 9 (PHQ-9) and the General Anxiety Disorder-7 (GAD-7). (19, 20) In addition to directly querying psychiatric history, a review of current medications may indicate ongoing treatment for psychiatric conditions. A history of psychiatric comorbidities may suggest increased risk for dissatisfaction, but the more important aspect of this initial assessment is to determine if a patient has active, untreated symptoms that may require additional support.(21) Patients with poorly managed psychiatric conditions may not have the psychological reserve or ability to cope with a significant complication." (Pages 4-5; Lines 96-105)

Comment 5: The authors note that patients should be referred to a mental health professional for optimization. How is one to know if a patient is "optimized" before moving to surgery with respect to mental health conditions.
Reply 5: Thank you for this comment. As urologists, we are not experts in mental health but do have an obligation to ensure that our patients are adequately counseled and prepared to undergo the surgeries that we offer. This is particularly relevant for elective surgery such as penile prosthesis. Based on your comments, we have updated the mansucript as noted below.
Changes in the text 5: "There are no clearly defined guidelines for determining whether additional mental health evaluation is warranted. In this context, referral to a mental health professional or engaging with the patient's established mental health care team prior to moving forward with prosthesis surgery should be guided through a shared decision-making framework supplemented by clinical gestalt from the evaluating urologic surgeon." (Pages 5, Lines 105-108)

Comment 6: The authors give a lot of great tips to avoid complications and important pearls regarding Peyronie's disease on lines 167-185, but it's unclear how this section relates to the topic of the manuscript, which is "mentally complex" patients. These concepts apply to cases in all patients.

Reply 6: Thank you for this comment. We agree that this section lacks context. We have moved pertinent discussion points to the "History and exam" portion.
Changes in the text 5: The following has been updated under history and exam: **"**Unrealistic expectations will compromise success with PP placement. It is important for all patients to understand that PP placement alone will not recover length, and most patients will actually perceive their penis to be shorter after surgery.(24) Documenting preop penile length can help with patient expectation setting. PD may be anticipated preoperatively based on patient history and physical examination, but the surgeon may also be surprised intraoperatively when encountering unanticipated curvature. The latter is more common in men who have a long-standing history of medication refractory ED, as they are unable to assess and thereby report any perceived penile deformity. Many patients with PD report significant baseline psychological distress.(25), includinga sense of shame and social stigmatization and isolation.(26) This can result in or exacerbate underlying psychiatric disroderssuch as depression and anxiety, leading to poor quality of life for many patients that extends beyond sexual health. Additional preoperative counseling may be necessary to ensure appropriate patient expectations after surgery."
(Pages 5-6, Lines 128-137)

Comment 7: It would be nice to have more detail on how to identify when a patient has body dysmorphia, and how to specifically address that, particularly when the patient's goals seem unrealistic.
Reply 7: Thank you for this helpful comment. We have updated the manuscript with additional comments/references.
Changes in the text: We have added the following "A complete review of penile dysmorphic disorder (PDD) is beyond the scope of our review, but it is worth noting. PDD refers to a subset of patients with body dysmorphic disorder (BDD) who are pre-occupied with the size and shape of their penises.(22) Many patients with medication-refractory ED and/or Peyronie's disease report bothersome penile length loss.(23) Most of these patients do not have PDD, but may still have significant anxiety related to penile size loss. Validated questionnaires for BDD can be useful to screen for the extent that penile size concerns impact a patient's quality of life extending beyond sexual activity alone.(22)" (Page 5, Lines 122-127)