Peer Review File
Article information: https://dx.doi.org/10.21037/tau-23-182

Review Comments

Reviewer A

This is a nice narrative review of the authors opinions and experience in penile prosthetics and AUS placement using an infrapubic approach.

While of interest, the authors provide few studies or objective support of their opinions and practices.

They have been doing these cases for 4 decades. Why did they not share with the readership their own data?

As mentioned in the introduction section, we make reference to some of our data in citations 7-9.

What are the advantages and disadvantages of their approach compared to subcoronal or scrotal?

We have included a paragraph/sub-section to discuss the differences in approach and included references

Can they share some studies that support their choices in patient management?

Added

I would like to see that their usual approach or patient management is based on some objective evidence rather than simply "this is how we do it".

The authors provide no comparative data.

Please see above comment. A new paragraph comparing approaches has been added.

They provide no information related to complications or strategies to avoid or get out of difficult situations.

This was not requested by the Editors

Reviewer B

Well done.

Reviewer C

Several additional details should be provided

-What device(s) (details) are used for the scenarios described; single or multiple surgeons/operative sites over what interval?

A 3 piece inflatable device was used in all the scenarios described. We have changed the title

and several statements throughout the manuscript to make this clear. A malleable or 2-piece device was not used for the sake of this manuscript.

-Further detail of surgery, perioperative antibiotics helpful

We have added the antibiotics used

-What is authors' outcome data (success, complications, need for revision/explant/replacement) in each challenging scenario

We have added some outcome data to some of the challenging scenarios

-What is the success rate when replacing new implant infrapubic approach after removal of an implant that was placed through a penoscrotal incision

Anecdotally, excellent. We unfortunately do not have data on this at this time.

-Can you provide any additional illustrative photos of their specific reservoir placement or suprapubic Lipodystrophy- removal of excess fat
We have added a Figure showing Midline SOR reservoir placement

We recently had this series accepted as well as accompanying video. We have added that reference to the text

Reviewer D
The authors provide their technique for infrapubic insertion of penile prostheses, including excellent description of challenges the surgeon may encounter. Unique scenarios in which the infrapubic approach are helpful are described and discussed with supporting literature.

Abstract, line 54 - which keywords were used in the Medline search to obtain other results?

Line 96 - what is the author's main technique for placing the pump through the infrapubic incision? Is a nasal speculum used? Any special maneuvers to prevent cephalad migration?

We have added a Figure to show our technique for pump placement. We do not use a nasal speculum.

Line 212 - can the author expand on these complications of concomitant buried penis repair and penile prosthesis placement and the length of follow-up thus far? What is considered "not significant"?
We have now had this series accepted for publication. I have added the reference and clarified the above statement

Line 215 - any specific complications that the prosthetic surgeon should be aware of specific

to the infrapubic approach? E.g. signs of neurovascular bundle injury?

As discussed in the general technique section, neurovascular injury and avoidance strategies are reviewed.

Reviewer E

IPP implantation represents a valuable option in men with drug-refractory ED. Over the decades, various surgical approaches (penoscrotal, infrapubic, subcoronal, suprapubic, perineal) for IPP implantation have been proposed: each approach has its good and bad.

With regard to infrapubic approach, especially the recently developed minimally invasive technique by Perito, it has been gaining increasing popularity among surgeons also in challenging scenarios.

In the present paper, the authors sought to perform a review on the use of infrapubic approach in the management of surgically complex patients

Title: accurate

Abstract: reflects the report

Introduction: states background and objectives

Results: the data are well presented. However, a Table summarizing data from main studies on the topic [i.e.. study type (single-centre or multi-centre, prospective or retrospective, etc.), level of evidence (I: High quality randomized trial or prospective study, systematic review of Level I RCTs and Level I studies; II: Lesser quality RCT; prospective comparative study; retrospective study; etc.), numbers of included patients, et.] would be very useful for readers

Conclusions: the interpretation is clear

References: I would suggest to check and update the references list. I.e. please see and eventually include the following paper: Di Pierro GB, Lemma A, Di Lascio G, El Motassime A, Grande P, Di Giulio I, Salciccia S, Maggi M, Antonini G, De Berardinis E, Cristini C, Sciarra A. Primary versus revision implant for inflatable penile prosthesis: A propensity score-matched comparison. Andrologia. 2021 Dec;53(11):e14240. doi: 10.1111/and.14240. Epub 2021 Sep 9. PMID: 34498769; PMCID: PMC9285038.

Reviewer F

Line 59-60: The suprapubic approach was the first description by Brantley Scott, not the infrapubic. Large incisions were required to bury the tubing so that it wouldn't kink. Development of kink resistant tubing (KRT) allowed for smaller incisions and the infrabubic approach was a natural transition because of the familiarity with the suprabubic approach. Please correct.

Thank you. We have corrected this

Line 67: Even though you guys are close, I would refer to him as Dr Boyd in the paper.

Changed.

Line 81-83: Please comment if there have been any cases of glans hypoesthesia in Dr Boyd's or your practice using the infrapubic approach.

Line 86: Overly aggressive lateral suture placement can also end up in the urethra. I would add that as I have heard from beginner IP surgeons about this happening.

Great point. I have added this

Line 103: I would add Space of Retzius in parentheses after retropubic space. This is how you refer to it in Line 114.

Added

Line 140: "Avoidance of dual prosthetic infection is obviously preferential, and we believe the infrapubic approach helps to prevent that". Does this mean that when an infection in one device occurs you salvage the other device? Please comment.

We have included a comment about our particular experience where we have not seen crossover infections. In 28 patients presenting with AUS erosion/infection who had a penile prosthesis, the IPP was not infected and did not require explant or salvage. We also clarified this comment so the overall message is clearer.

In the section "Patients with an Artificial Urinary Sphincter" please comment on transcorporal cuff placement and IP IPP.

Great point. Transcorporal cuff placement is notably more difficult when the implant was placed through a penoscrotal incision.

Line 162: Please add reference to the sentence. I think it is missing.

Line 171-173: "With the cylinders in place and the device partially inflated, the plaque is incised transversally through the dorsal plaque and extended laterally to the urethra". I think this is a scenario that can be done only with a smaller penis. Eversion of the penis and inflation is very difficult with a penis of any significant size. Please qualify.

Good point. We have added the suggested qualification

Line 211: "In our initial experience of approximately 15 patients, wound, mechanical, and infectious related complications have not been significant." Please specify what complications did occur.

We have included this.

Reviewer G
This article is quite good. I have only a few minor considerations.

Title: No concern.

Abstract: The author uses "our" in the abstract and "my" in the text. "My" is entirely appropriate given that there is only one author.

Introduction: It may be more appropriate to refer to urology elder statesmen by their formal titles.

I have changed this

General Technique: What dilators do you use? Also "fascia" does not need to be capitalized.

We use Hagars. I have clarified this.

Fibrosis/Scarring: Please cite the Levine article. Did you mean peer-reviewed in line 123?

I have included this reference and corrected it to read peer-reviewed

Patients with an AUS: In line 156, is this multicenter study forthcoming?

It is but is still in data collection phase so I have removed that statement for clarity.

Complex Dorsal Deformity: I would suggest also including plication to the list starting on line 161. The mention of Penuma requires corporate attribution and headquarters location please. I believe that is the first example of this need but if not please include for other devices, tools, etc.

I have removed the reference to Penuma. It should be apparent what the technique is with the Figure included.

Corporal Fibrosis: The comma in line 193 may not be necessary.

Buried Penis: No concerns.

Post-Operative Care: No concerns.

Conclusion: No concerns.

References: There is significant variation in reference formatting.

Figures: No concerns.

Reviewer H

The author reports his experience with the suprapubic approach for erectile prosthesis. Some parts of the discussion are interesting, but an important part of the article is based on non-referenced beliefs or opinions. This work may benefit from a more extensive analysis of the literature results of the complex cases in suprapubic approach.

General technique

The description of the technique of suprapubic implantation is quite common and may not be so pertinent to report in the article.

Fibrosis/Scarring of the Retzius Space

It may be relevant to have a more in-depth analysis of the reported complications associated with reservoir placement on complex cases, with a comparison between infra and suprapubic based on literature results.

Patients with AUS

The author acknowledges the lack of study comparing AUS outcomes by penile implant approach, but again a more extensive report of the knowns results in the literature with both techniques may be preferable to cite only one of the author's studies.

Buried penis.

A more thorough discussion of the published results would be interesting.

Conclusion

The conclusion appears not really supported by the article results.

Reviewer I

I have had the pleasure of reviewing the manuscript "Managing The Surgically Complex Penile Implant Through an Infrapubic Incision".

It is a narrative review of the advantages of the infrapubic versus the penoscrotal approach to penile prosthesis placement, based on the long-standing experience of a single surgeon.

Although this is a narrative review, the insight it provides and the expert notes it makes I think may be useful for young implanters.

It is true that much of the information documented in this manuscript has been previously reported in other studies and cannot be considered novel.

In general, the text can be considered to be adequately written, with no errors of any kind. The number of references is appropriate, and the structure of the manuscript is correct.

I believe that the type of article chosen (original article) does not correspond to the manuscript since it is, as I said, more of a narrative review.