Peer review file
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Review A:

Comment 1: This isn't a scientific paper despite the methods leading one to believe it is a systematic review/meta-analysis. It appears to be a review paper.

Reply 1: We do not claim that this is systematic review/meta-analysis, primarily because there simply is nothing written on this subject. The intention of this paper is to address this "controversy in urology" as this issue is so aptly titled.

Changes in the text: We have added a clarifying statement on page 8, lines 125-127.

Review B:

Despite clear attempt to describe strategies to manage men with concurrent BPH and penile prosthesis, the authors have not addressed the specific aims of this proposed "review" article

Comment 1:
h1. Preoperative workup- I don't see there is any clinical difference in the workup between men with or without penile prosthesis who have BPH. There is no literature to suggest that men with existing penile prosthesis implant should undergo additional tests.

Reply 1: We agree that there is no literature regarding management of BPH in the setting of penile prosthesis, which is the purpose of this review. Complications regarding management of BPH or urinary retention in the setting of penile prosthesis are rare, and go underreported.

Changes in the text: We have added a statement to this effect on Page 8, lines 129-134.

Comment 2: Surgical considerations- Again, I dont think the presence of a penile prosthesis mandates a different approach or modality of BPH therapies. However, it is important that surgeon do not use an OTIS urethrome at the start of surgery due to the risk of cutting through the spongisum/cavernosum (this is not highlighted by the authors). Also, the corporal bodies diverges proximally, the risk of prostatic capsular perforation while should not injure the cylinder, there is a risks of bacteremia with prosthetic infection- hence greater care to avoid capsule perforation.

Reply 2: We agree with your statement regarding capsular perforation exposing this sterile space to urine extravasation potentially increasing the risk of infection. We have also added direct vision internal urethrotomy to the list of procedures that should be approached with caution to avoid violating the corpus spongiosum.

Changes in the text: We have added a statement reflecting this on page 18, lines 330-331. On page 21, lines 382-385 we have included your suggestions regarding violating the corpus spongiosum.

Comment 3: Postoperative challenges- if the patient went into retention, a temporary catheter does not increased the risk of prosthetic infection or perforation. With chronic retention, the options can be SPC or self-catheterisation. Even with patients with infra-pubic penile prosthesis implant, a simple U/S guided SPC insertion will solve this (non)issue.

I would suggest the authors actually list the case reports on IPP related complications from BPH therapy and then expand the Discussion appropriately to address these issues.

Reply 3: We would argue that both a suprapubic tube and intermittent self-catheterization pose an infection risk. We have added one of our own cases to illustrate both of these points. Particularly with an infra-pubic prosthesis, the insertion site will be within close proximity to the cylinder tubing. The issue is not injuring the device during insertion, but rather extravasation of urine through the tissue layers around the suprapubic tube and seeding of bacteria. We completely agree with your comment regarding a list of our cases to illustrate these concerns, that's a great idea. We have included an illustration of our cases at the beginning of the review.

Changes in the text: Please see the addition of the cases that we have added to illustrate this point on page 8, lines 135-208.

Review C:

The paper presented is well-written and should be considered for publication.
Please find below comments/suggestions regarding the contents of the paper.

Comment 1: The authors might consider mentioning low intensity extracorporeal shockwave therapy for erectile dysfunction as a treatment modality for erectile dysfunction in the introduction. There some studies supporting that approach. A recent and relevant paper is: Sokolakis I, Hatzichristodoulou G. Clinical studies on low intensity extracorporeal shockwave therapy for erectile dysfunction: a systematic review and meta-analysis of randomised controlled trials. Int J Impot Res. 2019 May;31(3):177-194. doi: 10.1038/s41443-019-0117-z . Epub 2019).

Reply 1: We respectfully would decline to add a statement regarding extracorporeal shockwave therapy to this paper as the focus is patients with a penile prosthesis, no alternative treatments for erectile dysfunction.

Changes to the text: none

2) In the BPH work up in ED patients Section:

Comment 2:- IPSS-Score for assessment of male LUTS should perhaps be mentioned as an alternative to American Urological Association Symptom index. That is due to the wide use of the IPSS-Score in Europe.

Reply 2: We agree that this is an important point, and have made changes to the text.

Changes to the text: We have added a reference to the EAU and IPSS on page 13, lines 218 and 220-221.

Comment 3: For completeness, the authors might mention other new technique modalities for BPH treatment such iTind Olympus und Optilume BPH catheter system (still under investigation, see Pinnacle trial) in the context of preservation of erectile function und ejaculation.

Reply 3: We agree that for the sake of completeness we should include these additional treatment modalities.

Changes to the text: We have added both of these modalities to page 14, lines 230-233.

Comment 4: - Concerning urethral stricture und bladder neck contracture, some general expert advice based on the opinion/practice of the authors should be added. For instance, if the patient has had a surgery for the above mention conditions, a new urological re-examination in 6 months should be undertaken and in order not to compromise lower urinary tract, a penile surgery can be recommended. In my opinion, it would be extremely beneficial for the readers of the paper to have such an insight, whether to perform PPS or not.

Reply 4: We agree that providing some guidance on how to manage this situation would be helpful and have added this to the text.

Changes to the text: We have added a statement with our suggestions for management on page 22, lines 397-399.

Comment 5: 3) In Treatment of BPH after Penile Prosthesis Surgery Section : iTind Olympus and Optilume BPH should be mentioned as new treatment modalities of BPH.

Reply 5: As mentioned in Comment 3, we have added these modalities.

Changes to the text: We have added both of these modalities to page 14, lines 230-233.