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CME Information: Managing the Difficult Penile Prosthesis Patient

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CME

Managing the Difficult Penile Prosthesis Patient

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ABSTRACT

Introduction. Inflatable penile prostheses (IPPs) are associated with excellent long-term outcomes and patient/partner satisfaction. A small percentage of patients remain dissatisfied, despite acceptable surgical results.

Aims. This study aims to evaluate factors associated with patient satisfaction and dissatisfaction, define patient characteristics, which may identify elevated risk of postoperative dissatisfaction, and describe management strategies to optimize functional and psychological patient outcomes.

Methods. A review of urologic and non-urologic cosmetic surgery literature was performed to identify factors associated with patient satisfaction/dissatisfaction. Emphasis was placed on articles defining “high risk” or psychologically challenging patients.

Main Outcome Measures. Preoperative factors associated with patient satisfaction/dissatisfaction and character traits, which may identify elevated risk of postoperative dissatisfaction or otherwise indicate a psychologically challenging patient.

Results. Contemporary patient and partner satisfaction rates following IPP are 92–100% and 91–95%, respectively. Factors associated with satisfaction include decreased preoperative expectations, favorable female partner sexual function, body mass index ≤30, and absence of Peyronie’s disease or prior prostatectomy. Determinants of dissatisfaction include perceived/actual loss of penile length, decreased glanular engorgement, altered erectile/ejaculatory sensation, pain, diminished cosmetic outcome, difficulty with device function, partner dissatisfaction and perception of unnatural sensation, complications, and extent of alternative treatments offered. Personality characteristics which may indicate psychologically challenging IPP patients include obsessive/compulsive tendencies, unrealistic expectations, patients undergoing revision surgery, those seeking multiple surgical opinions, feeling of entitlement, patients in denial of their prior erectile/sexual function and current disease status, or those with other psychiatric disorders. The mnemonic **CURSED** Patient is presented: “Compulsive/obsessive, Unrealistic, Revision, Surgeon Shopping, Entitled, Denial, and Psychiatric.”

Conclusions. Although the majority of IPP patients experience excellent, durable satisfaction and outcomes, a challenging subset of patients may be at increased risk of postoperative dissatisfaction. Appropriate recognition/prevention and management of this cohort may help to establish and strengthen relationships, reduce physical, emotional, and legal risk, and ultimately enhance patient satisfaction. **Trost LW, Baum N, and Hellstrom WJG. Managing the difficult penile prosthesis patient. J Sex Med 2013;10:893–907.**

Key Words. Expectations; Cosmetic; Disappointment; Dissatisfaction

Introduction

Since its introduction, surgical placement of the inflatable penile prosthesis (IPP) has undergone continued improvements in both

surgical techniques and prosthetic design. These enhancements have ultimately resulted in excellent long-term functional and patient outcomes, such that the IPP arguably remains one of the most mechanically reliable and overall successful

prosthetic devices in current surgical practice. Contemporary series examining outcomes of three-piece IPPs have demonstrated patient and partner satisfaction rates of 92–100% and 91–95%, respectively [1–3].

Despite these excellent results, a small percentage of IPP patients are dissatisfied with the procedure. Additionally, patient reports of overall satisfaction have traditionally been lower than those identified in physician-completed surveys, indicating a discrepancy between surgeon and patient criteria for overall success [4].

As successful outcomes defined by the surgeon do not necessarily guarantee satisfaction as perceived by the patient, a psychological component of therapy is often present. Indeed, as is common with cosmetic surgery, implantation of a penile prosthesis may be termed psychosurgery, as it impacts factors beyond treatment of the organic condition. This is supported by findings of one survey which noted that among dissatisfied IPP patients, 66% (4/6) would continue to recommend the procedure to others, as they felt that it ultimately improved their overall couple relationship [5]. This furthermore highlights the complexity of accurately and comprehensively defining satisfaction following surgery.

Although dissatisfaction with a surgical procedure may relate to technical aspects, including complications or poor outcomes, it often reflects other factors including limited preoperative counseling, a lack of developed patient–physician relationship, poor patient selection, or patient-specific characteristics, among others. The successful prosthetic surgeon therefore is competent not only in surgical technique, but also in the ability to identify and manage patients more likely to be high risk for dissatisfaction, regardless of technical outcome.

To assist the prosthetic surgeon in avoiding potential pitfalls of dissatisfied patients, this communication will first review current rates, definitions, and contributing factors to patient satisfaction/dissatisfaction, followed by identifying several “high-risk” patient characteristics and warning signs. Subsequent strategies will be reviewed, including providing appropriate preoperative counseling, selecting appropriate patients for surgery, optimizing surgical outcomes, managing perioperative complications, and managing difficult/dissatisfied patients. The underlying objective of the current article is therefore to mini-

mize emotional, temporal, physical, and/or financial damage, which might otherwise occur.

It is important to note that there is currently minimal research and literature available regarding the current topic, and as such, much of the data and recommendations are based on compilations of prior authors’ works and recommendations with cosmetic surgical procedures. It is unclear to what degree patients seeking IPP overlap with those undergoing cosmetic procedures, particularly given that motivations for IPP placement for restoration of prior function may be distinctly different from those wishing to change a perceived undesirable, but otherwise functional physical attribute. As such, much of what is presented is based on expert experience (both in the urologic and cosmetic surgical fields) rather than empiric evidence. However, despite the previously discussed limitations, the current article provides an instructive review of personality traits and behaviors, which may be associated with postoperative patient dissatisfaction.

Patient Perceptions

Satisfaction

Defining patient satisfaction is a challenging objective with any surgical procedure and, in particular, with prosthetic surgery. Several methodologies have been proposed to accurately assess successful outcomes including patient questionnaires (Global Assessment Questionnaire [GAQ], Erectile Dysfunction Inventory of Treatment Satisfaction [EDITS], International Index of Erectile Function-satisfaction domain [IIEF], physician surveys), objective measures (length of penis/prosthesis), or defined in the absence of certain factors (operative complications, malfunction, infection) [6,7].

In reviewing reported patient satisfaction following IPP placement, with few exceptions, overall satisfaction rates (variably defined) have increased from 69–89% (1980–1990s) to 92–100% in more contemporary series [1–3,5,8–13]. Although comparisons are limited by methodological differences between studies, these findings appear to highlight a trend toward improving satisfaction rates, likely due in part to mechanical and design enhancements to the devices themselves.

Other factors, which have remained relatively unchanged over time include fulfillment of expectations (82–91%), ability to have satisfactory

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intercourse (83–92%), and continued use of the prosthesis (93–97%) [1,3,5,9,11,13].

In an attempt to identify factors, which may impact overall satisfaction, one study provided a preoperative expectation survey to 21 patients undergoing IPP surgery and correlated findings to a quantified overall satisfaction score at 4 months postoperatively [14]. Findings demonstrated an inverse correlation between patient expectations and postoperative satisfaction, with higher preoperative expectations accounting for ~24% of variability in decreased satisfaction. These results are particularly relevant given that patient expectations are potentially modifiable factors. Other factors that have been associated with improved postoperative satisfaction include favorable female partner sexual function, body mass index ≤30, and absence of Peyronie's disease (PD) or prior prostatectomy, while age, duration of erectile dysfunction (ED), and partner availability were not predictive [15,16]. Of interest, satisfaction rates with either AMS (Minnetonka, MN, USA) or Coloplast (Minneapolis, MN, USA) three-piece IPP devices are equivalent [8].

Although traditional methodologies may be quantifiable and reproducible, they reflect a surgical perspective of defining success rather than one focused on the patient's overall subjective experiences. In addition to surgical outcomes themselves, a patient's experience is also a composite of several other factors including expectations, pre- and postoperative clinic visits, relationships developed with office staff/surgeon, perioperative course (pain, etc.), complications, and personal/psychological issues. This is supported by the finding that persistent subsets of patients elect to not utilize their IPPs, even in the setting of optimal surgical outcomes [14].

Beyond outcomes identified in the urologic literature, there are significant data regarding determinants of satisfaction and the psychological impacts of surgery on patients undergoing cosmetic surgery. Aesthetic procedures have been shown to result in improvements in perceived body image, an effect which is sustained at 2 years following surgery [17,18]. Male and female patients undergoing cosmetic procedures may expect associated improvements in quality of life, self-esteem, and overall anxiety, with satisfaction judged by not only the surgical outcome, but also by its overall impact on the patient's self-esteem [18,19].

Similar to cosmetic surgery, it is likely that some patients undergoing IPP placement are anticipating beneficial, psychological effects such as enhanced self-esteem, body image, confidence, and control, in addition to improvement of their organic erectile function. The ultimate definition for success with IPP placement should therefore be to satisfy the patient, rather than to achieve a predetermined outcome defined by the operating surgeon [20]. Astute surgeons are therefore differentiated by their focus on satisfying the patient overall, regardless of other objective measures of surgical success.

Dissatisfaction

Similar to reported satisfaction rates of IPPs, dissatisfaction is inconsistently examined and defined, with reported rates ranging from 0% to 8% [3,5]. However, if the definition were broadened to include those requiring device explantation (and therefore not included in the majority of satisfaction surveys), those not satisfied or failing to use the device, or those who would not undergo surgery again, this number could be greater than 20–30% [8,9,11,21].

Key determinants of decreased satisfaction with IPP placement includes perceived/actual loss of penile length, decreased glanular engorgement, altered penile sensation, decreased sensation during ejaculation, perioperative discomfort, cosmetic outcome/ease of concealment, difficulty with device function, partner dissatisfaction and perception of unnatural feel, complications, and extent of treatments provided prior to surgery [1,11,14,21–29]. Each of these factors will be further addressed in the management section.

In reviewing cosmetic surgery literature, complications have been shown to increase the risk for patient dissatisfaction with breast reconstructions by 61%, with early (<90 days) complications resulting in a greater risk of dissatisfaction [30]. Additionally, the number of revision rhinoplasties performed is correlated with decreasing satisfaction, while other associated factors include high alcohol intake, poorly established relationships, and overall asthenic temperament [20,31].

As prosthetic surgeons frequently seek to achieve excellence in outcomes, it is not uncommon for a surgeon to feel that a particular outcome is less than the best that he/she can perform [18].

Table 1 Determinants of patient satisfaction and dissatisfaction following IPP placement

Satisfaction
Decreased preoperative expectations
Favorable female sexual function
BMI ≤ 30
Absence of Peyronie's disease
Absence of prior prostatectomy
Dissatisfaction
Perceived/actual loss of penile length
Decreased glanular engorgement
Altered erectile/ejaculatory sensation
Perioperative discomfort/pain
Cosmesis/ability to conceal IPP
Difficulty with device function
Partner dissatisfaction

These feelings are productive when they result in continual improvements in technique and overall treatment; however, they may also be counterproductive when they are projected onto the patient. This may subsequently convince an otherwise happy patient that they have received suboptimal care or results. Revision surgery should thus never be undertaken solely to placate a surgeon's desire for perfection.

Similarly, as surgeons take great pride in their achievements, patient dissatisfaction communicated to the surgeon may result in several natural, although counterproductive, reactions [18,32]. First, the surgeon may wish to satisfy the patient through offering additional surgery, even when surgery is marginally or not indicated. Second, surgeons may take a defensive position including antagonizing patient complaints, reassigning blame on patient actions/compliance, highlighting prior successful outcomes/achievements, or indicating that this particular outcome "never" occurs. These responses place the surgeon and patient at enmity and further strain existing relations. A third response is to try to avoid the conflict through reducing patient contact, declining to return calls or schedule appointments, failing to recognize or address patient concerns, or being insensitive to patient distress. Evading patient contact exacerbates the patient's concerns and may result in litigious behavior. See Table 1 for listing of factors associated with patient satisfaction/dissatisfaction.

Malpractice

Prosthetic surgeons are a relatively high-risk population for potential litigation, malpractice

claims, and threat of physical harm. Although the average urologist is sued twice during their career, a review of medical malpractice claims against urologists from 1995 to 1999 revealed that penile prostheses accounted for 11.8% of claims [33,34]. Additionally, the incidence of lawsuits appears to occur equally among all levels of urologists, regardless of reputation. In comparing average urologists to those listed in the "Best Doctors in America" publication, both were sued at an equal frequency (1.9—average urologist; 2.4—"Best Doctors") [35].

In examining the causes for successful litigations, a 2005–2010 survey of malpractice endourologic procedures found that 68% (17/25) resulted from intraoperative complications [36]. Other common causes of lawsuits include diagnostic errors, failing to properly monitor procedures, or lack of patient information, particularly in relation to vasectomy procedures [37,38].

In reviewing non-urologic literature, 75% of claims against surgeons performing aesthetic procedures occurred due to patient dissatisfaction, poor communication, or misunderstandings in regards to the informed consent [39]. Similarly, an orthopedic article examining patient reasons for bringing litigation found that the three most common factors included surgical error, incorrect diagnosis, or incorrect treatment [40]. Among cases where a poor physician relationship was a contributing factor, the most common causes listed included the physician appearing rushed and uninterested (81%), failing to return messages (52%), unrealistic treatment expectations (49%), condescending or rude physician (46% and 35%), rude or unhelpful office personnel (14%), or rude or unhelpful hospital personnel (12%). These results highlight the importance of the patient–physician relationship preoperatively as well as the significance of effective communication, including appropriate preoperative consultation.

In addition to potential litigation, prosthetic/cosmetic surgeons, in particular, are at an increased risk of threat to personal health. Extreme cases of dissatisfaction have, sadly, resulted in several known attempted or completed murders of surgeons [41–43]. These unfortunate cases further indicate the critical role for appropriate patient selection as well as development of interpersonal skills and relationships.

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Characteristics of Difficult IPP Patients

Despite any number of precautions, certain patients are more likely than others to have inadequate coping techniques or characteristics that place them at risk for having poor outcomes and decreased satisfaction [18]. In regards to psychiatric characteristics, the goal of the current article is not to provide an in-depth review of accepted definitions and diagnosis, but rather to identify certain aspects of personalities, which are high risk of dissatisfaction.

In reviewing the urologic and cosmetic surgery literature, certain character traits have been reported as higher risk for developing postoperative patient dissatisfaction. As very little data exists on this topic, many of the traits identified are taken from studies evaluating patient factors associated with dissatisfaction and from expert opinion publications of a similar nature with cosmetic procedures. The traits identified have not been evaluated using formal psychiatric criteria and are not based on empiric evidence; rather, the current review highlights character traits previously published in the cosmetic surgery literature [18,39,41,44,45]. Characteristics, which will be reviewed, include obsessive/compulsive tendencies, unrealistic expectations, patients undergoing revision surgery, those seeking multiple surgical opinions, feelings of entitlement, patients in denial of their prior erectile/sexual function and current disease status, or those with other psychiatric disorders. In an attempt to facilitate recall, a simple mnemonic is created to broadly classify the characteristics listed: “CURSED Patient” for Compulsive, Unrealistic, Revision, Surgeon Shopping, Entitled, Denial, and Psychiatric. See Table 2 for summary of character traits of psychologically challenging IPP patients.

Obsessive/Compulsive

The majority of patients seeking an IPP have a healthy interest in their sexual health, with an appropriate level of concern for postoperative outcomes. A smaller percentage of patients may exhibit more extreme preoccupation with the penis and therefore may be identified as “penocentric.” Obsessive/compulsive patients may repeatedly obsess about minor or age-associated changes in anatomy, sensation, and function of the penis. They are pathologically observant, overly detail oriented, and may frequently assign causative

Table 2 Character traits of psychologically challenging patients or those at high risk for postoperative dissatisfaction

Trait	Characteristic findings
Compulsive/obsessive	Penocentric Obsess about major or minor abnormalities pre- or post-op Perfectionist Overly optimistic about outcomes Impairs activities of daily life “Goldilocks syndrome” Frequently desire revision surgery
Unrealistic	Overly optimistic about outcomes Deny possibility of complications May present numerous, specific requests Resistant to suggestions of anything but a perfect outcome Seek reassurances about outcomes Underlying motives may be to improve self-esteem, improve relationship, etc.
Revision	Increased risk complications/poor outcomes Frequently seek surgery to satisfy underlying psychological problems
Surgeon shopping	Numerous prior consultations Report what other surgeons have “done” to them Have specific “list” of requests/desired outcomes May overly flatter selected surgeon Quick to criticize at undesirable outcomes May have experience in medical field
Entitled	Share many characteristics with narcissistic personality disorder Overly demanding of time and resources Disrespectful/patronizing, particularly to office staff Demand specialized attention and treatments Disregard clinic/hospital protocols Poorly compliant Increased risk of litigious behavior Poor listeners Have several “personal hypotheses” Dominate conversations
Denial	Common Exaggerated memories of prior penile length, girth, function Frequently occurs with Peyronie’s disease
Psychiatric (patient)	Auditory hallucinations, delusions, paranoia
Psychotic disorders	
Mood disorders	Depression, anxiety, bipolar, cyclothymia Focus on negative aspect of any outcome Unable to find satisfaction in results
Personality disorders	Extremely manipulative, intelligent Unstable/unpredictable Splitting (“best/worst doctor ever”) Alter prescriptions Severe dissatisfaction with undesirable results/complications
Body dysmorphic disorder	Excessive concern with a barely perceptible/absent defect Impairs daily activities Distorted self-image Overlap with obsessive personality

factors to observed changes. Obsessive/compulsive patients demonstrate persistent perfectionism, which is inflexible to change, unrealistic, and overly optimistic. Their focus on the penis may limit social or occupational functions and may significantly impact their quality of life.

Following surgery, obsessive/compulsive patients are at high risk for dissatisfaction and may complain of numerous surgical variables including the length or location of tubing, location of the distal cylinder, concern about penile length despite objective measures to the contrary, or minor/barely perceptible defects. They may exhibit a “Goldilocks-like syndrome” in which they are never happy unless everything is just right. For these patients, they are “happy with everything but . . .” As such, they are at a high risk for desiring further revision surgery, which may be otherwise not indicated. A good rule of thumb is that if the patient’s situation is ruining their life, it is likely to ruin yours.

Unrealistic Expectations

Similar to the obsessive/compulsive patient, those with unrealistic expectations are at high risk of being dissatisfied postoperatively. These patients may be excessively optimistic and discount the possibility of complications. They are very resistant to any information, which goes against their expectations and may have predefined requests as to surgical approach, techniques, or devices inserted.

Patients with unrealistic expectations may assume that the IPP will restore them to their original natural level of function, including penile length, engorgement, sensation, and ejaculatory function. As such, they may seek repeated assurances as to anticipated successful outcomes. Alternatively, these patients may be undergoing the procedure at a partner’s direction or request. They may anticipate that surgery will improve psychosocial factors including relationship difficulties, social anxieties, or other interpersonal limitations. This misplaced causation for their underlying psychological difficulties will likely result in unfulfilled expectations or decision to not utilize the device.

To elucidate potentially hidden motives and anticipated outcomes, directed questions should be posed preoperatively, with additional counseling provided. Patients with high expectations, in particular, should undergo a thorough discussion

of anticipated postoperative outcomes, including the possibility of complications and subsequent management. Patients should be instructed that the goal of surgery is improvement, and not perfection, and that specific results cannot be guaranteed.

Revisions

Patients seeking to undergo revision of an existing IPP are at increased risk for dissatisfaction, infection, and decreased length and sensation compared with primary candidates [46]. Additionally, patients who undergo revision IPPs for reasons other than malfunction, infection, or impending erosion/extrusion represent an estimated 16% of revision cases and may be at an elevated risk for subsequent dissatisfaction, given that patients in this category are, by definition, dissatisfied with their prior IPP experience [47].

One study reviewing outcomes of revision IPPs demonstrated a 58.3% rate of satisfaction with the IPP, with 75% indicating that they would be willing to undergo the surgery again [46]. This decreased rate of satisfaction following revision is consistent with cosmetic surgical literature, which has reported progressive decreases in overall satisfaction with each additional revision procedure [20]. These findings again highlight the unfulfilled psychological aspect of many patients desiring revision surgery for an otherwise functional device and emphasize the need for appropriate preoperative counseling and discussion of surgical goals and expectations.

Surgeons considering revision procedures may consider delaying the procedure for 6–12 months, both to provide sufficient time for tissue healing, as well as to allow the patient additional time to adjust psychologically to their current device and potentially revise their decision for repeat surgery.

Multiple Surgical Opinions

Patients seeking multiple surgical opinions, particularly in the setting of a consensus of opinions, are at increased risk for postoperative dissatisfaction. These patients may report extensive histories of what other surgeons have “done to them” without taking personal responsibility for prior procedures. Alternatively, they may be “shopping” for a particular set of desired outcomes with plans to select a surgeon based on a comparison of promised results.

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Some patients expressing abundant flattery with their selected surgeon may be equally as quick to criticize perceived shortcomings postoperatively. These patients frequently may have prior experience with or exposure to the medical field and may have concomitant psychiatric mood disorders including depression and/or anxiety.

In cases of dissatisfaction with a prior surgeon, patients should be encouraged to express their experiences and opinion without fear of judgment or retribution. Surgeons should, however, refrain from taking sides or disparaging fellow surgeons and should additionally avoid disregarding the complaint, as this may lead to further patient mistrust and strain communication. When appropriate, the previous surgeon may be contacted for further information and to potentially salvage the patient's existing relationship with the previous surgeon and thus prevent litigation of a colleague.

Entitled/Narcissistic

Patients who possess a feeling of entitlement or narcissistic traits are a challenging treatment population and frequently demand excessive amounts of time and resources. The office staff quickly identify entitled patients, as they may display disrespectful and patronizing behavior and may further demand specialized treatments, including unreasonable scheduling requests, frequent calls and/or visits, or individualized treatment protocols. They exhibit disregard for the surgeon, protocols, and office/hospital policies and may behave in an annoyed, hurried, or discourteous fashion. Entitled patients quickly learn the office hierarchy, as well as how it may be manipulated to achieve their goals. They may demonstrate delusions of personal grandiosity and often feel that their condition may only be managed by someone they determine to be of a relatively equivalent stature.

Prior to and following surgery, entitled patients are poorly compliant with instructions and are more likely to become upset or litigious at undesirable outcomes. They are resistant to listening during office consultations and may attempt to displace culpability on others when information is missed or not comprehended. They frequently have personal hypotheses as to etiologies and management plans for their current condition and are dismissive of alternative explanations presented. They dominate most conversations and may repeatedly request information, which was pre-

sented earlier in the discussion. They fail to accept personal responsibility for the decision to proceed with surgery, and as such, they are generally very poor operative candidates.

Denial

One relatively common attribute of patients undergoing IPP placement is denial of their prior erectile/sexual function and current extent of disease. It is not uncommon to have patients describe exaggerated memories of their prior penile length, girth, erectile function, libido, or ejaculation. Similarly, following surgery, these patients may express dissatisfaction due to inadequate length, girth, or any residual curvature. This is especially common among patients with PD, who may have experienced significant decreases in penile length/quality. Although this may be partially ameliorated by preoperative objective measures including penile length and Duplex penile U/S, these patients are at elevated risk of postoperative dissatisfaction with outcomes.

Psychiatric Disorders

As previously indicated, the purpose of the current publication is not to attempt to accurately or completely outline criteria for diagnosis of various psychiatric conditions, but rather to provide potential warning signs of patients who may be at increased risk for dissatisfaction postoperatively. Additionally, there is significant overlap among several of the previously described character traits and true psychiatric disorders including narcissistic personality disorder, obsessive/compulsive disorder, obsessive/compulsive personality disorder, and delusional disorders.

Psychotic Disorders

Patients exhibiting overt psychoses including auditory hallucinations, paranoia, and/or persistent delusions are clearly poor candidates for surgical therapy, particularly given the possibility for further decline in mental/functional status. These patients should be referred to appropriate psychiatric professionals and should be addressed in a straightforward, consistent, and clear manner.

Mood Disorders

In contrast to patients with overt psychoses, those with mood disorders including depression, anxiety, bipolar disorder, or cyclothymia may be considered for surgery following evaluation by psychiatry

and following a period of mood stability. Failure to address the underlying psychiatric disorder prior to surgery may increase the likelihood for dissatisfaction, which is further exacerbated by reduced coping skills and mechanisms.

Patients with mood disorders may tend to focus on any degree of negative outcome or may find negative aspects of any postoperative result. On occasion, they project or externalize their feelings and have difficulty in taking ownership of their current situation or overall happiness. Patients with more severe forms of mood disorders are not optimal surgical candidates as any procedure is unlikely to improve or reverse their emotional state and may, in contrast, exacerbate the condition.

Personality Disorders

Beyond the previously discussed narcissistic and obsessive-compulsive traits, patients with overt personality disorders are poor operative candidates. Borderline personality disorder, in particular, represents a particularly difficult subtype, which demonstrates patterns of instability and unpredictable, rapidly changing, and erratic behaviors. They have advanced manipulative abilities and frequently experience extreme swings in various relationships. Borderline patients may exhibit impulsive behaviors and characteristically “split” others into extremes (i.e., “you are the best and only doctor who understands,” “everyone at that hospital was cruel and uncaring,” etc.). They are often very intelligent and capable and may express extreme anger towards particular individuals whom they vilify. They may additionally attempt to manipulate the surgeon or alter prescriptions, especially in settings where secondary gain is present. These patients are very poor operative candidates and may demonstrate extreme dissatisfaction following surgery, particularly if complications are encountered.

Body Dysmorphic Disorder

Body dysmorphic disorder (BDD) occurs in an estimated 0.7–2.3% of patients, with an increased prevalence of 7–16% among those seeking cosmetic or dermatologic surgery [48–50]. To qualify for the disorder, patients must demonstrate the presence of three criteria: (i) preoccupation and excessive concern with a defect, which is absent, imagined, or that is not noticeable at a conversational distance; (ii) preoccupation hinders normal

social or occupational functioning; and (iii) symptoms cannot be explained by another disorder, such as obsessive-compulsive disorder [44].

Those with BDD have a persistently distorted self-image, with excessive emphasis frequently placed on one specific perceived defect. The patients may obsess over the region in question and may repeatedly evaluate, measure, or wish to frequently discuss the condition. These patients may seek repeated appointments to discuss their concerns despite multiple reassurances and may frequently present themselves to the urologist in a manner, so as not to be perceived as having BDD. In these settings, the staff may frequently assist the surgeon in identifying additional warning signs as to the patient’s underlying motivations and beliefs.

Management of patients with true BDD is complicated by the fact that those who undergo surgery report resolution of their concerned region in only 3.6% of cases [51]. Additionally, 40% of cosmetic surgeons report being threatened by patients with BDD, and 28% of BDD patients self-report violent episodes [43]. Because of these factors, up to 80% of cosmetic surgeons have noted a refusal to operate on patients suspected of having BDD [52,53]. If the operating surgeon ultimately elects to proceed with surgery, at minimum patients with BDD should be evaluated by a psychiatrist prior to the anticipated procedure.

Substance Abuse

Substance abuse, including alcohol and narcotic dependence have long been associated and suggested as causative factors for violent and antisocial behavior [54,55]. Patients with alcohol dependence have high rates of anxiety, cognitive avoidance coping behaviors, and pathological personality disorders, with only 33% of patients found to have secure attachment and coping behaviors among inpatient alcohol admissions [56]. Narcotic abuse is similarly associated with maladaptive personality traits, which may further predispose patients toward future substance abuse [57]. Given this background, patients with a history of substance abuse and/or dependence are likely higher risk for postoperative dissatisfaction. They additionally may have increased difficulty in coping with perceived or actual poor outcomes or complications. As such, these patients should be referred to psychiatric specialists for counseling and treatment prior to consideration of penile prosthesis placement.

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Management

Managing the difficult IPP patient may be one of the most challenging aspects of urologic prosthetic surgery and may be divided into preoperative, intraoperative, and postoperative settings.

Preoperative Consultation

Patient Selection

Appropriate patient selection is possibly the most important aspect of managing difficult IPP patients [58]. It is important to remember that the operating surgeon has authority to refuse to accept a patient as a new patient, and particularly has the responsibility to appropriately select those for whom surgery is indicated. Once surgery is performed, the surgeon has taken responsibility and is accountable for outcomes and future care, particularly in the setting of challenging patient characteristics. As is common in many aspects of medicine, an ounce of prevention is truly worth a pound of cure in regard to selecting appropriate operative patients.

Although there is no optimal method for selecting who is most appropriate for surgery, the previously described mnemonic of CURSED Patient may assist in identifying difficult patients and those with characteristics concerning for postoperative dissatisfaction. Another tool that may help identify “high-risk” patients is the Minnesota Multiphasic Personality Inventory, which has been used to identify a 48–50% prevalence of underlying mental or personality disorder among those seeking cosmetic surgery [59,60]. Other techniques have utilized personality profiles, with some success achieved in predicting postoperative satisfaction [39,58]. Several other articles have outlined concerning patient characteristics, from which many of the recommendations contained in this article were drawn [18,39,41,44,45].

Prior to any final decision on surgery, four criteria should be satisfied: (i) psychological and surgical goals should be defined and realistic; (ii) ability to successfully achieve the predefined goals should be within the surgeon’s level of experience and skill (particularly relevant with revision cases); (iii) the patient should understand and accept that a specific result or outcome cannot be guaranteed, nor can their satisfaction be assured; and (iv) in addition to medical fitness, patients must exhibit sufficient mental/psychological capacity to endure potential disappointments or complications [41]. Any patients not meeting the

above criteria should undergo additional evaluations and/or consultations, including referrals as appropriate.

If a patient is felt to not be an appropriate candidate for surgery, the surgeon may employ several direct or indirect techniques to discourage surgery including pricing yourself out of competition, referring for second opinion, or simply stating that based on the discussion, you would not be able to provide the outcome they are seeking. It may additionally be helpful to establish a relationship with another urologic prosthetic surgeon in the local community to whom you routinely interact with and send challenging patients. This may provide an avenue for both surgeons to obtain second opinions regarding surgical candidacy and postoperative complications, without creating a sense of competition. Regardless of method of communication, the surgeon should be consistent, resolute, and clear in their ultimate decision so as to eliminate any residual doubt or confusion.

Informed Consent/Counseling

In cases where surgery is elected, providing thorough informed consent is essential toward establishing realistic expectations. Although this is most frequently performed as a one-on-one discussion, other potentially more effective methods include watching a prerecorded video (with documented acknowledgment of the patient having viewed the video), having the patient’s partner, friends, or relatives present, or conducting the discussion over several visits. Additionally, patients may be referred to other IPP patients who are agreeable to participate and who are requested to specifically discuss their postoperative experience, outcomes, and expectations. To provide patients a baseline, objective assessment, penile Duplex ultrasound with vasoactive substance injection may be performed, with images and stretched/flaccid penile measurements obtained. This is particularly relevant among patients with PD.

An appropriate informed consent decreases the likelihood for potential physical, emotional, and financial injury sustained from difficult patients and allows the surgeon the opportunity to preempt any possible future issues, which may arise. In this regard, what is discussed preoperatively is informed consent, while the same information delivered postoperatively is interpreted as an excuse. To further assist providers with the informed consent process, the Sexual Medicine

Society of North America has previously published a Penile Prosthesis Information Form (see Appendix S1), which includes a detailed review of expectations and potential complications [61].

In addition to informed consent, patients should undergo education and counseling as to possible changes to penile sensation, engorgement, and length, post-op pain, and difficulty in device utilization, among others [23,24]. Patients should, ideally, have previously trialed other less invasive therapies (phosphodiesterase type 5 inhibitors [PDE5s], vacuum erection devices [VEDs], intracavernosal injection therapies, intraurethral suppositories), as those who have attempted multiple therapies are more likely to be satisfied than those with lesser exposure [14,62–65]. Patients electing to proceed directly to IPP without trialing other therapies should receive special counseling and warnings to reduce postoperative dissatisfaction.

Intraoperative Management

Although a thorough review of operative procedure is beyond the scope of the current article, several adjunctive techniques may be performed at the time of IPP in an attempt to address factors associated with dissatisfaction. As mentioned previously, reasons for patient dissatisfaction following IPP commonly include loss of perceived length, poor glanular engorgement, unnaturalness as perceived by the partner, or overall sexual dissatisfaction by the patient and/or partner [1,21,22,26].

To address concerns regarding penile length, the surgeon may elect to perform a ventral phalloplasty, release of suspensory ligament, or place an oversized prosthesis in the appropriate circumstances [66,67]. A cold glans penis or poor glanular engorgement may be improved through use of PDE5s, intraurethral suppositories, or concomitant use of a VED. Difficulties in patient/partner sexual satisfaction may be ameliorated through appropriate sexual counseling and therapy [68,69]. Each of these techniques creates no added morbidity and may enhance the patient's overall outcome and experience.

Postoperative Management

Patient's early experiences postoperatively may establish perceptions of the overall experience and create a pattern of dissatisfaction or concern early

on, despite optimal surgical results. This "postsurgical dissatisfaction syndrome" has been described with cosmetic surgical procedures and has been compared with posttraumatic stress disorder [19]. Factors, which contribute toward postoperative satisfaction, include optimizing pain control and enhancing patient relationships with the surgeon, office staff, and hospital staff. Patients should feel that they have ready access to medical care to ease potential concerns and receive treatment if needed. Experienced surgeons recognize the significant psychological impact of surgery and understand that ultimate success as perceived by the patient is as much a function of their established relationships with the surgical team as is the outcome itself.

Postoperative complications should be differentiated from unfavorable results, where the patient takes part ownership of the initial decision to undergo surgery. When complications occur, the patient/physician interaction should be increased to demonstrate support and empathy until a full resolution of the problem is achieved. Complications should be discussed immediately, openly, and honestly with patients so as to keep them informed and to maintain a trustworthy relationship. Where appropriate, patients may be referred to other surgeons, to provide assurance that they have been treated appropriately. It is noteworthy that complications frequently may either unmask deficient preoperative relationships or conversely, may further strengthen preexisting emotional bonds.

Summary

Surgical placement of an IPP is associated with excellent long-term outcomes, including mechanical function, infection rates, complications, and patient/partner satisfaction. Despite these results, the prosthetic surgeon is frequently faced with challenging patients who are at increased risk of postoperative dissatisfaction. Character traits of difficult IPP patients include obsessive/compulsive tendencies, unrealistic expectations, those undergoing revision surgery, those seeking multiple surgical opinions, feelings of entitlement, patients in denial of their prior erectile/sexual function and current disease status, or those with other psychiatric disorders. These traits may be recalled through the mnemonic CURSED Patient.

Several management strategies may enhance patients' overall experiences and assist the surgeon

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in managing challenging populations. Preoperative techniques include appropriate patient selection, counseling, education, and informed consent, while intraoperative performance of adjunctive techniques may optimize factors traditionally associated with patient dissatisfaction. Following the surgical procedure, patients should continue to receive regular postoperative care and attention, particularly in the setting of undesirable outcomes or complications.

By providing a framework to identify and interact with difficult IPP patients, it is hoped that this information will enhance the prosthetic surgeon's ability to establish and strengthen relationships, reduce physical, emotional, and legal risk, and ultimately enhance patient satisfaction.

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References

- 1 Montorsi F, Rigatti P, Carmignani G, Corbu C, Campo B, Ordesi G, Breda G, Silvestre P, Giannusso B, Morgia G, Graziottin A. AMS three-piece inflatable implants for erectile dysfunction: A long-term multi-institutional study in 200 consecutive patients. *Eur Urol* 2000;37:50–5.
- 2 Wilson SK, Delk JR, Salem EA, Cleves MA. Long-term survival of inflatable penile prostheses: Single surgical group experience with 2,384 first-time implants spanning two decades. *J Sex Med* 2007;4:1074–9.
- 3 Natali A, Olianas R, Fisch M. Penile implantation in Europe: Successes and complications with 253 implants in Italy and Germany. *J Sex Med* 2008;5:1503–12.
- 4 Slevin ML, Plant H, Lynch D, Drinkwater J, Gregory WM. Who should measure quality of life, the doctor or the patient? *Br J Cancer* 1988;57:109–12.
- 5 Bettocchi C, Palumbo F, Spilotros M, Lucarelli G, Palazzo S, Battaglia M, Selvaggi FP, Dittono P. Patient and partner satisfaction after AMS inflatable penile prosthesis implant. *J Sex Med* 2010;7:304–9.
- 6 Althof SE, Corty EW, Levine SB, Levine F, Burnett AL, McVary K, Stecher V, Seftel AD. EDITS: Development of questionnaires for evaluating satisfaction with treatments for erectile dysfunction. *Urology* 1999;53:793–9.
- 7 Rosen RC, Riley A, Wagner G, Osterloh IH, Kirkpatrick J, Mishra A. The international index of erectile function (IIEF): A multidimensional scale for assessment of erectile dysfunction. *Urology* 1997;49:822–30.
- 8 Brinkman MJ, Henry GD, Wilson SK, Delk JR 2nd, Denny GA, Young M, Cleves MA. A survey of patients with inflatable penile prostheses for satisfaction. *J Urol* 2005;174:253–7.
- 9 Carson CC, Mulcahy JJ, Govier FE. Efficacy, safety and patient satisfaction outcomes of the AMS 700CX inflatable penile prosthesis: Results of a long-term multicenter study. *AMS 700CX Study Group. J Urol* 2000;164:376–80.
- 10 Holloway FB, Farah RN. Intermediate term assessment of the reliability, function and patient satisfaction with the AMS700 Ultrex penile prosthesis. *J Urol* 1997;157:1687–91.
- 11 Goldstein I, Newman L, Baum N, Brooks M, Chaikin L, Goldberg K, McBride A, Krane RJ. Safety and efficacy outcome of mentor alpha-1 inflatable penile prosthesis implantation for impotence treatment. *J Urol* 1997;157:833–9.
- 12 Garber BB. Mentor Alpha 1 inflatable penile prosthesis: Patient satisfaction and device reliability. *Urology* 1994;43: 214–7.
- 13 Goldstein I, Bertero EB, Kaufman JM, Witten FR, Hubbard JG, Fitch WP, Geller RA, McKay DL, Krane RJ, Borges FD. Early experience with the first pre-connected 3-piece inflatable penile prosthesis: The Mentor Alpha-1. *J Urol* 1993;150: 1814–8.
- 14 Kramer AC, Schweber A. Patient expectations prior to coloplast titan penile prosthesis implant predicts postoperative satisfaction. *J Sex Med* 2010;7:2261–6.
- 15 Akin-Olugbade O, Parker M, Guhring P, Mulhall J. Determinants of patient satisfaction following penile prosthesis surgery. *J Sex Med* 2006;3:743–8.
- 16 Gittens P, Moskovic DJ, Avila D Jr, Chandrashekhar A, Khera M, Lipshultz LI. Favorable female sexual function is associated with patient satisfaction after inflatable penile prosthesis implantation. *J Sex Med* 2011;8:1996–2001.
- 17 Sarwer DB, Infield AL, Baker JL, Casas LA, Glat PM, Gold AH, Jewell ML, Larossa D, Nahai F, Young VL. Two-year results of a prospective, multi-site investigation of patient satisfaction and psychosocial status following cosmetic surgery. *Aesthet Surg J* 2008;28:245–50.
- 18 Adamson PA, Litner JA. Psychologic aspects of revision rhinoplasty. *Facial Plast Surg Clin North Am* 2006;14:269–77, v.
- 19 Tasman AJ. The psychological aspects of rhinoplasty. *Curr Opin Otolaryngol Head Neck Surg* 2010;18:290–4.
- 20 Hellings PW, Nolst Trenite GJ. Long-term patient satisfaction after revision rhinoplasty. *Laryngoscope* 2007;117:985–9.

- 21 Minervini A, Ralph DJ, Pryor JP. Outcome of penile prosthesis implantation for treating erectile dysfunction: Experience with 504 procedures. *BJU Int* 2006;97:129–33.
- 22 Deveci S, Martin D, Parker M, Mulhall JP. Penile length alterations following penile prosthesis surgery. *Eur Urol* 2007;51:1128–31.
- 23 Knoll LD, Henry G, Culkin D, Ohl DA, Otheguy J, Shabsigh R, Wilson SK, Delk IIJ. Physician and patient satisfaction with the new AMS 700 momentary squeeze inflatable penile prosthesis. *J Sex Med* 2009;6:1773–8.
- 24 Henry GD. Historical review of penile prosthesis design and surgical techniques: Part 1 of a three-part review series on penile prosthetic surgery. *J Sex Med* 2009;6:675–81.
- 25 Levine LA, Rybak J. Traction therapy for men with shortened penis prior to penile prosthesis implantation: A pilot study. *J Sex Med* 2011;8:2112–7.
- 26 Porena M, Mearini L, Mearini E, Marzi M, Zucchi A. Penile prosthesis implantation and couple's satisfaction. *Urol Int* 1999;63:185–7.
- 27 Anafarta K, Yaman O, Aydos K. Clinical experience with Dynaflex penile prostheses in 120 patients. *Urology* 1998;52:1098–100.
- 28 McLaren RH, Barrett DM. Patient and partner satisfaction with the AMS 700 penile prosthesis. *J Urol* 1992;147:62–5.
- 29 Whalen RK, Merrill DC. Patient satisfaction with Mentor inflatable penile prosthesis. *Urology* 1991;37:531–9.
- 30 Colakoglu S, Khansa I, Curtis MS, Yueh JH, Ogunleye A, Haewyon C, Tobias AM, Lee BT. Impact of complications on patient satisfaction in breast reconstruction. *Plast Reconstr Surg* 2011;127:1428–36.
- 31 Meyer L, Jacobsson S. The predictive validity of psychosocial factors for patients' acceptance of rhinoplasty. *Ann Plast Surg* 1986;17:513–20.
- 32 Wright MR. Self-perception of the elective surgeon and some patient perception correlates. *Arch Otolaryngol* 1980;106:460–5.
- 33 Sobel DL, Loughlin KR, Coogan CL. Medical malpractice liability in clinical urology: A survey of practicing urologists. *J Urol* 2006;175:1847–51.
- 34 Kahan SE, Goldman HB, Marengo S, Resnick MI. Urological medical malpractice. *J Urol* 2001;165:1638–42.
- 35 Kaplan GW. Malpractice risks for urologists. *Urology* 1998;51:183–5.
- 36 Duty B, Okhunov Z, Okeke Z, Smith A. Medical malpractice in endourology: Analysis of closed cases from the State of New York. *J Urol* 2012;187:528–32.
- 37 Benson JS, Coogan CL. Urological malpractice: Analysis of indemnity and claim data from 1985 to 2007. *J Urol* 2010;184:1086–90; quiz 235.
- 38 Koontz WW Jr, Russell JB. Thoughts on the prevention of urologic liability claims. *J Urol* 1977;118:695–7.
- 39 Terino E. Psychology of the aesthetic patient: The value of personality profile testing. *Facial Plast Surg Clin North Am* 2008;16:165–71, v.
- 40 Klimo GF, Daum WJ, Brinker MR, McGuire E, Elliott MN. Orthopedic medical malpractice: An attorney's perspective. *Am J Orthop (Belle Mead NJ)* 2000;29:93–7.
- 41 Adamson PA, Chen T. The dangerous dozen—avoiding potential problem patients in cosmetic surgery. *Facial Plast Surg Clin North Am* 2008;16:195–202, vii.
- 42 Gorney M. Mirror, mirror on the wall: The interface between illusion and reality in aesthetic surgery. *Facial Plast Surg Clin North Am* 2008;16:203–5, vii.
- 43 Ende KH, Lewis DL, Kabaker SS. Body dysmorphic disorder. *Facial Plast Surg Clin North Am* 2008;16:217–23, vii.
- 44 Glaser DA, Kaminer MS. Body dysmorphic disorder and the liposuction patient. *Dermatol Surg* 2005;31:559–60; discussion 61.
- 45 Zojaji R, Javanbakht M, Ghanadan A, Hosien H, Sadeghi H. High prevalence of personality abnormalities in patients seeking rhinoplasty. *Otolaryngol Head Neck Surg* 2007;137:83–7.
- 46 Caire AA, Boonjindasup A, Hellstrom WJ. Does a replacement or revision of an inflatable penile prosthesis lead to decreased patient satisfaction? *Int J Impot Res* 2011;23:39–42.
- 47 Henry GD, Donatucci CF, Connors W, Greenfield JM, Carson CC, Wilson SK, Delk J, Lentz AC, Cleves MA, Jennermann CJ, Kramer AC. An outcomes analysis of over 200 revision surgeries for penile prosthesis implantation: A multicenter study. *J Sex Med* 2012;9:309–15.
- 48 Phillips KA, Dufresne RG Jr. Body dysmorphic disorder: A guide for primary care physicians. *Prim Care* 2002;29:99–111, vii.
- 49 Phillips KA, Grant J, Siniscalchi J, Albertini RS. Surgical and nonpsychiatric medical treatment of patients with body dysmorphic disorder. *Psychosomatics* 2001;42:504–10.
- 50 Phillips KA, Dufresne RG Jr, Wilkel CS, Vittorio CC. Rate of body dysmorphic disorder in dermatology patients. *J Am Acad Dermatol* 2000;42:436–41.
- 51 Crerand CE, Phillips KA, Menard W, Fay C. Nonpsychiatric medical treatment of body dysmorphic disorder. *Psychosomatics* 2005;46:549–55.
- 52 Sarwer DB. Awareness and identification of body dysmorphic disorder by aesthetic surgeons: Results of a survey of American Society for Aesthetic Plastic Surgery members. *Aesthet Surg J* 2002;22:531–5.
- 53 Sarwer DB, Crerand CE. Body dysmorphic disorder and appearance enhancing medical treatments. *Body Image* 2008;5:50–8.
- 54 Boden JM, Fergusson DM, Horwood LJ. Alcohol misuse and violent behavior: Findings from a 30-year longitudinal study. *Drug Alcohol Depend* 2012;122:135–41.
- 55 Hoaken PN, Stewart SH. Drugs of abuse and the elicitation of human aggressive behavior. *Addict Behav* 2003;28:1533–54.
- 56 Wedekind D, Bandelow B, Heitmann S, Havemann-Reinecke U, Engel KR, Huether G. Attachment style, anxiety coping, and personality-styles in withdrawn alcohol addicted inpatients. *Subst Abuse Treat Prev Policy* 2013;8:1.
- 57 Shorey RC, Stuart GL, Anderson S. The early maladaptive schemas of an opioid-dependent sample of treatment-seeking young adults: A descriptive investigation. *J Subst Abuse Treat* 2012;42:271–8.
- 58 Ferraro GA, Rossano F, D'Andrea F. Self-perception and self-esteem of patients seeking cosmetic surgery. *Aesthetic Plast Surg* 2005;29:184–9.
- 59 Wright MR, Wright WK. A psychological study of patients undergoing cosmetic surgery. *Arch Otolaryngol* 1975;101:145–51.
- 60 Edgerton MT, Jacobson WE, Meyer E. Surgical-psychiatric study of patients seeking plastic (cosmetic) surgery: Ninety-eight consecutive patients with minimal deformity. *Br J Plast Surg* 1960;13:136–45.
- 61 SMSNA. Penile Prosthesis Information Form. 2008. Available at: http://www.smsna.org/pdf/PositionStatements/IPP%20policy_ns.pdf (accessed February 7, 2013).
- 62 Padma-Nathan H, Hellstrom WJ, Kaiser FE, Labasky RF, Lue TF, Nolten WE, Norwood PC, Peterson CA, Shabsigh R, Tam PY, Place VA, Gesundheit N. Treatment of men with erectile dysfunction with transurethral alprostadil. *Medicated*

Continuing Medical Education

- Urethral System for Erection (MUSE) Study Group. *N Engl J Med* 1997;336:1–7.
- 63 Goldstein I, Lue TF, Padma-Nathan H, Rosen RC, Steers WD, Wicker PA. Oral sildenafil in the treatment of erectile dysfunction. Sildenafil Study Group. *N Engl J Med* 1998;338:1397–404.
- 64 Rajpurkar A, Dhabuwala CB. Comparison of satisfaction rates and erectile function in patients treated with sildenafil, intracavernous prostaglandin E1 and penile implant surgery for erectile dysfunction in urology practice. *J Urol* 2003;170:159–63.
- 65 Lakin MM, Montague DK, VanderBrug Medendorp S, Tesar L, Schover LR. Intracavernous injection therapy: Analysis of results and complications. *J Urol* 1990;143:1138–41.
- 66 Henry G, Houghton L, Culkin D, Otheguy J, Shabsigh R, Ohl DA. Comparison of a new length measurement technique for inflatable penile prosthesis implantation to standard techniques: Outcomes and patient satisfaction. *J Sex Med* 2011;8:2640–6.
- 67 Miranda-Sousa A, Keating M, Moreira S, Baker M, Carrion R. Concomitant ventral phalloplasty during penile implant surgery: A novel procedure that optimizes patient satisfaction and their perception of phallic length after penile implant surgery. *J Sex Med* 2007;4:1494–9.
- 68 Mulhall JP, Jahoda A, Aviv N, Valenzuela R, Parker M. The impact of sildenafil citrate on sexual satisfaction profiles in men with a penile prosthesis *in situ*. *BJU Int* 2004;93:97–9.
- 69 Schover LR. Sex therapy for the penile prosthesis recipient. *Urol Clin North Am* 1989;16:91–8.

Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Appendix S1. Penile Prosthesis Information Form.

CME Multiple Choice Questions

1. Which of the following items is inversely associated with patient satisfaction following IPP?
 - a. Female partner sexual function
 - b. Number of alternative erectile function treatments attempted
 - c. Ability to easily cycle the device
 - d. Pre-operative erectile function
 - e. Pre-operative expectations
2. Which of the following statements is true regarding the psychological impact of surgery?
 - a. Body dysmorphic disorder patients universally receive no benefit from surgery
 - b. Placement of an IPP does not result in improved patient/partner relationships
 - c. Cosmetic surgery has a sustained, positive effect on body image
 - d. Narcissistic personality disorder is characterized by an underlying desire to enhance self-esteem through surgery
 - e. Patients with depression are not candidates for surgery
3. Malpractice claims:
 - a. Are more common with IPPs than any other urologic procedures
 - b. Occur with equal frequency among urologists, regardless of professional reputation
4. A patient who repeatedly requests revision surgery due to redundant tubing noted in the scrotum is best categorized by which personality trait?
 - a. Borderline personality disorder
 - b. Body dysmorphic disorder
 - c. Obsessive
 - d. Entitled
 - e. Unrealistic expectations
5. Borderline personality disorder is characterized by:
 - a. A persistent and recurrent fixation on a specific, perceived defect
 - b. Hypersexual behavior and attitudes
 - c. Vilification of selected individuals
 - d. Mild fluctuations between elevated and depressed states
 - e. Disorganized thought patterns

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