The Journal of Sexual Medicine, 2026, **23**, 1–6
https://doi.org/10.1093/jsxmed/qdaf332
Original Research

Evaluating the appropriateness of penile prosthesis in non-organic erectile dysfunction and premature ejaculation: a Delphi consensus among penile implant surgeons

Andrea Cocci, PhD[1], Marta Pezzoli, MD[1,*], Valeria Pizziconi, MD[1], Carlo Bettocchi[2], Andrea Salonia[3], Suks Minhas[4], Luca Boeri, PhD[5], Paolo Capogrosso, PhD[6], Nusret Can Cilesiz[7], Murat Gül[8], Georgios Hatzichristodoulou[9], Ates Kadioglu[10], Juan Ignatio Martínez Salamanca[11], Vaibhav Modgil[12], Giorgio Ivan Russo[13], Ege Can Serefoglu[14], Marco Falcone, PhD[15], Francesco Beniamin, MD[16], Francesco Berardinelli, MD[17], Christian Ladurner, MD[18], Andrea Lemma, MD[19], Alberto Parmigiani, MD[20], Marco Spilotros, MD[21], Nicolò Testino, MD[22], Massimiliano Timpano, MD[23], Andrea Minervini[1], Mattia Lo Re, MD[1]

[1]Department of Urology, University of Florence, 50134 Florence, Italy
[2]Department of Urology, University of Foggia, 71122 Foggia, Italy
[3]Division of Experimental Oncology/Unit of Urology, Urological Research Institute, IRCCS Ospedale San Raffaele, University Vita-Salute San Raffaele, 20132 Milan, Italy
[4]Department of Urology, Imperial Healthcare NHS Trust, Charing Cross Hospital, W6 8RF London, United Kingdom
[5]Department of Urology, Foundation IRCCS Ca' Granda - Ospedale Maggiore Policlinico, University of Milan, 20122 Milan, Italy
[6]Department of Urology and Andrology, Ospedale di Circolo and Macchi Foundation, 21100 Varese, Italy
[7]Department of Urology, Taksim Training & Research Hospital, 34433 Istanbul, Turkey
[8]Department of Urology, Selcuk University, 42250 Konya, Turkey
[9]Department of Urology, Martha-Maria Hospital Nuremberg, 90491 Nuremberg, Germany
[10]Department of Urology, İstanbul University, İstanbul School of Medicine, 34093 İstanbul, Turkey
[11]Department of Urology, Hospital Universitario Puerta del Hierro Majadahonda, 28222 Madrid, Spain
[12]Manchester Andrology Centre, Manchester Royal Infirmary, Manchester University Hospitals NHS Foundation Trust, M13 9WL Manchester, United Kingdom
[13]Urology Section, Department of Surgery, University of Catania, 95125 Catania, Italy
[14]Department of Urology, Biruni University School of Medicine, 34295 Istanbul, Turkey
[15]Urology Clinic, Città della Salute e della Scienza, University of Turin, 10126 Turin, Italy
[16]Department of Urology, Ospedale di Treviso, 31100 Treviso, Italy
[17]Department of Urology, Ospedale di Vasto, 66054 Vasto, Italy
[18]Department of Urology, Ospedale Centrale di Bolzano, 39100 Bolzano, Italy
[19]UROCLIN- Centro Uro-Andrologico, 00198 Roma, Italy
[20]Department of Urology, Ospedale "Michele e Pietro Ferrero", ASL CN2, 12060 Alba-Bra, Italy
[21]Department of Urology, University of Bari Aldo Moro, 70121 Bari, Italy
[22]Department of Urology, Policlinico San Martino Hospital, University of Genova, 16132 Genova, Italy
[23]Department of Urology, Ospedale Maggiore San Giovanni Battista – Molinette, 10124 Turin, Italy

*Corresponding author: Department of Urology, University of Florence, 50134 Florence, Italy. Email: marta.pezzoli@unifi.it

Abstract

Background: Non-organic erectile dysfunction (ED) and premature ejaculation (PE) are common conditions for which European Association of Urology guidelines lack specific recommendations on penile prosthesis implantation (PPI).

Aim: To establish expert consensus on the role of PPI in non-organic ED and PE using the Delphi method.

Methods: A panel of 24 international penile implant surgeons with significant experience in PPI participated in a 3-round Delphi consensus between February and May 2025. Participants were mainly European-based (Italy, $n=16$; Turkey, $n=4$; United Kingdom, $n=2$; Spain, $n=1$; Germany, $n=1$). Two online questionnaire rounds were followed by a final virtual meeting. Topics included diagnostics, treatment hierarchy, indications for PPI, ethical concerns, surgical risks, patient satisfaction, partner's involvement, and follow-up strategies. Consensus was defined as ≥75% agreement or disagreement on Likert-scale items.

Received: July 30, 2025. **Revised:** October 28, 2025. **Accepted:** October 30, 2025

Outcomes: Expert consensus was reached on all 53 items, including the ones regarding the appropriateness of PPI in non-organic ED and PE.

Results: Experts agreed on the importance of thorough psychosexological assessment, standardized diagnostic tools, and exhausting conservative treatments before considering PPI in non-organic ED. Seventy-five percent supported PPI as a last-resort option in non-organic ED, provided psychological evaluation and informed consent protocols are in place. In contrast, the panel rejected PPI as a treatment for pure PE due to insufficient evidence and lack of clinical experience. Emphasis was placed on ethical safeguards, long-term follow-up, and partner involvement in decision-making.

Clinical Implications: These findings suggest that, under strict conditions, PPI may have a role in treatment-resistant non-organic ED but not in pure PE.

Strengths and Limitations: Limitations include the inherent subjectivity of the Delphi methodology and the restricted representativeness of the panel, which was mainly European-based and composed exclusively of urologists specializing in penile implants.

Conclusion: Selective use of PPI in non-organic ED is supported by expert consensus, while its use in pure PE is not; updated guidelines and further research are warranted.

Keywords: penile prosthesis; erectile dysfunction; premature ejaculation; consensus; psychosexual disorders.

Introduction

Non-organic erectile dysfunction (ED) and premature ejaculation (PE) are common sexual disorders that significantly impact quality of life and psychological well-being.[1,2] Non-organic ED refers to erectile difficulties without identifiable organic or physiological causes, often influenced by psychological, relational, or situational factors.[3] Similarly, PE—characterized by a reduced intravaginal ejaculatory latency time and lack of ejaculatory control—can also have multifactorial origins including psychogenic components.[4]

The European Association of Urology (EAU) guidelines[5] provide recommendations on the diagnosis and management of non-organic ED and PE. For non-organic ED, the EAU advocates a psychological approach including Cognitive Behavior Therapy (CBT) combined with medical treatment to maximize outcomes.[5,6] For PE, selective serotonin reuptake inhibitors (SSRIs), topical anesthetics, and behavioral therapies are considered first-line options.[5,7,8] However, the guidelines are less explicit regarding invasive procedures, such as penile prosthesis implantation (PPI), in patients with non-organic ED or PE, largely due to limited evidence and clinical experience in this subset of patients.

Given this lack of clear guidance and the absence of robust data or consensus on the role of PPs in non-organic ED and PE, clinicians face challenges in decision-making, balancing potential benefits against ethical, psychological, and surgical considerations.

To address these gaps, we conducted a Delphi consensus study[9] involving a panel of international penile implant surgeons with extensive clinical and research experience in this field. The primary objective was to systematically gather expert opinion on diagnostic strategies, therapeutic hierarchies, indications for PPI, ethical and psychological considerations, surgical risks, and patient-centered outcomes in the context of non-organic ED and PE. The resulting consensus is presented in this article.

Methods

The Delphi method was used to achieve consensus among a panel of experts.

Panelists were selected based on their proven experience in clinical practice and research on the topic.

Online questionnaires were presented to participants in two subsequent rounds between February 1 and April 18, 2025, using an online survey platform (www.welphi.com, Lisbon, Portugal). Selected topics were diagnostic evaluation, alternative treatments and therapeutic hierarchy for non-organic ED and PE, indications for PPI, ethical concerns, surgical considerations and risks, patient satisfaction and outcome measure, long-term management and follow-up, and patient and partner involvement in decision-making. Participants were administered Likert-Scale questions. In both, the first and the second-round possible responses were indicated as "strongly agree," "agree," "neither agree nor disagree," "disagree," "strongly disagree." For some questions, participants have been asked to comment their responses; these comments were analyzed to highlight prevailing experts' opinions. To achieve consensus, $\geq$75% of respondents needed to converge on a category of agreement or disagreement; descriptive statistics were used to determine the response rate of each topic.

Final round was performed via an online meeting held by the platform Google Meet® on May 15, 2025, when the results of previous rounds were presented and questions that had not yet achieved consensus were discussed, leading to the final results.

Results

Demographics of consensus participants

Twenty-four international penile implant surgeons were invited and agreed to participate. Response rate was 100% (24/24) in the first round and 83.3% (20/24) in the second round. The panel included experts from 5 countries, predominantly from Europe: Italy ($n = 16$), Turkey ($n = 4$), the United Kingdom ($n = 2$), Spain ($n = 1$), and Germany ($n = 1$). All participants were urologists and all have performed at least 500 PPI procedures for ED, Peyronie's disease, priapism, or other conditions for which this surgery is indicated. In addition, some of the participants (A.C., P.C., S.M., C.B., L.B., N.C.C., M.G., G.H., A.K., J.I.M.S., V.M., G.I.R., E.C.S., M.F., A.S.) are current or former members of the EAU Guidelines Panel on Sexual and Reproductive Health.

Summary of the rounds

In the first round of the Delphi consensus, a total of 53 questions were presented and consensus was reached on 30 of them; the remaining 23 questions, for which agreement could not be achieved, proceeded to the second round. By the end of that phase, consensus was reached on 9 additional

questions, while the remaining 14 were carried forward to the final online round for further evaluation. During this last round, expert discussion led to the achievement of consensus on all remaining items.

Diagnostic evaluation for non-organic ED

All respondents (100%) declared that collecting a comprehensive sexual history is essential for diagnosing non-organic ED. The majority (83%) believed that the initial diagnostic evaluation should include a standardized ED questionnaire (eg, IIEF—International Index of Erectile Function), and 92% emphasized the importance of determining whether erectile difficulty occurs on quiet, predictable occasions or instead during conflicts or one night stands. The consensus further highlighted that a basic physical examination (96%) and hormonal profiling (92%) (eg, testosterone, prolactin levels) are crucial to exclude organic causes, and that a psychosexological assessment should be included in the diagnostic work-up (83%). In the final round, 75% agreed that nocturnal penile tumescence (NPT) tests are useful for distinguishing organic from non-organic-ED, and that both vascular assessment (eg, penile doppler ultrasound—PDU) and intracavernosal injection (ICI) test belong in the diagnostic flowchart. Finally, 83% of experts held that ED can be considered non-organic in patients who preserve morning erections and reach sufficient hardness during masturbation, and 75% agreed that the combination of normal hormonal tests, a normal ICI test and ineffective phosphodiesterase type 5 inhibitors (PDE5i) therapy likewise supports a non-organic diagnosis.

Alternative treatments and therapeutic hierarchy for non-organic ED

Most respondents (88%) declared that oral treatment with PDE5i should be offered to patients with non-organic ED, while 75% supported ICIs of alprostadil and combined therapy of both; in general, 88% agreed that all alternative treatments should be attempted before considering invasive options such as PPI.

Diagnostic evaluation for PE

Experts agreed that validated PE questionnaires (eg, PEDT—Premature Ejaculation Diagnostic Tool) are useful in the diagnostic pathway (85%) and that a physical examination is essential to rule out organic causes (80%). Intravaginal ejaculatory latency time is considered an important diagnostic element by 92%, and 96% emphasized the need to distinguish among lifelong, acquired, variable and subjective PE. As with ED, hormonal profiling (eg, testosterone, thyroid levels) should be included in the work up (75%), whereas 75% of participants disagreed that neurological assessment should routinely form part of the diagnostic evaluation.

Alternative treatments and therapeutic hierarchy for PE

SSRIs are unanimously recommended in the treatment of PE (100%), with 83% also endorsing on demand treatments such as topical anesthetics; moreover, 96% agreed that all alternative measures should be exhausted before any consideration of PPI for PE.

Further considerations

Nearly all experts rejected preventive or cosmetic PPI in men without ED or PE, whether intended preventively (95%) or for penile enlargement (80%).

Penile prosthesis placement

The consensus highlighted that PPI could be considered for patients with non-organic ED (75%). In these cases, expert opinion holds that there is no minimum (75%) or maximum (80%) age limit precluding this surgery; nevertheless, only adult patients were considered. Furthermore, 75% of participants believed that device preference—malleable versus 3-piece—does not differ from that of patients with organic ED. On the contrary, 75% of experts agreed that PPI should not be considered for patients with PE; nevertheless, had it been considered, there would still be no minimum (75%) or maximum (80%) age limits, nor upper IELT cut offs (75%), and device preference would likewise mirror that of the broader population.

Psychological and psychosexual considerations

All experts (100%) believed that psychological evaluation is important before considering PPI in this population, with 88% asserting that psychological counseling should be mandatory before surgery; moreover, 80% agreed that implantation could improve psychological well-being.

Ethical and professional guidelines

Offering PPI raises significant ethical concerns in patients with non-organic ED (90%) and PE (85%), and 91% of experts agreed that specific informed consent protocols are necessary. From a professional standpoint, 85% felt that specialized training in psychosexual assessment is essential for urologists offering prostheses to this population.

Surgical considerations and risks

Eighty percent of experts agreed that patients with non-organic ED or PE require additional counseling on potential complications compared to those with organic ED.

Patient satisfaction and outcome measures

Patient satisfaction surveys (eg, Satisfaction Survey for Inflatable Penile Implant) were endorsed by 96% of experts as useful for evaluating the success of PPI in non-organic ED or PE, and 79% agreed that satisfaction benchmarks should be prioritized in this assessment. Furthermore, the importance of regular follow-up evaluations to assess long term outcomes have been emphasized by 91% of experts.

Long-term management and follow-up

Structured follow-up care is necessary for patients who experience dissatisfaction after the procedure (96%), with 100% underscoring the need for resources available for patients facing psychological distress post implantation and 95% recommending ongoing psychological counseling as part of long-term follow-up care.

Patient and partner involvement in decision-making

Physicians should offer the patient the opportunity to involve the partner in the decision-making process (92%), while 75% emphasized that considering the partner's expectations and

Table 1. Similarities and differences between the Delphi consensus results and the 2025 EAU guidelines.

Domain	Delphi Consensus	EAU Guidelines
Diagnostic evaluation for non-organic ED	Emphasizes thorough sexual history, standardized questionnaires, hormonal profiling, psychosexological assessment, NPT, ICI, PDU for differential diagnosis.	Recommend detailed sexual history, physical exam, hormonal testing; psychological assessment emphasized; PDU for medico-legal and selected cases.
Therapeutic hierarchy for non-organic ED	Supports exhaustive conservative treatments (PDE5i, ICI) before PPI.	Advocate combined psychological and medical treatment; no specific stance on PPI.
Role of PPI in non-organic ED	Supports PPI in selected cases after exhausting conservative treatments.	Non-committal on PPI
Diagnostic evaluation for PE	Supports validated questionnaires, IELT, physical exam, labs; excludes routine neurological assessment.	Recommend validated questionnaires, IELT, physical exam; labs only if clinically indicated.
Therapeutic Hierarchy for PE	Supports SSRIs and topical anesthetics	Recommend SSRIs, topical agents, behavioral therapy
Role of PPI in pure PE	Rejects PPI due to insufficient evidence and clinical experience.	Do not mention PPI for PE; not recommended
Psychological evaluation and counseling before PPI in non-organic ED	Supports mandatory psychological evaluation and counseling before PPI	Emphasize psychological assessment in non-organic ED; pre-PPI counseling not specifically addressed.
Ethical considerations and informed consent for PPI in non-organic ED	Highlights ethical concerns, and need for tailored informed consent	Do not specifically address ethical implications of PPI in non-organic ED
Follow-up and long-term management for PPI in non-organic ED	Stresses structured follow-up, psychological support post-PPI, and satisfaction monitoring.	Recommend follow-up for treatment efficacy, but not specifically for PPI in non-organic ED.
Partner involvement in decision-making for PPI in non-organic ED	Recommends partner involvement and relationship-focused counseling before PPI.	Encourage partner involvement in sexual dysfunction management generally.

Abbreviations: ED = erectile dysfunction; NPT = nocturnal penile tumescence; ICI = intracavernosal injection; PDU = penile duplex ultrasound; PDE5i = phosphodiesterase type 5 inhibitors; PPI = penile prosthesis implantation; PE = premature ejaculation, IELT = intravaginal ejaculatory latency time; SSRI = selective serotonin reuptake inhibitor.

providing relationship focused counseling are essential for those with non-organic ED or PE considering PPI.

Similarities and differences between the Delphi consensus results and the 2025 EAU guidelines are show in Table 1.

Discussion

This Delphi consensus study provides a comprehensive evaluation of expert opinions regarding diagnostic and therapeutic approaches to non-organic ED and PE, focusing particularly on the appropriateness of PPI in these challenging clinical contexts. Notably, this represents the first Delphi consensus specifically addressing the role of PPI in non-organic ED and PE—a topic that remains largely unexplored in the scientific literature and for which existing clinical guidelines offer limited or no explicit recommendations to guide clinical decision-making.

Starting with the diagnostic evaluation of non-organic ED, there was unanimous agreement on the central importance of a detailed sexual history, standardized questionnaires, and differentiating erectile difficulties in various psychosocial contexts. This is entirely consistent with the EAU guidelines, which underscore the need for a holistic clinical assessment.[5] The consensus on the utility of basic physical examination and hormonal profiling also mirrors guideline recommendations to exclude organic causes before labeling dysfunction as non-organic.[10] The inclusion of psychosexual assessment as an integral diagnostic component reflects the recognition that psychological and relational factors may coexist with an organic basis of ED or, in some cases, may represent the sole underlying cause. Therefore, a thorough psychosexual evaluation is recommended across both contexts to ensure a comprehensive understanding of the patient's condition.[11]

The experts' support for NPT test, ICI test, and vascular assessment using PDU reflects a comprehensive approach to distinguish organic from non-organic causes.[5] However, while consensus was reached on the inclusion of all three modalities in the diagnostic workup, the specific role of PDU was the subject of nuanced discussion within the panel. Although PDU is traditionally valued for its ability to objectively assess penile vascular function, many panelists questioned its actual impact on therapeutic decision-making. Indeed, the equivalence observed between PDU and ICI test—especially in ruling out significant vascular impairment—is consistent with growing literature suggesting that routine Doppler use may have limited influence on clinical management strategies.[12,13] That said, the panel recognized a distinct medico-legal value in performing PDU, particularly in patients for whom PPI is being considered. In these scenarios, objective vascular assessment may serve to document the appropriateness of surgical intervention and mitigate potential legal challenges. Nevertheless, the panel advocated for future re-evaluation of the role of PDU in ED diagnostics, stressing that its use should remain at the discretion of the clinician.

Turning to the treatments for non-organic ED, the panel endorsed the use of oral PDE5i and intracavernosal alprostadil—alone or in combination—as possible therapies, effectively extending the pharmacological approach commonly used in organic ED to psychogenic cases. This aligns with EAU guidelines, which also recommend medical therapy combined with psychosocial interventions such CBT.[5,14] Notably, the expert panel diverged from the current EAU stance on treatment hierarchy for ED: while the 2021 guidelines removed a stepwise model and positioned medical, injective, and surgical options on equal footing,[15] the experts strongly emphasized that all non-invasive treatments should

be thoroughly exhausted before considering PPI in non-organic cases. This highlights a more cautious approach to surgical intervention in non-organic ED, prioritizing conservative strategies before proceeding to invasive procedures.

Despite this appropriate caution regarding surgical intervention, the panel expressed openness to the use of PPI in cases of non-organic ED. While current EAU Guidelines and routine clinical practice recommend PPI primarily for patients with organic ED who are unresponsive to other treatments or based on patient preference, they offer no specific guidance on its use in psychogenic cases.[5] In this context of clinical ambiguity, the expert panel's endorsement—reflected by 75% agreement—represents a novel and noteworthy position. It underscores the recognition that non-organic ED, although typically managed with psychological and pharmacological therapies, may in selected cases benefit from surgical intervention—particularly when all conservative strategies have been exhausted, and the patient demonstrates full decisional capacity.

This perspective is supported by emerging literature. For instance, a recent cohort study[16] investigating PPI outcomes in men under 40—some of whom with non-organic ED—demonstrated high satisfaction rates and good functional results. Similarly, a 2024 pilot study involving patients with psychogenic ED showed marked improvements in self-reported quality of life, self-esteem, and partner intimacy following implantation.[17] These early findings suggest that, with rigorous preoperative evaluation and counseling, selected patients with non-organic ED may derive substantial benefit from PPI.

Importantly, all experts emphasized the need for mandatory psychological evaluation and counseling before proceeding with surgery. This reflects a strong consensus that any surgical intervention in this population carries unique ethical implications and should be reserved for patients who fully understand the risks, limitations, and expected outcomes.

The panel further agreed there are no strict age limitations or device preferences differentiating non-organic from organic ED patients, indicating that surgical technique and device selection can be consistent with current standards.

Regarding diagnostic evaluation for PE, the consensus closely aligns with guidelines, supporting the use of validated questionnaires (eg, PEDT), IELT measurement, and physical examination to rule out organic causes.[5] While experts also recommended routine laboratory testing, this goes beyond EAU guidance, which suggests such testing only when clinically indicated.[5,18] Moreover, experts agreed that neurological assessment is unnecessary in typical cases.

For PE treatment, the panel's unanimous endorsement of SSRIs and support for topical anesthetics are fully consistent with international standards.[7,8] In realm of PPI, significant differences between non-organic ED and PE management pathways have emerged. During the final Delphi round, this topic generated substantial discussion among the experts. Notably, none of the participants reported direct clinical experience with PPI in patients with pure PE, nor did the panel identify robust scientific support for this indication. While some literature, such as the study by Moussa et al.[19] has suggested a potential added value of PPI in delaying ejaculation, these observations concerned patients with coexisting ED and PE—not pure PE—and cannot be generalized. Given this context, the panel reached a consensus of disagreement, concluding that at present, the use of PPI in pure PE cannot be supported. Nonetheless, the panel acknowledged that if future high-quality evidence emerges, the issue may warrant re-evaluation in light of new clinical data.

In light of the panel's agreement on the potential role of PPI in non-organic ED and its rejection in cases of pure PE, the ethical and clinical safeguards discussed in the results—such as specific informed consent protocols, psychosexual training for implanting urologists, enhanced counseling on surgical risks, structured long-term follow-up, and the inclusion of partners in the decision-making process—were considered applicable exclusively to non-organic ED. These measures reflect a shared commitment to patient-centered care, ensuring that any surgical intervention in this complex group is approached with the utmost responsibility and sensitivity.

Limitations of the study

This study has limitations inherent to the Delphi methodology. While this structured approach is valuable for gathering expert consensus in areas lacking strong empirical evidence, it is ultimately based on expert opinion rather than objective data. The resulting statements reflect the clinical experience and judgment of a limited number of urologists, which may affect the generalizability of the findings. The panel was predominantly composed of European-based experts which may further limit the global representativeness of the consensus. In addition, the consensus does not address all issues of potential relevance to clinicians and patients.

Importantly, only urologists with extensive experience in PPI were included in the Delphi panel, so the perspectives of other professionals involved in the management of ED—such as non-implanting urologists, endocrinologists, and psychosexologists—were not represented. This selection criterion may introduce a potential bias and should be considered when interpreting the conclusions.

Conclusions

In conclusion, this Delphi consensus contributes novel perspectives that complement and, in some aspects, challenge current guidelines. While reaffirming standard diagnostic and conservative treatment pathways, it innovatively supports considering PPI in selected non-organic ED patients following thorough psychological evaluation and after all other treatments have failed. In this scenario, the importance of tailored informed consent and extensive counseling on surgical risks becomes particularly evident, reflecting the ethical sensitivity and clinical complexity associated with offering PPI to this population. Conversely, the consensus rejects PPI for pure PE due to lack of clinical experience and supporting evidence in the literature. Together, these findings should stimulate updated guideline discussions and future research to refine management strategies in this complex field.

Author contributions

A. Cocci and M. Pezzoli equally contributed to this article. Andrea Cocci (Conceptualization [lead], Project administration [lead], Writing—review & editing [lead]), Marta Pezzoli (Data curation [lead], Formal analysis [lead], Project administration [lead], Writing—original draft [lead]), Valeria Pizziconi (Investigation [equal], Writing—review & editing [equal]), Carlo Bettocchi (Investigation [equal], Writing—review & editing [equal]), Andrea Salonia (Investigation [equal], Writing—review & editing [equal]), Suks Minhas (Investigation [equal],

Writing—review & editing [equal]), Luca Boeri (Investigation [equal], Writing—review & editing [equal]), Paolo Capogrosso (Investigation [equal], Writing—review & editing [equal]), Nusret Can Cilesiz (Investigation [equal], Writing—review & editing [equal]), Murat Gul (Investigation [equal], Writing—review & editing [equal]), Georgios Hatzichristodoulou (Investigation [equal], Writing—review & editing [equal]), Ates Kadioglu (Investigation [equal], Writing—review & editing [equal]), Juan Ignacio Martínez-Salamanca (Investigation [equal], Writing—review & editing [equal]), Vaibhav Modgil (Investigation [equal], Writing—review & editing [equal]), Giorgio Ivan Russo (Investigation [equal], Writing—review & editing [equal]), Ege Can Serefoglu (Investigation [equal], Writing—review & editing [equal]), Marco Falcone (Investigation [equal], Writing—review & editing [equal]), Francesco Beniamin (Investigation [equal], Writing—review & editing [equal]), Francesco Berardinelli (Investigation [equal], Writing—review & editing [equal]), and Christian Ladurner (Investigation [equal], Writing—review & editing [equal])

Funding

None declared.

Conflicts of interest

The authors have nothing to disclose.

Data availability

Data are available from the corresponding author on reasonable request.

References

1. Fisher WA, Eardley I, McCabe M, Sand M. Erectile dysfunction (ED) is a shared sexual concern of couples I: couple conceptions of ED. *J Sex Med*. 2009;**6**(10):2746–2760. https://doi.org/10.1111/j.1743-6109.2009.01457.x
2. Xia Y, Li J, Shan G, *et al*. Relationship between premature ejaculation and depression a PRISMA-compliant systematic review and meta-analysis. *Medicine (United States)*. 2016;**95**:e4620. https://doi.org/10.1097/MD.0000000000004620
3. Wright LN, Moghalu OI, das R, *et al*. Erectile dysfunction and treatment: an analysis of associated chronic health conditions. *Urology*. 2021;**157**:148–154. https://doi.org/10.1016/j.urology.2021.08.009
4. World Health Organisation. *ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) 2018 Version*, 2018. https://Icd.Who.Int/Browse11/L-M/En.
5. Salonia A, Boeri L, Capogrosso P , *et al*. European Association of Urology Guidelines Office. EAU Guidelines on Sexual and Reproductive Health. Arnhem, The Netherlands: European Association of Urology; 2025.
6. Dewitte M, Bettocchi C, Carvalho J, *et al*. A psychosocial approach to erectile dysfunction: position statements from the European Society of Sexual Medicine (ESSM). *Sex Med*. 2021;**9**(6):100434. https://doi.org/10.1016/j.esxm.2021.100434
7. Pryor JL, Althof SE, Steidle C, *et al*. Efficacy and tolerability of dapoxetine in treatment of premature ejaculation: an integrated analysis of two double-blind, randomised controlled trials. *Lancet*. 2006;**368**:929–937. https://doi.org/10.1016/S0140-6736(06)69373-2
8. Liu H, Zhang M, Huang M, *et al*. Comparative efficacy and safety of drug treatment for premature ejaculation: a systemic review and Bayesian network meta-analysis. *Andrologia*. 2020;**52**(11):e13806. https://doi.org/10.1111/and.13806
9. Hsu CC, Sandford BA. The Delphi technique: making sense of consensus. *Pract Assess Res Eval*. 2007;**12**(10):1–8.
10. Ghanem HM, Salonia A, Martin-Morales A. SOP: physical examination and laboratory testing for men with erectile dysfunction. *J Sex Med*. 2013;**10**:108–110. https://doi.org/10.1111/j.1743-6109.2012.02734.x
11. Brotto L, Atallah S, Johnson-Agbakwu C, *et al*. Psychological and interpersonal dimensions of sexual function and dysfunction. *J Sex Med*. 2016;**13**:538–571. https://doi.org/10.1016/j.jsxm.2016.01.019
12. Cocci A *et al*. The efficacy of penile duplex ultrasound in erectile dysfunction management decision-making: facing the opinion leader. *J Mens Health*. 2024;**20**:8. https://doi.org/10.22514/jomh.2024.084
13. Nashed A, Lokeshwar SD, Frech F, Mann U, Patel P. The efficacy of penile duplex ultrasound in erectile dysfunction management decision-making: a systematic review. *Sex Med Rev*. 2021;**9**:472–477. https://doi.org/10.1016/j.sxmr.2020.10.006
14. Han M, Wang X, Yang H, Wang X, Zhu H, Song M. Efficacy of online cognitive behavioral therapy for nonorganic erectile dysfunction in reproductive-age males during the COVID-19 pandemic: a randomized wait list-controlled trial. *J Sex Med*. 2023;**20**:1325–1332. https://doi.org/10.1093/jsxmed/qdad117
15. Salonia A, Bettocchi C, Boeri L, *et al*. European Association of Urology guidelines on sexual and reproductive health—2021 update: male sexual dysfunction. *Eur Urol*. 2021;**80**:333–357. https://doi.org/10.1016/j.eururo.2021.06.007
16. Sevinç AH, Şenel S, Teke İ, *et al*. Outcomes of penile prosthesis implantation in patients under 40: insights and efficacy. *Int J Urol*. 2025;**32**:1250–1256. https://doi.org/10.1111/iju.70145
17. De Rocco M, G. S. (150) satisfaction after penile prosthesis implant IN patient with psychogenic erectile dysfunction. *J Sex Med*. 2024;**21**(Suppl 6):qdae161.122. https://doi.org/10.1093/jsxmed/qdae161.122
18. Althof SE, McMahon CG, Waldinger MD, *et al*. An update of the International Society of Sexual Medicine's guidelines for the diagnosis and treatment of premature ejaculation (PE). *J Sex Med*. 2014;**11**:1392–1422. https://doi.org/10.1111/jsm.12504
19. Moussa A, Shaeer O, Saleh Y, Sayed D, farag, mohamed. Assessment of ejaculatory function in men undergoing malleable penile prosthesis implant surgery. *Hum Androl*. 2023;**13**:1–5. https://doi.org/10.21608/ha.2022.176513.1095

The Journal of Sexual Medicine, 2026, 23, 1–6
https://doi.org/10.1093/jsxmed/qdaf332
Original Research