Erectile dysfunction is very, very common in the United States, affecting upwards of 50% of men in some studies.

Most men when they seek treatment will start with the simple things, the Viagra, the Cialis, the oral medications to help.

Most men at some point are going to need to move beyond that level of treatment because it's just not powerful enough anymore.

And so at that point we start talking about multiple different treatment options.

There are vacuum erection devices, there's injection therapy, or the surgical implant.

The penile implant is another option for them.

Now, the surgery is a relatively minor outpatient surgery that you go home the same day from.

When performing a penile prostheses surgery, there are a couple of really important factors that need to be considered.

The first and foremost is infection.

The biggest risk with these devices is risk of infection.

So performing an extra sterile technique, what we call a no touch technique, where the skin is completely covered and not touched during the entire procedure, not letting the device touch the skin is hugely important.

That's the number one source of infections.

Following extra sterile technique, changing gloves multiple times through the procedure, using antibiotic solutions to rinse out the areas as you're going through the surgery is important for the entire procedure.

In addition, the surgical technique is-- every guy's a little bit different, you need to get the device fitting and sizing exactly right or you're going a very dissatisfied patient afterwards as they're going to have issues with the device is going to curve, or buckle, or not fit properly in their body, which is going to negatively impact their enjoyment and their partner's enjoyment of the device.

The surgical technique I utilize is called a peno-scrotal approach.

That's one of the two major approaches to penile prostheses surgery, the other being the infrapubic approach, which has an incision just at the base of the penis on top.

About 80% of practitioners will utilize the peno-scrotal approach because it gives you slightly better access to the corporal bodies where we will be placing the cylinders as well as better access to the scrotal area where we'll be placing the pump.

So when placing this device, there are three major components we need to implant during the procedure.

One component is the pump in the scrotum, as mentioned.

Another component is the reservoir, which typically sits down the perivesical space around the bladder.

The third component are the two cylinders that go inside the shaft of the penis.

The great thing about this device is satisfaction rates in large scale studies show it to be about 95%, both for the male partner and for their female partner as well.

So both people in the relationship are satisfied.

The majority of men undergoing an implant, there are going to be in their late 50s into 60s and 70s.

We've certainly implanted men as early as their 40s, if they had other medical issues that had caused accelerated erectile dysfunction, so to speak.

And the latest man we've done has been 88 years old, so this accompanies a whole range of spectrum of what men-- what age men can get this at.

One thing you have to consider is the average mechanical lifespan of these devices is about 10 years.

So while some men in their early 50s may want it, you may want to encourage them to try a few other treatments prior to get the maximum life out of this.

Because while we can replace it after 10 years, increased risk of infection for every time we have to go back in.

So Peyronie's disease affects about 10% to 15% of patients out there.

It is an acquired disease that usually occurs from a lifetime of just having intercourse and sex.

Over time, small little traumatic events during intercourse build up, causes scar tissue to build up, which will eventually causes penile curvature in that subset of men.

Studies have shown to have more negative mental health effects than erectile dysfunction itself.

Men are more depressed, more frustrated, less likely to seek treatment for Peyronie's disease.

And a lot of times Peyronie's disease and erectile dysfunction go hand in hand.

Now, we can treat men non-surgically for penile curvature, Peyronie's disease, if they have good, strong erections.

But if they are coming together, the Peyronie's disease and erectile dysfunction, the AUA guideline suggests that a penile prostheses is the best choice because you're able to correct the erectile dysfunction and the penile curvature in one quick outpatient procedure.

Once the device is placed in the standard fashion for the erectile dysfunction, then you have to go further and address the curvature.

In some men with mild curvature, the device itself is strong enough to overcome this mild curvature.

Men with more severe curvature, sometime we have to do more advanced mechanical manipulations to disrupt the plaque.

Sometimes we need to place sutures to help pull the penis in a more straightward direction.

And in some extreme cases, we actually have to cut out that portion of the plaque from the penis itself and place a small graft in there.

So I've completed a fellowship training under Dr. Tom Walsh at the University of Washington in Seattle.

He's one of the highest volume implanters in the world.

And so I do bring special unique fellowship training here to the low country that-- while other people do implants in the area, none of them are fellowship trained in this technique.

So I have a few more tools in my toolbox, how to address certain issues.

The run of the mill patients, I just have done more implants than many people.

And the more complicated patients, again, there's more tricks up my sleeve, so to speak, to help address it and get it-- the perfect sizing, the perfect fit, that are going to most satisfy these patients.