

The prosthetic urology opportunity

Erectile dysfunction (ED) is a common male sexual health problem affecting many men and poses a significant quality of life burden on men and their partners. One study found that although there are over 1.7 million insured men in the United States with ED who may benefit from a penile implant, only 1.1% or approximately 18,000 of these patients undergo a first-time penile implant procedure (IPP) annually.¹

In addition, male stress urinary incontinence (SUI) is a significant quality-of-life issue for men as it can rob them of their freedom to live a normal life. One study showed that severe SUI is 7x less tolerable than even severe ED.² In 2022, an estimated 280,000 untreated men with persistent SUI could have potentially benefited from surgical intervention.³ Treating SUI can provide these men an opportunity to live a more fulfilling life.

Offering treatment options for ED and SUI presents an opportunity for health care providers to extend this much-needed care and grow their urology service line. Currently, demand for IPP procedures is increasing. In 2023, more than 17,000 new IPP procedures were performed, equating to a 4.4% increase from pre-COVID surgery volume in 2019.⁴ By addressing barriers to treatment, such as lack of awareness and access to prosthetic urologists, health care systems can potentially impact patient outcomes and quality of life.

By expanding treatment options to include surgical procedures, health care systems can provide more options to patients suffering from ED and SUI — potentially adding life back to their years, while also growing the urology service line.



Challenges

Research indicates that, on average, it takes a patient up to 6.2 years from ED diagnosis to undergo their penile implant procedure.⁴ This patient journey is too long and can be frustrating for patients.

➤ ED impact to patient

ED may cause men to fall into depression, burden personal relationships, and reduce overall quality of life

- A meta-analysis including 48 studies and nearly 170,000 patients found that men with ED are 2.92 times more likely to suffer from depression, which may lead to a decline in mental health-related quality of life.⁵
- A survey study reported that 69% of males who had experienced ED and 74% of females with an ED-afflicted partner stated that ED was a “problem” in their relationship.⁶
- A US study found that overall, men with ED had lower emotional and social functioning compared to aged-matched population norms, indicating a potentially profound impairment in quality of life.⁷

Complexities in selecting ED treatment options

Around 1/3 of patients

in a study that included renewal information for 158 patients found that patients using phosphodiesterase 5 inhibitors (PDE5i) either do not respond or discontinue therapy for other reasons at first follow-up.⁸

~\$4,000 annual cost

for intraurethral alprostadil (IA) and intracavernosal injection (ICI) treatments.⁹

\$1,676 one-time cost

is the out-of-pocket patient cost for an inflatable penile prosthesis (IPP). Based on the 2025 national unadjusted patient co-pay for the OPPS Hospital Outpatient site of service, as listed in Medicare Addendum B.¹⁰

Impact to productivity and employment

- ED can pose an economic impact on employers, as men with ED report higher rates of work productivity loss.¹¹
- ED has been shown to cause an average of \$7,224 in lost productivity per man per year to employers who exclude IPP benefits.¹¹
- U.S. employers excluding IPP benefits could cumulatively lose \$9.3 billion/year of productivity due to additional work impairment from ED.¹¹

➤ ED impact to providers and facilities

In the U.S., 1% of the 12,145 practicing urologists perform 50% of the prosthetic urology procedures⁴

Limited supply of urologists

- For every one new urologist in the U.S., an estimated 10 urologists are of retirement age.⁴
- A 2025 Medscape survey of more than 9,100 physicians reported that 63% of all urologists were either depressed, burnt out, or both.¹²
- Only 9.6% of urologists have completed a Prosthetic Urology focused Fellowship in 2024.¹³
- By 2030, the per capita supply of urologists could decline by 17.3%.¹⁴

Outmigration of IPP:

Limited access to IPP treatments causes patients to travel for care

- In an analysis of 16,000 men with Medicare insurance and ED, 56.4% of men traveled out of their county to receive an IPP. These men traveled an average of 251.2 miles round trip for treatment (125.6 miles one way).¹⁵



One analysis found men traveled an average of 251.2 miles round trip

Opportunities

Growing patient demand suggests that prosthetic urology, within the urology service line, is a source of procedural volume and new patients.⁴

Patients: IPP can be a long-term and affordable solution for patients

Treatment type	Inflatable Penile Prosthesis (IPP)	Phosphodiesterase type-5 Inhibitor (PDE5i)	Vacuum Erection Device (VED)	Intracavernosal Injection (ICI)	Intraurethral Alprostadil (IA)	Extracorporeal Shock Wave Therapy (ESWT)
AUA recommendations ¹⁶	Strong	Strong	Moderate	Moderate	Conditional	Investigational
Frequency of treatment	Single	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Cost ^{11,12}	\$1,676* One procedure	\$696 Annual cost	\$213 One unit	\$3,947 Annual cost	\$4,022 Annual cost	\$3,445 Per treatment course
Estimated lifetime cost (20 years) ^{9,10}	\$1,676	\$13,920	\$213	\$78,940	\$80,440	\$13,780 ¹⁷

* Based on the 2025 national unadjusted patient co-pay for the OPPS Hospital Outpatient site of service, as listed in Medicare Addendum B

Potential benefits of prosthetic urology for patients

Strong AUA recommendation

- IPP has a strong AUA recommendation, contrasting with the moderate or conditional recommendations given to most other ED treatments such as VED, ICI, IA, and ESWT.¹⁶

High satisfaction rates

- IPP satisfaction rates (86–95%) are high, indicating that most patients are satisfied with the treatment option.^{16, 18, 19}
- In a retrospective study of 158 long-term AUS post-implantation patients at 5-year follow-up, overall patient satisfaction was high, with 92% of patients satisfied with their current continence status.²⁰

Cost efficiency

- IPP is a long-term treatment with up to 20-year durability.¹⁵ Though IPP has a higher upfront cost, it may be a more cost-effective long-term option compared to other treatments that require frequent use or recurring costs.⁹

Mental health

- In a Boston Scientific Health Economics retrospective claims analysis of 678 men with depression and pre-IPP antidepressant prescriptions, 15% had no antidepressant prescriptions post-IPP, while those with continued prescriptions had fewer prescriptions and refills within 12 months after IPP.²¹
- In a post-AUS implantation study, depression ratings significantly improved from baseline to 12 months, with the proportion of patients reporting feeling at least 'a little' depressed dropping from 85% to 39%.²²

Providers: Opportunity to connect men to the care they need

- ED Prevalence:** One study found that although there are over 1.7 million insured men in the U.S. with moderate to severe ED who could benefit from a penile implant, but **only 1.1%** of these patients undergo a penile implant procedure annually.¹
- Patient Satisfaction:** In a survey of 155 IPP patients, 59.4% wished they had received the implant earlier.²³
- Demand for Implanters:** Demand for IPP procedures is increasing. In 2023, more than 17,000 new IPP procedures were performed, which represents a **4.4% increase** from pre-COVID surgery volume in 2019.⁴
- SUI Prevalence:** Based on estimated rates of persistent SUI, approximately **280,000 men** were living with untreated SUI and could have benefited from interventions such as male slings or artificial urinary sphincters.³
- Financially Viable:** One physician reimbursement analysis co-authored and funded by Boston Scientific found urologists who treated post-radical prostatectomy (RP) patients suffering from both SUI and ED with an artificial urinary system (AUS) and IPP, respectively, received on average **~17x more physician reimbursement** compared to RP patients who are not treated.²⁴

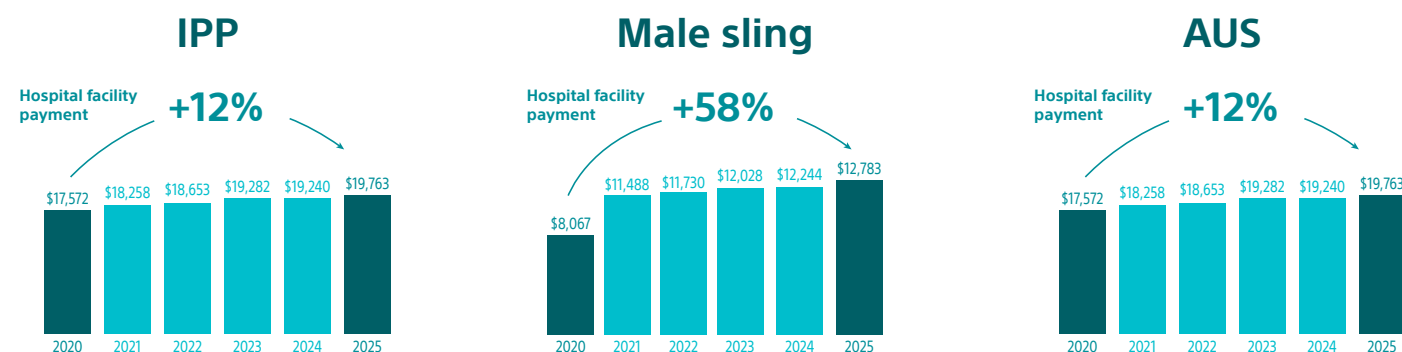
Opportunities continued

Facilities: Inflatable penile prosthesis can offer favorable procedural economics to facilities

Subsequent downstream health care utilization may be generated through IPP patients across multiple service lines, such as cardiology and endocrinology, in the 5 years post IPP.²⁵

- In a recent Boston Scientific Health Economics study, men with ED who received an IPP yielded nearly 10 times higher revenue for health care systems over a 5-year period compared to men without ED who did not receive IPP, excluding the direct revenue from the IPP procedure.²⁵
 - This represents a \$31,182 revenue difference between men with ED treated with IPP and men without ED who did not receive IPP, excluding IPP procedural revenue.²⁵
- On average, men with ED who received an IPP yielded \$10,258 more in revenue over the 5-year period post IPP within the circulatory service line than men without ED.²⁵

Medicare national average hospital outpatient department reimbursement for prosthetic urology has increased over the last 5 years from 2020 to 2025⁴:



Population health: Findings from a single systematic review suggest that ED may serve as a catalyst to screen patients who may also be candidates for other treatments, as ED can be connected to other comorbidities.²⁶

- ED can be a predictor of future cardiovascular events.²⁶
- The severity of ED has been shown to be associated with the severity of heart disease.²⁶
- Screening men who have symptoms of ED for CVD may lead to cost-savings by preventing future complications related to both conditions.²⁶

- On average, ED precedes a cardiovascular disease (CVD) event by 3 years.²⁶

Key benefits of Prosthetic Urology

- **Patients:** IPP stands out due to its strong AUA recommendation, cost-effectiveness over time, long-term durability, and potential to have a positive impact on mental health. Similarly, AUS offers high satisfaction rates and has been shown to improve symptoms of depression in men with urinary incontinence.^{9, 16, 18, 19, 25}
- **Providers:** Based on a Boston Scientific-supported health economic analysis, an estimated 1.7 million insured men in the U.S. may be affected by moderate to severe erectile dysfunction. With favorable procedural economics and growing demand for care, this represents a significant opportunity for providers.¹
- **Facilities:** IPPs can be economically viable for facilities. An advanced ED program can attract patients from farther away, boosting unique patient counts.^{15, 21}
- **Population health:** The presence of an ED diagnosis may prompt screening for other underlying health issues, such as cardiovascular disease, and treating ED can lead to patient retention for future procedures.²⁶

Important Safety Information



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AMS 800 Brief Summary
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References

1. Rojanasart S, Williams AO, Edwards N, Khera M. Quantifying the number of US men with erectile dysfunction who are potential candidates for penile prosthesis implantation. *Sex Med.* 2023;11:qfad010.
2. King MT, Viney R, Smith DP, et al. Survival gains needed to offset persistent adverse treatment effects in localized prostate cancer. *Br J Cancer.* 2012;106:638–645.
3. Shaw NM, Sato R, Rojanasart S, Rusilko P. Quantifying the number of US men with incident persistent stress urinary incontinence. *JU Open Plus.* 2025;3:e00071.
4. Data on file with Boston Scientific.
5. Liu Q, Zhang Y, Wang J, et al. Erectile dysfunction and depression: a systematic review and meta-analysis. *J Sex Med.* 2018;15:1073–1082.
6. Wagner G, Fugl-Meyer KS, Fugl-Meyer AR. Impact of erectile dysfunction on quality of life: patient and partner perspectives. *Int J Impot Res.* 2000;12(Suppl 4):S144–S146.
7. Litwin MS, Nied RJ, Dhanani N. Health-related quality of life in men with erectile dysfunction. *J Gen Intern Med.* 1998;13:159–166.
8. Fagelman E, Fagelman A, Shabsigh R. Efficacy, safety, and use of sildenafil in urologic practice. *Urology.* 2001;57:1141–1144.
9. Nguyen V, McGovern AM, Rojanasart S, et al. Patient out-of-pocket costs for guideline-recommended treatments for erectile dysfunction: a Medicare cost modeling analysis. *Int J Impot Res.* 2025;37:45–50.
10. Centers for Medicare & Medicaid Services. 2025 OPPS Addenda. U.S. Department of Health and Human Services. <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/quarterly-addenda-updates>. Accessed May 5, 2025.
11. Rojanasart S, Bhattacharyya SK, Burnett AL. Cost of lost productivity due to erectile dysfunction and impact of employer benefit exclusion of penile prosthesis implantation treatment. *J Occup Environ Med.* 2022;64:403–408.
12. Koval ML. Striving for Balance in Your Specialty: Medscape Urologist Mental Health & Well-Being Report 2025. *Medscape.* March 7, 2025. March 7, 2025. <https://www.medscape.com/slideshow/2025-mentalhealth-urologist-6018058>. Accessed November 12, 2025.
13. American Urological Association, The State of Urology Workforce and Practice in the United States 2024. Linthicum, Maryland, U.S.A., April 22, 2025.
14. Nam CS, Daignault-Newton S, Kraft KH, Herrel LA. Projected US urology workforce per capita, 2020–2060. *JAMA Netw Open.* 2021;4:e2133864.
15. Rojanasart S, Morris K, Nicholson T, Walsh T. Access to inflatable penile prosthesis surgery as indicated by distances traveled among US men with Medicare. *Sex Med.* 2024;12:qfad073.
16. Burnett AL, Nehra A, Breaux RH, et al. Erectile dysfunction: AUA guideline. [published correction appears in *J Urol.* 2022;207:743]. *J Urol.* 2018;200:633–641.
17. Chung E, Cartmill R. Evaluation of long-term clinical outcomes and patient satisfaction rate following low intensity shock wave therapy in men with erectile dysfunction: a minimum 5-year follow-up on a prospective open-label single-arm clinical study. *Sex Med.* 2021;9:100384.
18. 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.* 2012;80:333–357.
19. Otero JR, Cruz CR, Gómez BG, et al. Comparison of the patient and partner satisfaction with 700CX and Titan penile prostheses. *Asian J Androl.* 2017;19(3):321–325. doi:10.4103/1008-682X.172822.
20. Deruyver Y, Schillebeeckx C, Beels E, De Ridder D, Van der Aa F. Long-term outcomes and patient satisfaction after artificial urinary sphincter implantation. *World J Urol.* 2022;40(2):497–503.
21. Golan R, McGovern AM, Shin YE, et al. Improved health care utilization among men with depression undergoing inflatable penile prosthesis in a U.S. commercial population. *Am J Mens Health.* 2024;18:15579883241290714.
22. Peterson A, Wood H, Chaussee E, et al. The artificial urinary sphincter improves depression, anxiety and overall emotional health in men with stress urinary incontinence; analysis of the artificial urinary sphincter clinical outcomes trial (AUSCO). *J Sex Med.* 2024;21(Suppl 7):qdae167.136.
23. Van Huele A, Mennes J, Chung E, Van Renterghem K. Majority of erectile dysfunction patients would have preferred earlier implantation of their penile prosthesis: validation of the recently changed EAU guidelines. *Int J Impot Res.* 2023;35:731–735.
24. Babbar P, Rojanasart S, Shin YE, Sun A. Economic benefits of patient care for prostate cancer survivors with stress urinary incontinence and/or erectile dysfunction: a physician reimbursement analysis. *J Sex Med.* 2024;21(Suppl 1):qdae001.358.
25. Sun A, Williams AO, Rojanasart S, et al. Downstream revenue realized by facilities placing inflatable penile prosthesis in Medicare beneficiaries to treat erectile dysfunction. *Urology.* 2024;189:112–118.
26. Gandaglia G, Briganti A, Jackson G, et al. A systematic review of the association between erectile dysfunction and cardiovascular disease. *Eur Urol.* 2014;65:968–978.

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