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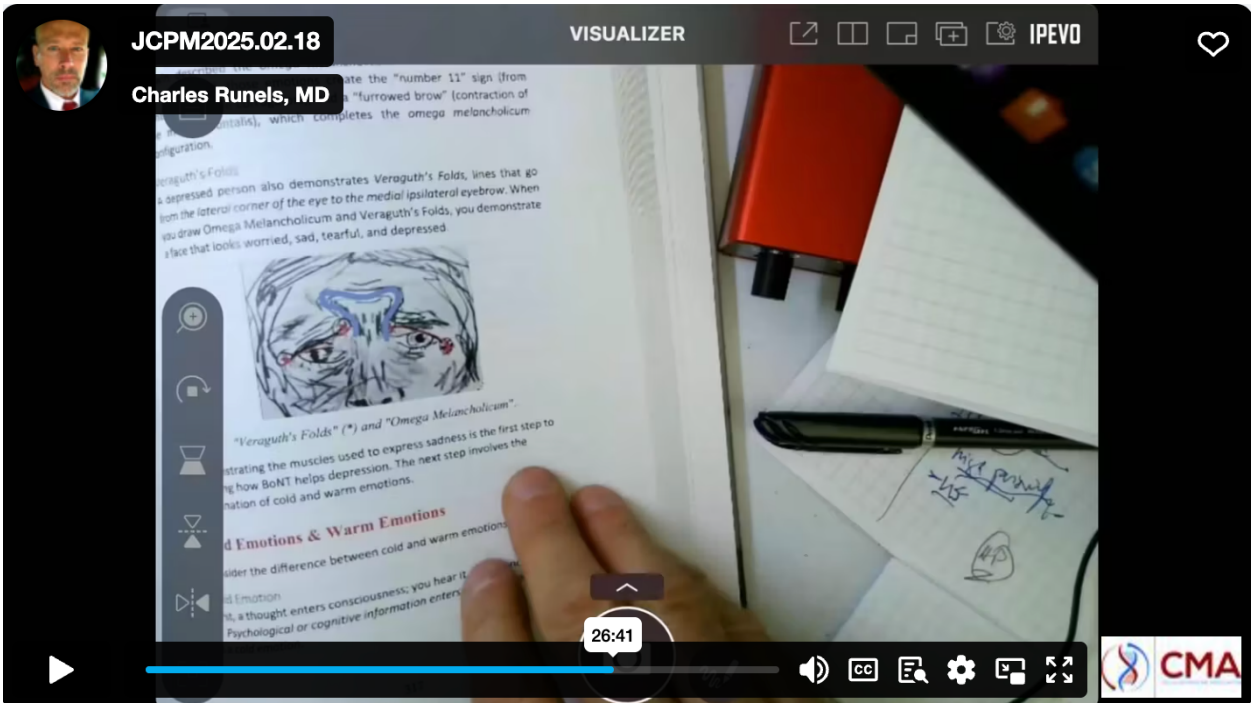
The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of February 18, 2025, with Charles Runels, MD.

>-> The video of this live journal club can be seen here <-<



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- **Using the research as news for your patients**
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- **How does botulinum toxin help depression?**
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Charles Runels, MD
Author, researcher, and inventor of the Vampire Facelift®, Orchid Shot® (O-Shot®), Priapus Shot® (P-Shot®), Priapus Toxin®, Vampire Breast Lift®, and Vampire Wing Lift®, & Clitoxin® procedures.

Transcript

Thank you for being on the call. Today, we have quite a number of papers, but three categories. I wanted to show you two new papers out of the continued avalanche of stuff that's coming out every week regarding TMJ and looking at PRP versus cortisone for treating the symptoms of TMJ.

The second is alopecia. Of course, we've looked at androgenic alopecia before, many times with PRP, but this is a beautiful, finally crossing the finish line study.

And then the other papers are regarding using botulinum toxin for treating depression. Now, these are older papers, but I thought it might be helpful to do a really deep dive into why and how to treat depression with botulinum toxin. I thought I'd open up my textbook, take you through the highlights about the facial feedback hypothesis, about the Omega sign that Charles Darwin determined and how it relates to the trigeminal ganglion and why treating depression with botulinum toxin has not become so popular and what we might be able to do about it.

Oh, and I thought I'd finish out also by looking at the flow of the legal analysis and implementation in protecting our brand while we're doing it. If we have time, I just did a yearly report with one of our partners on this endeavor, BrandShield, and it looks like we took down somewhere around a little over 500; that's a five with two zeros, websites, or social media accounts during 2024. Those are people who lost their website or their social media account because they were falsely advertising they were part of our group. Why we did that, how much it cost, and how it goes into protecting our patients, not just our brand, but of course, our brand is there to protect patients, so I'll go a deep dive into that. I go a little over today, but I'll cover the science part within 30 minutes for sure, and then if you want to stay around for the legal part and depression, I'll be here. I'll try to do it all under 30 minutes.

Treating TMJ with PRP vs. Hydrocortisone

Okay, so let's start with TMJ. When we looked at this, the only study that has come out came out a few months ago, and you can find it in one of our journal clubs; looking at the idea, it wasn't much about treatment, but just the idea that you should think about temporal mandibular joint pain as part of your workup for sexual dysfunction.[1]

It can be a hindrance, and actually, this study showed that the one I'm referring to, not this one but in the past that we discussed, it showed that this tends to occur more often in women who do sex for money, which might indicate somewhat of an overuse syndrome.

But let's go through what they showed here, which I think is very important. Whether it's interfering with sexual function or not, it's worth noting that the conclusion was that the people who got PRP for TMJ did much better than the people who got hydrocortisone.[2]

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[1] Leonid, "Exploring the Relationship between Temporomandibular Disorders and Sexual Function."

[2] Mittal et al., "Efficacy of Intra-Articular Platelet-Rich Plasma versus Hydrocortisone with Local Anaesthetic Injection in Temporomandibular Joint Disorders - A Prospective Study."

If you look, the pain was much more decreased with the PRP than with hydrocortisone.

And the mouth opening was about the same, but...,"

Let me just read it you about the MRI. This was what was exciting. "So an increase in mouth opening was similar in both groups, and the TMJ sounds were reduced in patients who received PRP."

This is the kicker. "Magnetic resonance imaging showed that PRP-treated patients showed better articular disc repair than patients treated with hydrocortisone," which makes sense, of course, but it's nice to have a study that shows what you would hypothesize.

"***PRP increases chondrocyte proliferation***, the production of matrix molecules and helps maintain the integrity of the chondral surface," which is what you would predict with so many studies now about joints. "...facilitating joint movement, whereas corticosteroids are more potent anti-inflammatory agents and they act by inhibiting prostaglandin synthesis, which is a mediator of inflammation. Thus, the use of PRP has been proven to show better results in reducing symptoms and in repairing the joint."

So there's a lot of people with popping TMJ, pain and popping TMJ. By the way, look at that. That's an interesting idea. I never thought of doing that measurement as part of your objective data that goes into your chart.

We should look into where we could buy that instrument. Of course, you'd need some sort of cover for that probe that's in the mouth, but that's beautiful how they're objectifying the measurement for the ability to open the mouth.

Using the research as news for your patients

So I call this meeting, "Journal Club with Pearls and Marketing". Now the marketing piece of this, here's the journal club part. There you have it, black and white, good study, out recently. So if you look at when this came out, all the studies, 2024, it came out at the end of 2024, so accepted in November, published November 2024, last revision. Anyway, that makes this news, right? It makes it news.

So, news is what people want. They don't want an ad. They want news. They want you to be their version of the health letter from the Mayo Clinic. They would rather read your email about health news because you are their hero if you're their physician. And even if you're not their physician, if they're on their email list, you are the person they're looking at for the latest relative news.

So here's the research that is now news. If you wrote an email, it could be literally three lines long. "Hello, first name. If you or someone you know suffers from pain or popping or difficulty in the joint, the temporal mandibular joint, and they have trouble opening their mouth," you can use TMJ. Patients probably know that more than they know the temporal mandibular joint.

So sentence one is, "If you have pain or suffer with pain and popping when you try to eat and that possibly it's affecting your sexual relations, then there's new research that shows that we may have something that could be of help to you," or, "We do have something that may be of help to you," that would be the correct way to say it. "And here's the research to show it," and then you just put a link.

This is open source, so you could put a link to this and actually put the article on your website if you wanted. This is an open-source source article, so you're able to share it freely as long as they're able to see where it came from, all right?

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And then the second sentence is, "If we now have this available, if you or someone you know suffers with this, please contact us." And then, of course, with every email you have your name and address. And then if you wanted to overdo it, you open up this research, you do a screenshot of it or you make a video of it with whatever tool you like to use and then you discuss the paper and put that on your YouTube channel or whatever you're doing. I use Vimeo more than YouTube. And now you will have not 100 calls, but you'll get a call or two and you'll change someone's life. And of course, you can always also use botulinum toxin in their master muscle for a combination treatment.

If you have someone open their mouth, it's so easy to palpate the TMJ joint. It's right there. You can feel the articulation on it and just if you get close to it, you're going to be good enough. I don't think you need ultrasound for this, but if you have it, use it. But just get close to it and put about a quarter cc of PRP in the joint. You don't have to use a lot. They give their technique here. You can just follow that if you want, so there you go. Let's get to the next paper. I love that paper because so many people suffer with this and they just decide that's what I got, and they wear something around at night and they suffer with it and think nobody can help them. So that's one thing.

PRP for Alopecia—a Comprehensive Evaluation Concludes Standard of Care

The next one is not news about what they showed. We all know, because most of us are doing it, that PRP helps alopecia, both androgenic and autoimmune in origin, alopecia areata, and it helps in women and it helps recover hair with traction alopecia or alopecia post-chemotherapy.

But this is what I love about this paper. So it starts off with the variability in treatment. What they did is they did a survey of the research. I don't think it qualifies as really meta-analysis, but they call it a comprehensive evaluation because their math maybe is not strict enough to call it a meta-analysis. But they read a bunch of research and they talked about it and they talked about it in a smart way.

Their conclusion, in my opinion, makes this standard of care.

So read this, ***"The overall evidence supports PRP as a promising treatment for androgenic alopecia. In conclusion, PRP is a viable therapeutic option for androgenic alopecia, particularly for increasing hair density and thickness."*** [3]

I mean, what else is there, right? "However, the variability in treatment protocols highlights the need for standardized PRP preparation and application methods," which is part of what our group supplies. So if

[3] Lopes-Silva et al., "Platelet-Rich Plasma Effectiveness in Treating Androgenetic Alopecia."

you're part of the vampire facelift group, you have access to the vampire facial materials and you have access to the vampire hair materials, so we have a standard protocol there.

But this is the part that made this study or this paper worth looking at because we already have probably 100 papers we've talked about with PRP helping alopecia.

This one sentence, "***Future research should focus on refining these protocols and exploring the potential of combination therapies to maximize treatment effectiveness and consistency***." In other words, quit trying to show that this stuff works.

It works.

So instead of doing that, do studies looking at PRP combined with minoxidil versus not or PRP with a double centrifuge versus a single centrifuge with a different platelet concentration, or PRP combined with B-12 or whatever other things you're adding into it, or PRP with a red laser cap versus PRP alone.

So between the lines what they said here is this is the standard of care. So the next paper you do to show that it works, nobody cares anymore, which is what we just said. We don't really care if you just show it works because we know it and there's 100 papers before you, so tell us something new. And the thing I think this paper did that is new is say to us quit trying to show it works. This is standard of care. So now let's do the next 1,000 papers we need to do to define the protocols and the combination therapies. That's the future for the coming research.

And this backs up what you've heard me say a lot is that people have this idea that, not the people on this call, but especially lay persons, they might think, well, you do when paper and it proves it or disproves it and it's done.

You never prove anything.

That's the scientific method. You put out a hypothesis. Then you try to disprove it, and then until it is disproven, if it is supported, it's considered viable.

And so we have a volume of research now showing that in our Priapus Shot® method is actually helpful for erectile dysfunction, and we have one one-off paper that I think was poorly designed to conflict with the other 50 papers showing that, or more, showing that it might work, and so it's never proven. It's just gets more standard of care until it's disproven or until it's not disproven.

So that's where we are with this. With hair growth, we have a stack of papers. It hasn't been shown to be not viable. It's been shown to be a good idea, and now you're really just at the starting line or a new starting line because you've gone from trying to disprove your hypothesis and instead you've supported it sufficiently that it becomes standard of care. And then there's an infinite number of variabilities. How much do you inject? Where do you inject? Where do you decide where the hairline is? Who do you choose to treat? What are the things do you do with diet and topicals? What do you do with light therapies? What blood work do you check? How often do you treat? And then for every one of those variables, there's 1,000 different things you could do. So it becomes truly so voluminous it takes another

20 years before we get a really good best idea by trial and data what's the best method. So that's where we are, and that's the thing.

So if I did hair, what I would do is I would put a link, ***here's the marketing part of this***, I would put a link to this paper, which is also open source and it's in your handouts, put a link to this open source paper to an email that says that, "We're treating alopecia, and if you or someone you love suffers with this, we have another study that's out." That's the news. So now you're not advertising. You're reporting the news. So we have these new studies that came out on January the 13th of this year showing that this is a viable thing and this has quit being experimental. It's become standard of care, or at least it should be, and that's what we do. And they say there should be some protocols in place and we have those protocols and it's preparing our PRP with our FDA-cleared device and then whatever else you're doing.

That following our protocol allows you to call it it's our vampire hair treatment. We're part of this group, the Cellular Medicine Association, we have a protocol that's been working now for over a decade, and that's what we do. And then of course, just so you know, we do recommend for your best therapy use topical minoxidil if they can use it. Always remember one of the side effects is atrial fibrillation. Rare, but it happens, and so you have to watch for that. And light caps, the laser caps also help and you want to make sure you've checked them, of course, if someone has hypothyroidism. And it could be also from rapid weight loss if that's what they're doing using the new weight loss drugs. They should probably wait until they're through with that and then you start the treatment and you'll help them grow it back faster. If they're on chemotherapy, then it's not likely to help until they're off the chemotherapy. That research has been done.

So there's your protocol, not that complicated.

How does botulinum toxin help depression?

Let's talk about depression first. And before I do that, just to mention, I used to try to field on this call questions about the protocols which come up pretty regularly and are best asked by posting to the websites. You can also, of course, email us or text me, but... Unless it's urgent. If it's urgent, just text me and I'll answer it 24 if you have something that's truly urgent and needs to be figured out within 24 hours or less. It hardly ever happens, but you may have a worry or sometimes it's a good thing, somebody wants to interview for the press or something. But most of the time it can be handled within a week or less, which means you can post the question to one of the forums on any of our membership sites. And I used to cover those every journal club, but then the research became so voluminous because it's been logarithmic in growth, there become less time, and shame on me, I became less diligent about making sure every question got answered.

The other thing is in the beginning we were all beginners, but now we have people who've been in the group for 12, 14 years and some of the questions that are more basic are less valuable for the members who have been in with us for a long time, so it seemed helpful to me to separate it. So I committed to a full two hours every Monday starting yesterday, and now from 2:00 PM until 4:00 P.M., from 2:00 P.M. until 4:00 P.M. Eastern Standard Time, New York time, every Monday I'm just going to answer the

questions that have been posted. Or if you show up, I'll unmute the mic and you can ask it, just that. And the preference is to write it, and I'll unmute your mic, that way we'll have a place of marker within the website documenting your question and I'll post the answer to it, and you'll have, of course, not just my views but others who might be on the call who want to help answer the question.

But that seems to me a good way to get a group consensus and a group mastermind thinking. And it seemed that finally we've developed as a group, there's enough of us now at 2,800 members that we need a separate meeting for, like we're doing now, looking at the research versus someone who might just be trying to figure out how to log into the website and how to find the how do it video. So we did the first one yesterday and I've posted the answers to all the questions on the websites, either in words or in videos that were recorded yesterday. All right, so just so you know, that's available, and I'll send out another email with that link if you missed the first one, and it'll be in our newsletter now that's coming out every month.

Okay, so let's run through depression, and I'm going to just pull out the textbook.[4] I want you to see this physical textbook and where it lives. This comes to you, and I'm not going to skip over anything. I'm going to show you all the main points in the textbook about how to treat depression.

But first, let me quickly run through some of the ideas behind the research, and I'll show it in the textbook and how it's practically applied.

The first one is this *facial feedback hypothesis* that I just mentioned, and I'm going to show you how I diagram it.[5] The idea is that when you move your muscles, your muscles tell your brain what you're thinking, and then your brain says, okay, if that's what we're thinking, then I should make the muscles keep doing this. There's this negative feedback loop that spirals you down into further anguish.

And that's described as going from a cold emotion to a hot emotion. Cold in that you know about it, but you're not as emotional about it, you just have an awareness of it. That you're not emotional about it yet, that you're just like maybe someone who has some personality disorder that they're aware that they should be crying about this now, but they don't feel the tears coming. They just intellectually know about it. That would be a cold emotion.

And it takes, according to this hypothesis, it takes the facial feedback. The brain intellectually knows an emotion, tells the facial muscles how to then configure to demonstrate that emotion, and then the facial muscles feedback and tell the brain how to feel about that emotion, and blocking that is thought to be a way botulinum toxin might help treat major depression.

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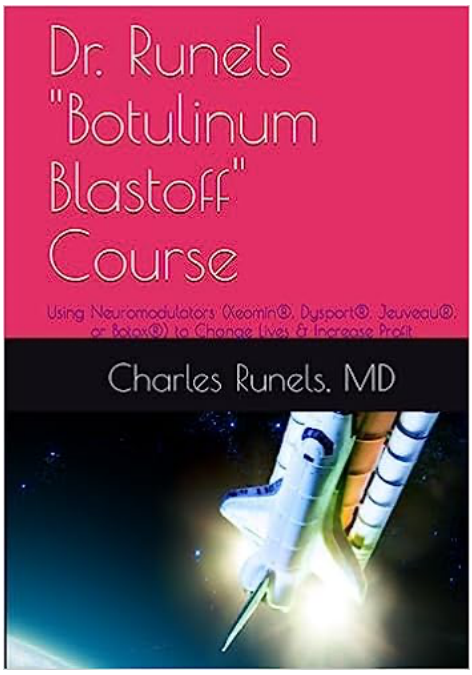
[4] Runels, *Dr. Runels "Botulinum Blastoff" Course: Using Neuromodulators (Xeomin®, Dysport®, Jeuveau®, or Botox®) to Change Lives & Increase Profit*.

[5] Alam et al., "Botulinum Toxin and the Facial Feedback Hypothesis."

Now I put some of these in your handouts. This one is one. So far I've counted eight double-blind placebo controlled studies that show that botulinum toxin helps depression.[6] This is one of those places where I think calling something placebo is probably knowingly deception. You act like you're tricking people, but everybody knows that you're really not.

In other words, if I do a placebo-controlled study and I inject your procerus and your corrugators with botulinum toxin and the other groups get saline, does it really take Sherlock Holmes to figure out who the placebo arm is? So I would debate this word placebo, but people go through the motions because there's still so many people think that it's a worthless study unless you do a placebo control. And there's never been a placebo-controlled study of parachutes or birth control pills, but we use both because we know what they do.



But anyway, this, to me, is tongue-in-cheek because you can't really do a blinded placebo with botulinum toxin injected into the face. But anyway, there have been eight studies that show major depression, unresponsive to antidepressants they get better. So this facial feedback loop, or whatever it is, it may truly be very powerful.

Let's see. There's another study. And this study, I brought it up because this is huge and it got very little press. It came out two years ago. Let me expand it because I was always taught that the way serotonin uptake, the inhibitors work is that people who are depressed have low serotonin levels. What this study showed is that, I'll just read it to you, "The main areas of serotonin research provide no consistent of there being any association between serotonin and depression and no support for the hypothesis that depression is caused by lowered serotonin activity or concentrations. Some evidence was consistent with the possibility that long-term antidepressant use reduces serotonin concentration."[7]

And what's one of the effects of antidepressants, of serotonin uptake inhibitors? Suicide. And so you could make a case they might make people more depressed. And they don't say this, but my, this is Charles's hypothesis, my hypothesis is that because we know in some people they help their depression, but of course they become anerogasmic and they become flat-lined or anhedonia, or whatever the word is. They can't have fun because they're flat-lined. They're not depressed, but they're not really especially happy either oftentimes. And so this is just me connecting the dots, which sometimes happen when you're reading too much. But I think what could be happening is that the serotonin uptake inhibitors

[6] Magid et al., "Treating Depression with Botulinum Toxin."

[7] Moncrieff et al., "The Serotonin Theory of Depression."

also are blocking that feedback loop so the person maybe intellectually knows they're sad, but they don't feel it as much because their serotonin goes down. I don't know. I don't really have the answer to that.

But the point is that because of that paper, which is only two years old, and this was one of those landmark papers that got some press when it came out, but people weren't really sure what to do with it because do you go pull off all these people off their serotonin uptake inhibitors? I don't think so.

Well, I'll tell you what you do with it. You do what the research shows, which shows that botulinum toxin helps people with depression who are resistant to this stuff that now we know has really no biological basis for it and makes them an increased risk for shooting either themselves or their lover in the brain, and that's a fact. So why are we still even doing this? Why are we doing serotonin uptake inhibitors, which as of two years ago, three years ago almost, we now know don't have a solid basis for use. We just know by experience that it does work in some people, even though it makes them more at risk to take out their pistol. But we have double-blind placebo-controlled studies, eight of them showing that botulinum toxin works, and we have another reason why it may be working.

How to do the procedure (treating depresson with botulinum toxin)

So let me swap over and show you what I'm talking about. Oh, and we have not just the double-blind placebos, we have meta-analysis studies showing that, and this was a true meta-analysis, and this is in your handouts too showing that this stuff works. So why is it not standard of care? I'll tell you why. You've seen the ads for using Botox for depression, right? You've seen those ads because they have on-label approval for it and your neurologist or if you are still accepting insurance, god help you, but if you're still accepting insurance for a big piece of your practice, you can get it covered.

And so the patient gets, they get their migraines treated for copay, but treating depression is still off-label. So let me swap over to my textbook so you can see because now I'm off the research and I wanted you to know that, but now I want you to go through the Charles take on some of this stuff. I don't think we're going to have time for the legal thing yet, but we'll finish the depression idea. Hold on just a second.

Change what you're looking at. Okay, you're now looking at the textbook. It's 400 and something pages. It sells on Amazon for 250 I think, give or take, but there's an online version of it where we'll mail you this book and I have videos demonstrating all these different techniques. But let me show you, first of all, this Alpha sign I was telling you about, and I promise I'm going to show you exactly how to treat depression.

First, look at these numbers. ***300 million people worldwide suffered with mental and physical pain and comorbidities of depression***. According to the World Health Organization, depression is the leading cause of disability worldwide, leading cause of disability. So it's one of those things.

I just had a dear friend who was in the hospital with depression, and she's not posting that to Facebook. So it's one of those hidden things. It's like sexual dysfunction. People who suffer with it often suffer in silence and in solitude and in secrecy because it's hard sometimes for those without depression to understand it and to sympathize with someone who's you know they're young and they're good-looking

and they have a good family and a good job, but they're in the bed with depression. What do you do with that? People who are not depressed have trouble with it. Depressed people know that so they keep it a secret.

Okay, so I just want to put those numbers out and tell you this is not, you shoot out an email about depression, probably one in 10 people, a good, significant number of those people who are reading your email suffer with it, and they all have a friend suffering with it or a family member. Excuse me. So I make a point here you still got to think about other things. This is one of the things you can do. I don't even know this works for many people. I always like to remind people I don't have a magic shot that's guaranteed to treat everybody, and you should say the same thing on your website.

Okay, that's the Alpha sign. Obviously, this person looks depressed and they look, excuse me, the Omega sign, Omega Melancholicum[8] was what Darwin called it. And Veraguth's Folds are these lines right here. Veraguth's Folds and the Omega sign. Those are signs of depression. And look what's causing that expression. You have contraction of the corrugators, and you have some contraction of the ocularis. And so it makes sense if you can get in front of the mirror and smile and it might make you happy because you're just making the facial expression of the smiling, and we've all tried that and it actually works, that if you could block the frown and the sad expression, it might block the feeling. And this was my way of illustrating when you block that, it keeps it as a cold expression and it keeps it from turning into a hot or a warm expression.

I'm getting to where you put the needle. And this is my little diagram sketch of what's happening. So you have this thought that should make you sad. Someone died. Or sometimes you don't have a thought, it's just biochemical, but for whatever reason, usually oftentimes it's situational, but sometimes it's your just perception from your biochemical thing that's going on.

One of my mentors told me you'll never successfully treat depression in someone who's an alcoholic. They have to go to AA first, get off their alcohol. Then you can treat them for their depression. But it's whatever's going on biochemically. But there's often a situational component to it, and then something makes you feel depressed. And then it hits the muscles, the muscles that form that Omega sign and the Veraguth's Folds and the downturned mouth, those muscles have proprioceptors on them. That feeds back to the brain and says, "Hey, we're sad." And then that sadness makes this vicious negative feedback loop where the muscles stay downturned and you feel more and more sad and people do kill themselves. So you want to break that cycle.

And when you put botulinum toxin in the muscles where I'm about to show you, then whatever, whether it's situational or biochemical, and your brain tries to tell your corrugators to make the Omega sign or Veraguth's Folds and the downturned mouth, you can't. You can't even do the downturned mouth if you do the triangularis. So this whole feedback loop is blocked, and you might still be sad, but

[8] Alam et al., "Botulinum Toxin and the Facial Feedback Hypothesis."

you've blocked at least one of the negative spiral loops that can take people further down. I call it the death spiral.

Okay, then the other thing that happens is that, or one of the theories that could be happening is when you inject the procerus, and you've heard me talk about this in relation to migraines and the same thing we think is happening when we use Clitoxin® and Priapus Toxin®, that when you inject an area, we know that botulinum toxin migrates along the axon. So if it migrates along the axon from the procerus, it's going to the trigeminal ganglion, which is shared by the interference from the meninges, and then that goes to the caudate nucleus or nucleus caudalis.

So you have this feedback loop where the sympathetic nervous system is attenuated, parasympathetic is increased, and part of the symptom of depression of course is anxiety, and anxiety/depression is a lethal combination. So by doing this, by attenuating the sympathetic nervous system when botulinum toxin migrates to the ganglion, you are then also relatively increasing parasympathetic nervous system and taking out some of the anxiety component of depression, and probably also helping the depression directly. We're not sure.

I meant for this to be insulting. This is my sketch of what it looks like when the tail is wagging the dog. And that's what I think is happening now when we know by research that the low serotonin as a cause of depression theory is bogus. We know it. The research of many years, that was a summary paper that I gave you that is reaching the conclusion by looking at multiple papers. It's bunk.

And so yeah, serotonin uptake inhibitors help some people, but it's not really the way we think it was doing, and it's increasing the risk of suicide, but yet we have eight double-blind placebo-controlled and meta-analyses showing that botulinum toxin helps depression, but it's still not standard of care. And why not? Because the tail is insurance, and we are the do and we're going, not us hopefully, but many of your colleagues, most of them, are deciding what they do based on the insurance policy.

And you can say, "Well, they have to do it that way because not everybody has the money." Well, so what? That's a reason for saying why we're letting the tail wag the dog. And I'm saying that this group, which is my son, my youngest son actually gave me this phrase recently. He said, "Dad, you're dealing with the breakaway doctors." We're the doctors who are breaking away. We say, "No longer will the tail wag me. I'm going to cut the freaking tail off if I have to and do what I think is best for my patients," and that includes best is defined by what's supported by the research.

I don't mean best is defined by the health food store or the left Lunar Moon Journal of Crazy Medicine, but I'm showing you research. And I gave you a few papers, but in this book I have probably, I have two pages of research. There's one page of it goes to that page and that's the page. So those are the references about this working, all right?

So I'll just show you the picture. It's really easy. All you have to do is to treat, here's your pearl. *You treat procerus and corrugators the way I teach it with the doses that I teach.* And I think you avoid the frontalis, which is what you would expect. One study actually showed if you treat the frontalis, you could make their depression worse, which is what you'd expect because of the frontalis would cause the

brows to droop as you would when you're feeling depressed and sad. Remember Veraguth's Folds, this lateral brow comes down.

So if you had a surprised, happy look, your frontalis is working. So in depressed people, leave the frontalis alone, unless you just have to put a little bit up there because they spock out, and I tell you how to treat spocking out people in here, but treat corrugators and procerus, treat it as heavy as you need to keep any movement away. And you can't droop the brow by just treating procerus and the corrugators, so you can treat it as heavily as you need to.

I usually tell people, "Come back in two weeks and if you can frown it all, I'll add more," or better yet, "Look in the mirror and if you can move," I'll have them demonstrate in the mirror. If they can make the corrugators, make the 11 signs or procerus, make the dash sign at all and tell them, "Come back and I'll touch it up for free."

So that's how you treat depression with botulinum toxin. It's very easy, and it doesn't take very much of it. And I think with that, that's 45 minutes. I think I'll go over the legal flow later, and thank you guys. I see quite a number of you still on the call, so I hope that was helpful to you. Let me see if there are questions. I don't see any, so have a great week.

Remember, if you have questions about protocols to show up to our, we're calling the Cell Doctor Forum on Mondays at 2:00 P.M. New York time. Otherwise, I'll see you next week on our journal club. Have a great week, bye-bye.

=>Next Hands-On Workshops with Live Models<=

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Tags

TMJ, PRP, Cortisone, Botulinum Toxin, Depression Treatment, Facial Feedback Hypothesis, Alopecia, Androgenic Alopecia, Hair Restoration, Vampire Hair Protocol, Brand Protection, Medical Marketing, Patient Education, Journal Club, Platelet-Rich Plasma, Trigeminal Ganglion, Sexual Dysfunction, TMJ Pain, Legal Strategy, Medical Aesthetics, Clitoxin, Procerus Injection, Corrugator Injection, Standard of Care, Clinical Protocols, Botulinum for Depression, Medical Research, Cosmetic Medicine, FDA-cleared Device, Medical Ethics, Charles Runels

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