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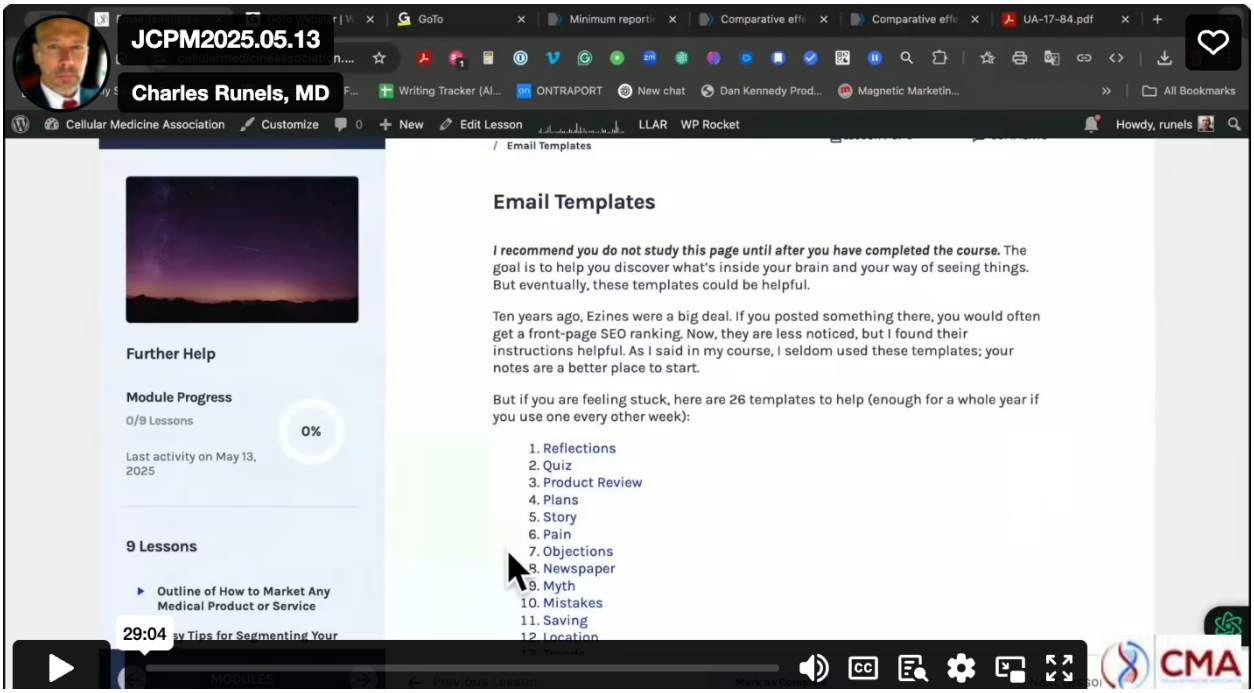
The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of May 13, 2025, with Charles Runels, MD.

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



Topics Covered

- **What You Should report When You study PRP Procedures (or What Should You Look for When You Wish to Duplicate Research Findings)?**
- **Shock Wave for ED: Which is Best, Radial or Focused?**
- **Propaganda About Marketing**
- **An Email Template to Use for Any Procedure**

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Transcript

Welcome to our journal club.

We have three papers that came out this week that, I think, you'll find helpful.

What You Should report When You study PRP Procedures (or What Should You Look for When You Wish to Duplicate Research Findings)?

The first paper considers a problem that has been talked about quite a bit on our journal club: what are the important variables that should be reported when doing studies regarding PRP use in soft tissue. These variables are well defined in orthopedic studies but not so well defined for soft tissue studies.[1]

Though we talk about joint procedures here in our journal club, mostly we're talking about soft tissue with aesthetic and sexual medicine. And a way to get to those answers with research is to report a consistent and complete spectrum of variables when we do studies.

This article was about what those variables might be so that, in theory, when someone publishes something, we can go duplicate it with our patients or with future research.

So, the gist of it was that we should include the platelet count, the white blood cell count, the red blood cell count, and they talk about some of the classifications we've covered in journal club quite a number of times.[2] [3] [4] [5] [6] [7]

If you just log into the membership site and put PRP classification, you'll pull up some of those ideas. And what they call establishing minimal reporting requirements.

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[1] Banu and Sharun, "Minimum Reporting Requirements for Platelet-Rich Plasma in Biomaterial Research."

[2] Smith et al., "An Evaluation of the Effect of Activation Methods on the Release of Growth Factors from Platelet-Rich Plasma."

[3] Magalon et al., "DEPA Classification."

[4] Okumo et al., "Multifactorial Comparative Analysis of Platelet-Rich Plasma and Serum Prepared Using a Commercially Available Centrifugation Kit."

[5] Sheean, Anz, and Bradley, "Platelet-Rich Plasma."

[6] DeLong, Russell, and Mazzocca, "Platelet-Rich Plasma."

[7] Fermín et al., "Review of Dohan Eherenfest et al. (2009) on "classification of Platelet Concentrates."

When I taught in Serbia, they did cell counts at the bedside. We usually don't check CBCs if they're healthy. I don't. If someone comes to me for a P-Shot®, they're a young, healthy person, I don't do a CBC on them usually, and same with an O-Shot® or a Vampire Facelift®.

But when we do studies, I think it's important that we report these variables and not just which kit we use, which could be done, of course, with some little extra expense and trouble.

And I'm guilty of having done studies without reporting this. I've only reported which kit I have used and not as suggested here.[8] [9] [10] [11] [12]

So, I won't dwell on it. But some of you're doing research, and I think it's a reasonable observation that we should be doing this.

Shock Wave for ED: Which is Best, Radial or Focused?

The next one has to do with shockwave. Many of you are combining shockwave with your P-Shot® procedure. There are several devices out and I'll show you a recent review article that is attempting to give you an idea about which one might work the best.[13]

If you remember, about three weeks ago there was a review article looking at the combination of shockwave with our P-Shot® or some variation on the P-Shot® with a definite synergy documented.[14] ***The two together definitely work better for ED than shock wave alone.***

They didn't actually look at PRP alone versus PRP with shockwave, so there was not that third arm. But the shockwave with PRP worked better than shockwave alone.

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[8] Runels, "A Pilot Study of the Effect of Localized Injections of Autologous Platelet Rich Plasma (PRP) for the Treatment of Female Sexual Dysfunction."

[9] Brandeis et al., "(130) Increasing Penile Length and Girth in Healthy Men Using a Novel Protocol."

[10] Posey and Runels, "In-Office Surgery and Use of Platelet Rich Plasma for Treatment of Vulvar Lichen Sclerosus to Alleviate Painful Sexual Intercourse."

[11] Goldstein et al., "Intradermal Injection of Autologous Platelet-Rich Plasma for the Treatment of Vulvar Lichen Sclerosus."

[12] Runels and Runnels, "The Clitoral Injection of IncobotulinumtoxinA for the Improvement of Arousal, Orgasm & Sexual Satisfaction- A Specific Method and the Effects on Women."

[13] Ramadhani et al., "Comparative Effectiveness Radial Shockwave Therapy versus Focused Linear Shockwave Therapy as an Erectile Dysfunction Treatment Systematic Review and Meta-Analysis."

[14] Geyik, "Comparison of the Efficacy of Low-Intensity Shock Wave Therapy and Its Combination with Platelet-Rich Plasma in Patients with Erectile Dysfunction."

In the article we are considering today, they went looking for the best of studies, and the bottom line is that the focused seems to work better than radial.[15]

They say, "We postulate that focus shockwave therapy should be considered as one of the treatment modalities, either as a single or combined treatment with medications and exercise." So interesting that

[15] Ramadhani et al., "Comparative Effectiveness Radial Shockwave Therapy versus Focused Linear Shockwave Therapy as an Erectile Dysfunction Treatment Systematic Review and Meta-Analysis."

even with the stack of research we have now,[16] [17] [18] [19] [20] [21] [22] [23] [24] [25] [26] [27] [28] [29] [30] [31] [32] [33] [34] [35] [36] [37] including the recent article about the combination therapy, they couldn't bring themselves to mention our P-Shot® procedure—medications and exercise, but nothing about our P-Shot®.

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[16] Javier et al., "(219) AUTOLOGOUS PLATELET-RICH PLASMA IMPROVES ENDOTHELIAL AND TADALAFIL-INDUCED RELAXATIONS IN CORPUS CAVERNOSUM FROM PATIENTS WITH ERECTILE DYSFUNCTION."

[17] Narasimman et al., "A Primer on the Restorative Therapies for Erectile Dysfunction."

[18] Chung, "A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction."

[19] Taş et al., "Early Clinical Results of the Tolerability, Safety, and Efficacy of Autologous Platelet-Rich Plasma Administration in Erectile Dysfunction."

[20] Ruffo et al., "Effectiveness and Safety of Platelet Rich Plasma (PrP) Cavernosal Injections plus External Shock Wave Treatment for Penile Erectile Dysfunction."

[21] Du et al., "Efficacy of Platelet-Rich Plasma in the Treatment of Erectile Dysfunction."

[22] Anastasiadis et al., "Erectile Dysfunction."

[23] Anastasiadis et al.

[24] Chung, "Medical Sciences A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction."

[25] Schirmann et al., "Pilot Study of Intra-Cavernous Injections of Platelet-Rich Plasma (P-Shot®) in the Treatment of Vascular Erectile Dysfunction."

[26] Poulios et al., "Platelet-Rich Plasma (PRP) Improves Erectile Function: A Double-Blind, Randomized, Placebo-Controlled Clinical Trial."

[27] Masterson et al., "Platelet-Rich Plasma for the Treatment of Erectile Dysfunction."

[28] Chung, Ryu, and Yin, "Regenerative Therapies as a Potential Treatment of Erectile Dysfunction."

[29] Hinojosa-Gonzalez et al., "Regenerative Therapies for Erectile Dysfunction."

[30] Francomano et al., "Regenerative Treatment with Platelet-Rich Plasma in Patients with Refractory Erectile Dysfunction."

[31] Matz, Pearlman, and Terlecki, "Safety and Feasibility of Platelet Rich Fibrin Matrix Injections for Treatment of Common Urologic Conditions."

[32] Finkle, "Sexual Impotency."

[33] Hu et al., "The Effect of Platelet-Rich Fibrin on the Biological Properties of Urothelial Cells."

[34] Yogiswara, Rizaldi, and Soebadi, "The Potential Role of Intracavernosal Injection of Platelet-Rich Plasma for Treating Patients with Mild to Moderate Erectile Dysfunction."

I wrote a summary of some of the bias that leaves our P-Shot® out of current protocols after the JAMA article correction was made.[38] [39]

Anyway, focused seems to work best, but they both work.

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If you've got the radial, then it's working too, but as soon as you can, I'd swap it out for a focused linear shockwave.

Okay. And so if you happen to have a focused linear shockwave therapy device, then I would brag about it by sending a link to this paper (it is an open-source article). I'll copy and paste that into the chat box.

You could send that to your people in an email and say, "Hey, I have one of these and I do the P-Shot® along with it."

And always, I like to do the energy first and then PRP. I know some have reversed it. Still get great results, but most of us are doing shockwave then a P-Shot®.

It can be in the same visit, but shockwave, P-Shot® or it could be shockwave, shockwave, shockwave, and then a P-Shot® immediately after the third shockwave if you're going to do a series. So that's it. I won't dwell on it, but it's a feather in your cap if you're already have a focused that you could brag about.

Propaganda About Marketing (Rules for Breaking the Arrows Aimed at You)

Okay, and let's look at this last paper.

This one is very political and anytime you are doing something for cash, you're by definition, doing something political. Because I think, it's very useful to acknowledge the fact that if you're collecting cash, you draw a target on your back for those physicians who do not bill cash, most of them resent it.

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[35] Towe et al., "The Use of Combination Regenerative Therapies for Erectile Dysfunction."

[36] Garcia et al., "Treatment of Erectile Dysfunction in the Obese Type 2 Diabetic ZDF Rat with Adipose Tissue-Derived Stem Cells."

[37] Siroky and Azadzoi, "Vasculogenic Erectile Dysfunction."

[38] "Errors in Text."

[39] Runels, "Memo in Response to the JAMA Article."

So, it's good to look at the arrows that might be in the quiver of the person who might consider aiming at you. And if you're following our recommendations about how to talk about our procedures, then you will be doing what you need to do to make things right with those who might criticize us.

In this article, Maintaining Truth in the Era of Misinformation, [40] the first thing that jumps out at me is the word I I hate, "misinformation." You're either telling the truth, or you're lying, or you are saying something that I am unsure about (I neither know if it is true or false).

But what is "misinformation"? It's either the truth or a lie.

If I think it may be true, but I do not like it and want to call it false, I call it "misinformation."

And I think people in general, when they use that word are afraid to say "lie" when it's a lie or they're wanting to make the truth look like a lie. But to me, it's a wishy-washy word that I don't like, but that doesn't matter (that I think of the word) I don't guess in the big scheme of things, but that's what I think when I see that word.

Maintaining the truth in the era of lies or maintaining the truth in the era of truth that you don't particularly like so you're going to call it misinformation.

I don't know what that word means. But let's dive into the points that are made and see what we can do.

One more background thing that's probably more important than what I just said, is that doesn't ***if you are accepting cash, you should by definition, do something for the person that the doctor taking insurance cannot do, or at least is not choosing to do because insurance pay for it.***

Take it one more level and meditate on this: A doctor who chooses to only do what insurance reimburses for, a doctor who chooses to only do that for which reimbursement can be obtained by insurance, that doctor who is letting insurance define the spectrum of available therapies. *If insurance doesn't pay for it, she doesn't offer it. Therefore, insurance is defining the spectrum of available therapies.* ***That to me, is by definition, the tail wagging the dog.***

In my opinion, we should read the research, decide what might be helpful to our patient who is sitting in front of us suffering, who may not at 65 years old, my age, have time for 20 more years for insurance to finally decide they're going to pay for platelet-rich plasma to help with erectile dysfunction.

Which has almost zero risk, many potential upsides based on now a stack of research that goes back 20 years showing neovascularization and neurogenesis, which are good things in the penis.

So that background, I think, when you read criticism of doctors who take cash for medical procedures is worth remembering.

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[40] Olsen, Modi, and Ramkumar, "Maintaining Truth in the Era of Misinformation."

If you're not doing that, you're letting the CPT, the insurance codes define what you will do. And remember, there are not any insurance codes for some of the sexual dysfunctions seen in women. If you're doing surgical repair that corrects some of the causes of anorgasmia in a female, you're having to fiddle with the codes to get that paid for.

You're having to fiddle, waste your time and money and energy to play the insurance game instead of just doing what you know is right for the person.

Okay. That's the background, in my opinion, that overlays this wishy-washy article that could have been written by the CEO of Blue Cross Blue Shield.

But let's go through it and see, examine the arrows in the quiver of those who might aim for you. And, I'll get to how our group helps with this: "In today's digital era, media platforms such as YouTube have become dominant sources of health information, yet much of the content on orthobiological treatments, such as PRP is low-quality, misleading, and unreliable."

Okay, you said it, now, let's prove it. See if they do.

"Commercial incentives and algorithm-driven content promotion allow misinformation to outpace evidence-based guidance."

Okay, still a statement. Prove it. You're telling me there's no commercial incentives. And then ads every commercial break (when you watch the news or sports) about ED medicines and rheumatic or rheumatology medicines, ***there's always commercial incentives***.

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"Despite this field's promising therapeutic potential, the unchecked spread of digital misinformation threatens patient understanding, informed consent, and trust in medical care."

Okay, you're still preaching, but prove it.

"Given digital media's profound influence, it is an ethical and clinical imperative for academic and medical communities to intentionally produce successful high quality evidence-based content."

Rule 1

That's what I'm talking about, evidence-based content. So, one of the rules when you're making your video is to talk about the research.

Note: I'm not a big fan of YouTube because they are prone to censoring anything about sexual medicine, but I know many of our people in our group have large followings on YouTube.

Talk about the research.

Rule 2

Always say, always, every time, somewhere if I'm speaking, I'm going to say, "There's no guarantee that any therapy will work every time."

Rule 3

Other things that you do is on your website, on the webpage where you talk about the P-Shot®, ***have a link to your consent form***, which can be based on ours, which pretty much lists everything that could go wrong with the penis, as does the consent form for the O-Shot®.

Things we've never seen happen. Most of it we've never seen happen but we list it because we don't know.

Have you've ever seen all the possible complications in the package insert for Viagra or Cialis or any other medicine really? So, people expect you to warn them that pretty much anything could happen.

So there's your first clue to what should be your subject do unlike this person has done so far, and give evidence for what you're saying.

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Okay. So there's a study that says, "'YouTube is an inconsistent source of information,'" offers compelling and necessary examination."

"The majority of YouTube videos addressing orthobiologic treatments, substandard quality."

By who's ruler, "unregulated," as it should be for freedom of speech, "poorly sourced."

I agree with that. Whenever we say something, we should back it up with the research, "and critically lacking in comprehensiveness."

Okay, well, I'm not sure what to say to that. How much do you need to say to be comprehensive, right?

Let's say you're going to talk about ED. If you talk about the studies regarding platelet-rich plasma, do you also need to talk about PRP and do you need to talk about all 30-plus cytokines and growth factors that are in the platelets and how they're activated and how cells grow and how stem cells, pluripotent stem cells migrate to the area and how the cytokines work.

Obviously, ***any simple thing can be expanded to require a whole encyclopedia to explain it.***

So I think, the answer to that is that you talk about the research at hand and you let the references to that article take care of all the back comprehensiveness, and you have your consent form on your page about it.

"Not surprising, orthobiologics exists with a therapeutic gray zone where scientific promise meets regulatory ambiguity."

As you guys know, there's no FDA control over your blood and your spit and your urine and your hair and your skin, those all belong to you.

So, if it's minimally manipulated, autologous and homologous use comes from your body, it's used in your body and I don't do much to it and I'm using it for its intended purpose, then it's not the government's business. It's your business and your doctor's business.

"33% of the reviewed videos were uploaded by independent users."

Great. Should doctors not be able to speak with their patients?

"With only 1% originating from government or news agencies."

God help us if we get all of our medical stuff from the news, "highlighting a significant void left by the academic and medical communities in public education."

The medical community is you.

And so we're going to talk in a minute about emails, but this is how you stay solid. ***As you talk about the research, you have a good consent form and you talk as if you are speaking to your patient about the possibilities, about the realities.*** For example, you can't fix iliac arterial disease with a shot in the penis. You can't fix a spinal cord injury resulting in ED with a shot in the penis.

Although, we did have a study that showed that 40% of people with that and other serious problems of ED not responding to PDE5 inhibitors did achieve erection when the penis was injected with botumlinum toxin combined with the PDE5 inhibitor.[41] So that's an example of not over promising, but quoting the literature and a solid video by you as part of the medical community.

"The most concerning was observation that neither video verification status nor uploader identity significantly correlated with content quality."

I don't even know what that means. "

The illusion of authority granted by high view counts, polished production and self-proclaimed expert labels, impossible for lay audience to discern."

Here's how to think about this: You're really only talking to your patients.

Others will listen in. My best example is that one of my YouTube videos, excuse me, one of my YouTube channels completely disappeared.

Had 140 plus videos on it. If you consider that you spend sometimes a few minutes, but often a few hours to make one. Well, that's the best part of a half of a year's work, not counting the other time that might've gone into researching it.

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[41] Giuliano, Denys, and Joussain, "Effectiveness and Safety of Intracavernosal IncobotulinumtoxinA (Xeomin®) 100 U as an Add-on Therapy to Standard Pharmacological Treatment for Difficult-to-Treat Erectile Dysfunction."

And one of them was a simple little video showing how to give yourself a testosterone injection in the lateral thigh. And 240,000 people had watched it before the video was taken down because one of my videos about how to mix growth hormone, which was made for my patients who were involved in the IRB approved study, was labeled by YouTube as promoting illegal drug use.

But my point is, obviously I don't have 240,000 patients, but I was making that for my patients so that when I showed them how to do their own testosterone injection, they could remember it by just looking at that video the next time they needed to give themselves a shot. So, you're really talking to your people and others will listen in.

You're really talking to one of your patients who might have a problem and you talk to that one patient and then the next patient that has that problem that belongs to you will watch it. And if it's a really good video, others who have that problem will watch it. So, you're labeled an expert, is what I'm getting at, for good reason because you are the physician of that patient, of that person.

And others will listen in. Maybe 240,000 of them will.

Rule 4

And of course, you have a disclaimer that you're not their doctor. This is for your patients. And if I'm not your doctor, watching this video doesn't make me your doctor. Somewhere that's in a script or in the description or something.

So, you can tell this person writing this obviously once they're not a big fan of TikTok, I don't think. And the implications... So, list a couple more clues about how to make your stuff and then I'll give you my template.

"The implications for patient education are profound with non-verified sources drowning out the few authoritative health organization-based sources available."

Implication that we should just be watching what some organization puts out?

"Patients seeking information are frequently exposed to low quality, unreliable, less comprehensive content to the natural minimally invasive therapies."

And why not?

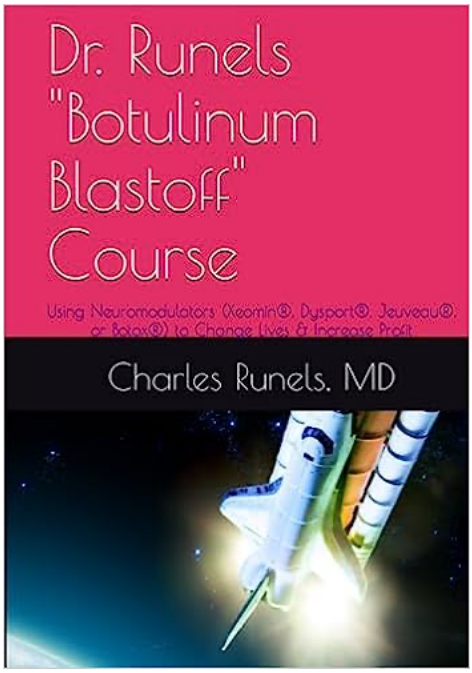
Yes. "But this tendency makes patients more susceptible to unverified claims."

Okay, let me skip down here.

"Patients entering consults with preformed opinions molded by persuasive online narratives."

As if that fricking ad on the Superbowl is not molding opinions? That video of the woman smiling, jumping in the swimming pool with her skin cleared up from psoriasis and birds are flying and butterflies are in the background. That's not molding opinions?

And somehow that's okay for that company to spend 10 million bucks on a TV ad, but you can't make a YouTube video for your patients. ***So yeah, we are molding opinions, but always by educating people about the research and what we know about how to take care of them.***



Another way to say that is that it's not the responsibility of your patient to know what you're able to do. It's our responsibility to teach them and to have the courage to do it, always referring to the research.

One more thing and then I want to stop. That's more about the FDA thing. Okay, here we go. This is really the heart of what's got this person angry.

"Patients are following extravagant claims and ***paying hefty fees*** for unregulated, potentially even dangerous or fraudulent treatments that are not backed by strong evidence."

Okay, that's a political preaching statement right there. What's extravagant? What's a hefty fee? Our initial P-Shot® is 1,800 bucks and then if it's a new patient, it's around 1,000 for repeated treatments. A series of six Xiaflex treatments for Peyronie's disease, if you had to pay for it instead of insurance paying for it would cost around $27,000.

So, and if your Xiaflex happens to cause a penile fracture, which is understandable, you might wind up needing a penile implant for $10,000 (total $37,000).

I don't begrudge the money for the drug. The companies recover their research and development. The urologist deserves every penny of that penile implant.

Every penny of it. I think it should cost twice as much or more.

But a massage therapist at the hotel on the bay near where I live makes $350 per hour and a half massage. And that's a six-month course. And nobody calls you at night and there's nothing serious could possibly happen versus okay, 1,000 bucks, three times that for a P-Shot®, and you have to know how to handle the blood safely.

You have to know how to talk with a person to make sure they're a potential candidate and follow up with them. You spend an hour of your time or more on that first visit, and you don't deserve $1,000 versus 350 for a massage versus $27,000 for Xiaflex?

So, this is a political ranting in my opinion, but let's look at the errors that he's asking us to go put stuff out there but he's also definitely a company, organization person.

Rule 5

So, there was one thing I was looking for. He talks about protocols, okay? Having a protocol, which we do. Here we go.

"Scrutiny should be employed to indicate trusted health sources and flag promotional material, lacking scientific backing."

Who's going to decide that flagging? I think that should be left up to our patients to decide whether they believe something or not and let them flag it.

But I just told you I got flagged and lost a whole channel because some, I don't know, some little college co-ed somewhere working for YouTube decided my video, which was part of a research protocol explaining to my patients how to mix growth hormone. And I'm a licensed doctor with a licensed pharmacy in my office. Somehow I'm encouraging illegal drug use.

Like Larry Flynt said when Jerry Falwell sued Larry Flynt; Flynt took him to the Supreme Court because he said, "I could have settled for 150 grand. But you must take up for the right of people to say things you do not want to hear. Once they get to where they can censor you, they will take away the things you need to hear."

So anyway, thinking people are too stupid to look at a video and decide whether this is real or not. Long as they can't go do it themselves, they need to get to a doctor, you're never going to get a P-Shot® on Amazon One.

You can’t get it through a video.

So, as long as we’re regulating who actually is licensed to do our P-Shot®, which we do through our Cellular Medicine Association, and as long as you’re talking about the research and you have a consent form on your website that tells every possible thing that can go wrong with somebody, even though we haven’t seen any serious sequelae of granulomas, no necrosis, you still put all those possibilities because who knows, maybe it could happen.

Rule 6

The other way to break one of the arrows in the quiver of the person who likes to talk about misinformation (because they're too cowardly to call something a lie or to discover if it is true) is that they're worried about the money you're going to make so: ***make sure that you have a money back guarantee that breaks that arrow. You must tell everybody that you have to love what I'm doing or I won't keep your money.***

Now that arrow is completely broken (as an example) because you're charging less than Xiaflex, way less than an implant, much safer than a PDE5 inhibitor, and you are not keeping the money if they don't love what you did. So, all the arrows are broken.

And so I think, let me end this. I just wanted you to see what's being said in this era: where people are afraid to say the word “lie” and they want to, because they're not sure if it's a lie or not, they just don't like it.

I say it's either the truth or it's a lie or "I don't know"—it is never "misinformation."

You said something, I don't know if it's the truth or not, but I'm not going to label it some stupid word like misinformation.

An Email Template to Use for Any Procedure

Okay. So, let me show you, let me swap over and show you a really nice template to do some of these educational type things for your patients. That's who you're talking with.

Okay, let's go to this template and then I'll call it a day. I think you're going to love this. Just a moment.

Okay, I'm inside over the course that I spent a 8 weeks doing; I call it my
5-Notes course

And in this ninth lesson, I have email templates.

I'll put them to where you can see them (see the video). So there's 26, so you could send out one every other week for a year by just filling in the blanks and have a very well thought out email campaign.

Most people have trouble staring at a blank page, but if I can give you an outline, then you can roll with it. And it's all in your brain.

I don't have to make you smart (because you already are smart), but if I can unblock you so that you're just able to get out of your brain what's in there, you will have all of the writing material you would ever need for books and articles and web pages and magazine articles and news reports and standing on stage…by just getting it out of your head.

So, here's a nice example. "Jumpstart your writing and keep your readers in the know by identifying trends in your niche. Let's say you're an expert on we're going to use cars. Know everything there is. But you want to expand your writing repertoire, finding writing about"...

Okay, "In order to identify trends in your niche, find out what other people know."

So, this is what we just did. You go to PubMed, it's a good example. And you do, instead of searching the news, you just search PubMed. You could go to Google and put in incontinence or ED or dyspareunia, whatever it is you're treating.

I usually go platelet-rich plasma and I look for problems that we talk about dyspareunia and urinary incontinence and such. You can also go to the Google, you can just ask Google for Google trends and see what is trending.

And then you start with the headline.

Write about the trend, starting with the headline that has to do with it and then with a question mark. And there you go.

There's your outline. "Provide examples of the trend, if the trend is for something the reader can take advantage of."

So, we talked about, as an example, we talked about the article about radial versus focused shockwave. So that trend would be that people are going towards focused shockwave. You could put that out and you could talk about that trend and send it out there. So, there's your title, there's your outline for it, where you got it.

Your conclusion would be that yes, shockwave combined with PRP within our P-Shot® protocol works very well and the trend is towards focused and we have a focused shockwave.

There you go. So there's, let me download this and send it over to you.

Of course, if you have... I'm not going to go through all 26 of them, but if you have the course you would have one for... Maybe I'll do one next week, I'll do another one. But let's see. Pull this up and I'll put it in your download section. And then if you have no questions, we'll call it a day. Here we go. Okay, there it is.

So, you have that outline for an email you could do. Of course, you could just keep doing that one every other week. But I think, part of what happens is if you go through the exercises in that course, or if you just subscribe to my emails on one of the membership websites, go to the Priapus Shot® website or the O-Shot® website, subscribe to those emails and rewrite them.

After you do a few times, you get the hang of it, and you'll be able to do marketing in such a way that your patients want to see what you're teaching them, and you'll do it in such a way that you're not, you're allowing that person with a quiver full of anger to shoot his stuff at you, calling you misinformation.

Let's see if there's any questions. If not, we'll call it a day. Okay. Hope that was helpful to you. I'll give you another second or two to download that outline for an email. And I guess, that's it. Have a great week. Thank you for being on the call.

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