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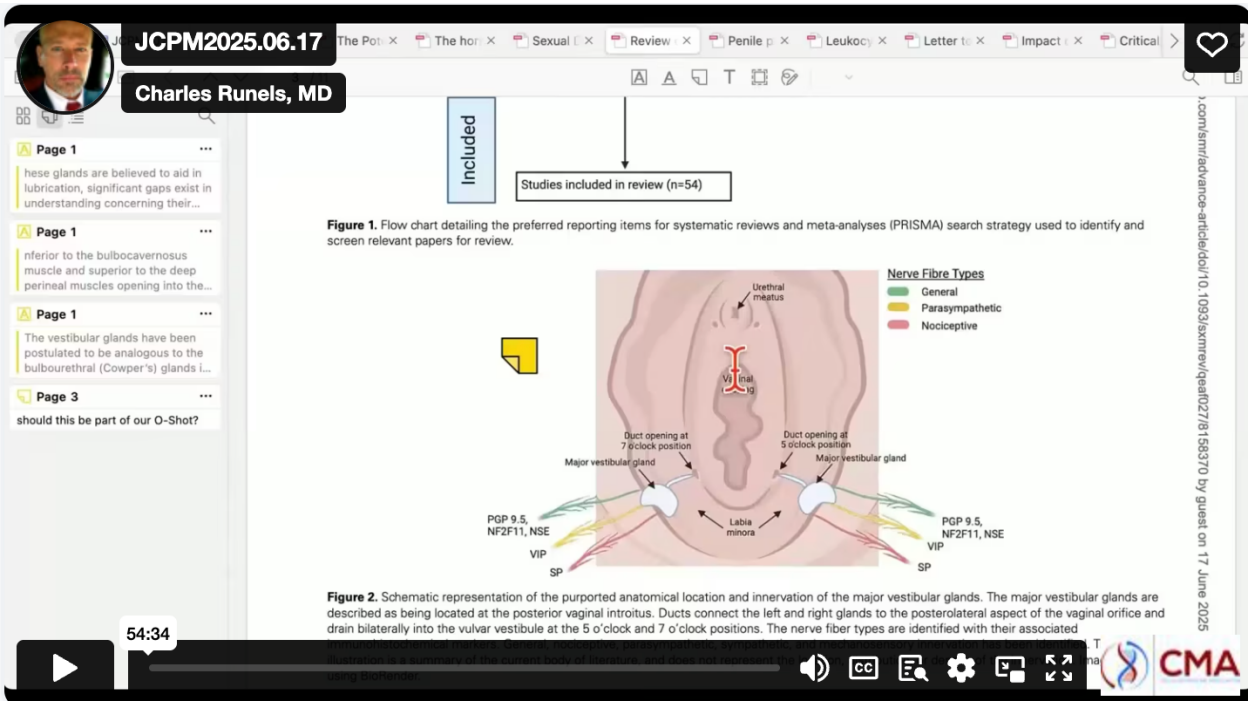
The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of June 17, 2025, with Charles Runels, MD.

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



Topics Covered

- PRP FDA-Approved for Treating **Diabetic Wounds**
- When RED Blood Cells ***Improve*** the Results of Your PRP Treatment
- Thirty-six Rules (from the Research) for Helping Men to Better Sex
- *Correction: A Change in My Practice (this is not in the video; it is a correction-addendum)*
- *Growth Hormone (My Emotional Trigger, I Promise I have Bias)*
- Why the Official Numbers for the Incidence of Sexual Dysfunction in Women Hide the Women Who May Most Need Your Help
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- What's Next in the Study of Treating Stress Urinary Incontinence in Women Using Our O-Shot® Procedure?
- Another Way to Isolate Platelets
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- References
- Helpful Links

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

Welcome to our journal club. We have a crazy number of clinically useful science-progressive papers that came out in the past week. So I'll go briskly, but I promise to stop because I'm interested in your feedback about what you're seeing and what you think. We'll start with this one. And by the way, I'll also come back at the end and talk a bit about marketing. There's another business book that I read this week that I think is really pointed and helpful if you're trying to grow your practice in a way that you're doing more of what you want to do. So we'll get to that.

PRP FDA-Approved for Treating Diabetic Wounds

All right. This first one concerns diabetic wounds.[1] The first thing I want to point out is how well this is reimbursed. So, if you're still taking insurance, treating diabetic wounds with platelet-rich plasma now reimburses you for over a thousand dollars. RegenLab has a kit that is now FDA-approved on label. The device is on label for treating diabetic wounds.

This is dear to my heart. Back 20 years ago, I worked at a hyperbaric chamber hospital-based wound care center, and at the Gulf Coast we actually took care of an occasional case of diving injry or the bends, but mostly it was distal extremities, trying to salvage limbs. And it sounds like maybe not the most exciting thing, but it sure was rewarding trying to help people and often helping people salvage their leg or a greater part of their leg by treating wounds.

But I had no idea about platelet-rich plasma back then. This paper, if you're treating wounds or you have a general practice where you see people with wounds, gives a nice overview of multiple therapies. It talks about the new regenerative solutions, stem cells, platelet-rich plasma, and so on.

[1] Mondal et al., "Unraveling the Mechanisms of Diabetic Wounds."

But then it's funny because it talks about it being new, but when you come down further, it's new, but it's also been around for a long time. And they point that out. Look at that. Platelet-rich plasma is a long-standing treatment for wound healing, particularly for diabetic foot ulcers and other types of wounds. So yeah. Some of this is new and of course the mention hyperbaric oxygen therapy, but it's been around enough and now I think most of the people in our group don't realize, but it's now actually, as I mentioned, covered by insurance for multiple treatments reimbursed to over a thousand dollars per treatment.

=> Apply for *Online Training for Multiple PRP Procedures* <=

So it's worth knowing if you're doing general practice and seeing people with lower extremity wounds.

When RED Blood Cells Improve the Results of Your PRP Treatment

This one has been emotionally rewarding for me because I always like to think when the salesperson is talking to me about some kit, and let's say they're saying, "Oh, well this kit gives you zero red cells."

I always think, "Well, why do I need that? Whenever my wife does a hysterectomy, she doesn't have to get all the red cells out of the wound for the platelet-rich plasma and the thrombin cascade and all the growth factors to do its work."

Now, I know there's been some studies about maybe RBCs being toxic in the joint, but I've not been a red blood cell foe.

And this paper, again, was emotionally satisfying to me because it points out some of the reasons why maybe we shouldn't be so afraid of red cells in our platelet-rich plasma.

Or at least to a point.

I think the point they bring out is we just need to find out everything, where's the sweet spot depending on what you're treating. I think more and more you're going to see studies that are looking for the exact ***best recipe, which varies depending on the indication*** and the tissue. Both indication and tissue. This paper gives ideas and references that make the case that red blood cells have a function, too, e*specially with enhanced musculoskeletal healing*.[2]

Of course, this is from a paper that caters to that (sports medicine and muscle injury).

But important if you're not in sports medicine, it's usually important because it has so much to do with sexual function. The muscles that are torn playing NFL football are important. It makes for good TV, and people make lots of money and sell lots of beer. But those muscles in your mama's pelvis that pushed you out, those are just as important, I would argue. Those muscles that keep your wife or yourself from peeing on your leg are important, too. I'd say they're at least as important as Tom Brady's thigh muscle.

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[2] Costa et al., "The Potential of Red Blood Cells in Regenerative Medicine."

And all ***this sports medicine literature that has to do with muscles, I think, should be click and drag right over into female sexual function studies***.

Some of you know from listening to me talk, when I first came up with the O-Shot® idea, I was thinking more in terms of improving the function of the distal part of the urethra, where the skene's glands are, and improving orgasmic function, particularly thinking about how to make it easier to trigger a ejaculatory orgasm.

I wasn't even thinking about urinary incontinence.

But thankfully, my second patient told me it was helpful, and over the past 16 years, I have been shocked over and over again about how helpful it is in people that you wouldn't expect it to work in. More so than you could expect from any bulking that happens with PRP. So we may actually be injecting into the musculature of the urinary sphincter. There are multiple layers.[3] [4] [5] There's transverse and longitudinal, and then there's circumferential layers, some going around the urethra and some going around the urethra and the vagina.

And when we inject in the distal part of the vagina near the introitus, my imagining is that we're hydrodissecting into those muscular layers. Put another way, if you tried to inject there and avoid injecting the muscles of the urinary sphincter, you'd have much difficulty.

There's a need for more visualization of what we're actually doing. It is one of these papers, we'll get to it. More visualization with either MRI or ultrasound about how those muscles are changing when we're treating continence. But that's why this is relevant I think even if you're not treating sports injuries. And if you look at what happens ...

This nifty little chart here talks about the different cells and what they're doing. So the red blood cells also have extracellular vesicles and immunomodulation, and they don't have nitric oxide activity on this chart. So you come down here. So the potential benefits of retaining red blood cells are orthopedic, but we think they're orthopedic. They don't just mean bone; they're talking about musculoskeletal muscles too. Represents a gap in the literature. It was jettisoned from the literature and from studies because some initial studies talked about possible problems in the joint when it was injected.

Let's see. Where was it? Okay. Vascular regulation, oxidative stress balance, and intercellular communication regulate the vascular tone through nitric oxide metabolism, influencing angiogenesis and

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[3] DeLancey and Starr, "Histology of the Connection between the Vagina and Levator Ani Muscles. Implications for Urinary Tract Function."

[4] DeLancey, "Structural Support of the Urethra as It Relates to Stress Urinary Incontinence."

[5] Pipitone, Sadeghi, and DeLancey, "Urethral Function and Failure."

blood perfusion. So all those are wonderful things when you're treating muscles of the thigh or muscles of the pelvic floor or around the urethra.

So their conclusion, or maybe the highlight of the study, is that we're oversimplifying by obsessing about getting all the red cells out, and perhaps some trace amounts are useful. I know that some of you have kits that allow you to regulate how many red cells are in there, and it could be that there's some benefit to having some.

From a clinical standpoint, until we know more, you could make a case when treating anything other than a knee joint. When you're treating soft tissue the way most of us are doing, you can make a case for having a little pink tinge to your PRP.

Thirty-six Rules for Helping Men to Better Sex

Yeah, they came up with this list of rules when it comes to thinking about hormones with men who have a sex problem.[6] And although I think a couple of rules are BS, most of it is a nice guide.

We'll go through some of it and I'll tell you where it, in my opinion, is BS. Most of it, though, like I said, is very useful, and I recommend you print this one out. It's an open-source article and it's worth sticking in a drawer somewhere in your office or in an easily accessible file for reference.

They start off, okay, for sexual desire and testosterone, clinicians should consider that testosterone ... I'm not going to read all these to you, but just the highlights are important, I think. One should consider that testosterone significantly contributes to the regulation of male sexual desire. And I think we would all say that would be the same for females. Trying to have a sexual desire as a female, I don't care if you have an O-Shot® every other day, if you don't have testosterone, it's hard to want to take your clothes off.

Number two, clinicians should measure serum testosterone in all men complaining of reduced desire. And I think the same goes with women, and then they said it's okay to use it, and they give you a guideline there for how to measure it.

And then the next topic is estradiol and dihydrotestosterone. And here's where I kind of part ways with them. They're downplaying clinicians to consider the adrenal hormones, DHEA cortisol are not involved in the regulation of male sexual desire and therefore their routine measurement is not recommended. That I think you can say maybe is BS. They say it's high-quality of evidence. But the other side of this coin is we have three FDA-approved drugs for women to help with desire and one of them is a freaking DHEA cream.

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[6] Rastrelli et al., "The Hormonal Regulation of Men's Sexual Desire, Arousal, and Penile Erection."

How is it that DHEA replacement is only one of three FDA-approved drugs to help women but we should not even measure it in men? Either it matters (making the drug useful) or it does not (so throw out the drug and the testing).

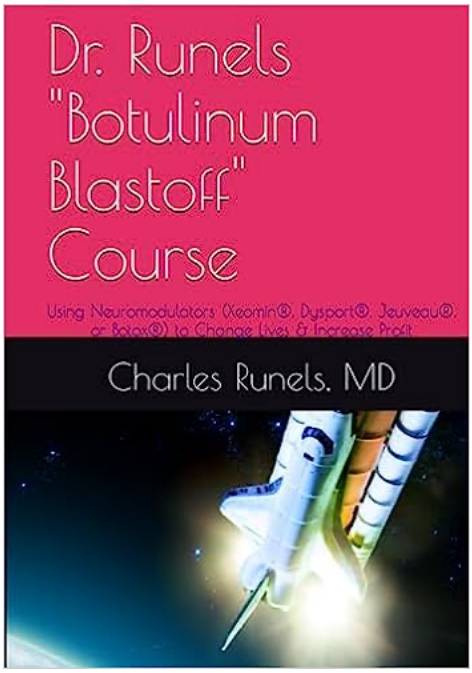
Mixing men and women in this analysis may be inaccurate, but it at least poses a legitimate question (the one I just gave you).

Actually, let me start over. You've probably heard me say that I think that's a weak treatment, but it is a treatment. And DHEA is known to have effects separate from testosterone separate, and of course it's split into testosterone and estradiol. So it can be a non-prescription way of raising testosterone. The problem is it's unpredictable whether it's going to split to more testosterone, a more estradiol. But the bottom line is I'm having trouble buying that it has no effect and I routinely still prescribe just over-the-counter DHEA for people that have a low sex drive. But whatever, you've got the rule and that's my opinion, which may just be wrong.

This one is huge.

And not so long ago, the recommendation was not to measure prolactin levels unless LH and FSH were abnormal.

And I've always screamed, "Wrong, wrong, wrong!"



When I say always, I started doing hormone replacement 26 years ago, measuring hormones in men and women. And back then, it was almost unheard of to give testosterone to women, unless you gave Estratest, which is Testosterone combined with estradiol, and it was a new thing to give it to men.

Mostly, people thought of it as something bodybuilders did.

So, 26 years ago, checking for prolactin was considered not the thing to do.

And up to, I know it as late as seven or eight years ago, they were still saying don't even think about prolactin unless you have LH and FSH are off. But when you find this, and if you check it in every man who has a low sex drive, when you find it, it can be life-changing.

You put them on little Dostinex twice a week, and their prolactin goes back to normal. Usually they just have a microadenoma. You don't have to go in there, cutting and sewing on their pituitary gland. You just do that, and they love you for it.

Consider that it is unlikely that their mild increases in prolactin. I think that's true if it's up by 5%. But if it's up by 25% or more above the upper level of normal, then you have a good chance of helping it. And sometimes the athletes know things 20 years before we know them.

And I've heard for more than 20 years from athletes that taking a little Dostinex not only helps your sex drive, but it can shorten your refractory period. Which makes sense because if you ejaculate, you're releasing that prolactin which makes you sleepy and not want to have sex just like it does with a woman. And when you release that prolactin, it makes sense that it might extend or be partly responsible for your refractory period and being on Dostinex might shorten that refractory period by dropping. So I wouldn't argue with a little Dostinex as a trial for someone that has decreased desire. But I think it might be better ... Anyway, I think it's worth trying. So that's another place where I'm a little bit different than their recommendations.

Now this one I'm really opposed to, but still, most of this is right on. And again, it's a good reference. And who am I to say. I've just been doing this for almost 30 years. But that's all anecdotal and they've got the study, so who knows.

But this one, "clinicians should ***not*** consider estrogen measurement in assessing erectile function," I'm going to call BS on this one.

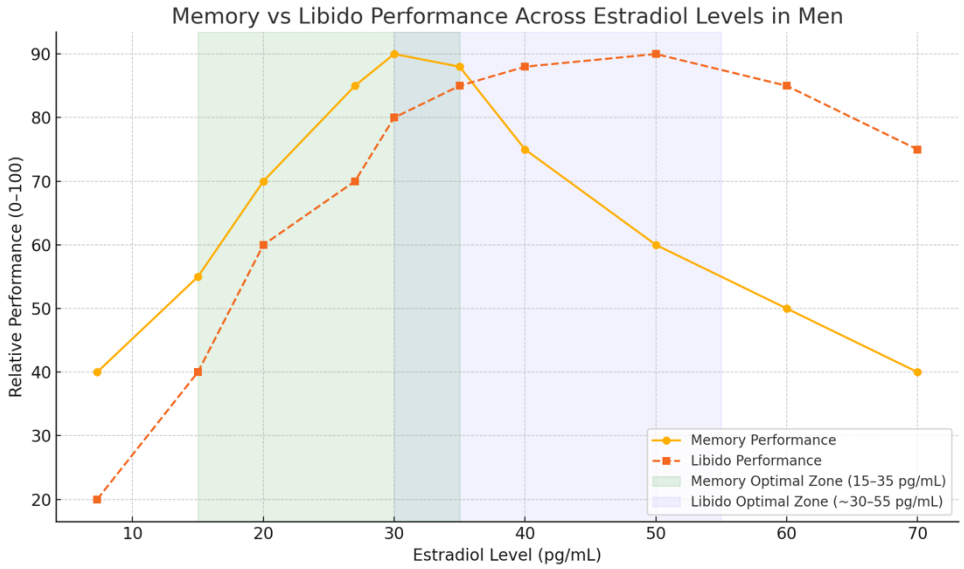
I always want to know estrogen levels in men because, first, I like to have a ratio. I think a ratio matters. I like the testosterone level to be at least 12 times higher than estradiol. Of course, you have estriol and estrone, but I'm talking estradiol.

And then the other thing in both men and women, you drop estrogen (E2) too low, less than about 50 the last time I read about it, you're increasing the risk of dementia. Memory becomes more of a challenge. So even a man, I like estradiol level around 50 to 70, no higher, but around the 50 range so that I can hope he keeps his memory.

Correction: A Change in My Practice (this is not in the video; it is a correction, addendum)

Rule 38 is Total BS!

Please look at the following chart.



After the webinar, I returned to the literature and found I was wrong. Yes, and an estradiol level of 50 to 70 is associated with better libido. However, memory is better at levels 15 to 35. Memory goes to dirt at an estradiol level less than 15. So, it appears to me if you want a brain and have great sex, the best range is around 35 to 40.

For either indication, their rule 38 is BS, but the goal is more nuanced that what I indicate in the live webinar.

This updated plot shows how **memory and libido respond differently to estradiol levels** in men:

- **Memory performance** peaks between **15–35 pg/mL**, then declines above 40–50 pg/mL.
- **Libido**, in contrast, tends to **increase up to 50 pg/mL**, plateauing or slightly declining afterward.

This helps explain why **HRT clinicians may favor higher E2 levels** (e.g., 50–70 pg/mL) for libido or vitality, while neuroscientific data support **lower levels for optimal cognition**.[7] [8] [9] [10] [11] [12] [13]

Growth Hormone (My Emotional Trigger, I Promise I have Bias)

Rule 33 is about growth hormone. Some of you know I was involved in some clinical trials with growth hormone years ago, before it became so politicized.

Back in 2002, your IGF-1 level was not age-adjusted. No one really cared if you wrote a prescription for it. Blue Cross Blue Shield was paying for growth hormone replacement if someone had symptoms (fatigue, depression, LOW LIBIDO) and a low IGF-1.

That's all it took, no STEM testing was needed.

But, because I was involved in some clinical trials where you did STEM testing (30 grams of arginine IV over 30 minutes. You did a baseline growth hormone one level at times zero 30 minutes, hour, hour and a half and two hours. Almost similar to a glucose tolerance test or something), all my patients who received a prescription for growth hormone had failed stem testing.

Growth hormone levels are usually very low, but they boost when you give arginine IV to someone who's fasting. GH is also released during phase four sleep with exercise and fasting. So you can't really measure it with a random blood test, just measure a level like you do a blood sugar or something because it's usually near zero. So you have to stimulate the pituitary to see if the pituitary is able to release it.

Anyway, so I had 337 people that I proved had low IGF-1 and symptoms and failed STEM testing and because these people were costing Blue Cross too much money, I was audited by Blue Cross Blue

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[7] Liebscher et al., "Circulating Stress Hormones and Multimodal Measures of Brain and Cognition in Older Adults."

[8] "Midlife Steroid-Binding Globulin Levels and In Vivo Neuroimaging Measures of Tau in Older Men and Women - Buckley - Annals of Neurology - Wiley Online Library."

[9] Vila-Castelar et al., "Sex Hormones and Brain Pathology in Autosomal Dominant AD."

[10] Zhao et al., "Sex Hormones and Risk of Incident Dementia in Men and Postmenopausal Women."

[11] Wolf and Kirschbaum, "Endogenous Estradiol and Testosterone Levels Are Associated with Cognitive Performance in Older Women and Men."

[12] Moffat et al., "Longitudinal Assessment of Serum Free Testosterone Concentration Predicts Memory Performance and Cognitive Status in Elderly Men."

[13] Hogervorst et al., "Serum Levels of Estradiol and Testosterone and Performance in Different Cognitive Domains in Healthy Elderly Men and Women."

Shield in September 2003. Then, in October, they changed their policy because my people were costing them too much. It wasn't a secret.

They audited me. They called me up there, told me they were going to change the policy, and they did. And they made it where you must almost be pan-hypo pit to get growth hormone replacement as an adult, even with symptoms, even with a low IGF-1.

So I don't want to go off on a tangent too much, but you can tell I wasn't happy ***because they cut off my patients***. And these were not bodybuilders. One of them (as an example) was a bank vice president who dated his obesity to a head injury in Vietnam, which (head injury) is known to cause shearing forces on the pituitary stalk and result in growth hormone deficiency from secondary microinfarctions of the anterior pituitary gland.

I replaced it (his GH), he lost 40 pounds, came off his blood pressure medicine, came off his diabetes medicine and Blue Cross Blue Shield cut him off.

Another was a lady diagnosed with polycystic ovarian disease, a hundred pounds overweight, two different diabetes medicines plus injections. I've diagnosed her growth hormone deficiency. She lost a hundred pounds, got pregnant, sent her to the high-risk OBGYN, department of University Alabama in Mobile (since she was technically high risk from her previous diagnosis of diabetes even though she now had normal blood sugars on no medications). They diagnosed her with empty sella syndrome, kept her on her growth hormone until the second trimester (when the placenta makes GH), and she delivered a healthy baby boy. Blue Cross Blue Shield cut her off because she just had that low IGF-1 and symptoms and she didn't have other pituitary hormones that were abnormal.

In other words, they changed their policy to save money, not based on the current literature or the success of my patients. Soon after that, I went all cash.

Now they (BC/BS employees) are not evil people. They have to make a profit for the company, that is their job. And if you gave growth hormone to everybody that has type two diabetes due to obesity, secondary growth hormone deficiency defined the way it used to be defined, it'd break their bank.

But all that to say that, I'm not guessing when I say that when you diagnose adult growth hormone deficiency by having symptoms usually fatigue and they have trouble with their weight and depression and hyperlipidemia and IGF-1 that's in the dirt usually less than 120 and they fail STEM testing, that's growth hormone deficiency. I don't care if the rest of the pituitary is working or not, and they will have erectile dysfunction to go with it.

I think rule 33 is just more politics, and it's the tail wagging the dog. I saw it, I lived through it.

But now it's a prison sentence last time I checked to write a prescription for growth hormone.[14] [15]

And talk about a catch 22, you go to jail for writing a prescription for GH without a proper diagnosis, but the method of diagnosis is still debated; so all it would take is to write the prescription based on one set of criterion and then have a medical board member decide your method was not proper, so off you go to jail—not what I had in mind in the first grade when I dreamed of going to medical school.

At best, prescribing growth hormone is something that will cause you to lose your license if you don't prove the diagnosis (by vaguely defined and often-changing criteria).

I don't know what you do about this one anymore. I don't write growth hormone prescriptions anymore (people try to get around this one by writing prescriptions for Sermorelin, but that drug helps the least those who need it most, those with a pituitary that cannot respond to growth hormone-releasing hormone.

These are some reasons I think rule number 33 is wrong.

Anyway, the rest of those rules are correct, and most of what I told you could be wrong, but those are my ideas about that, and it's still worth printing off this article and sticking it in a drawer to ensure you're not missing something.

Remember, we're not just doing the P-Shot® procedure on everybody with ED as if it is a magic shot.

We want to think about our patients and fix everything we can.

And it's okay if you want someone else to do the hormonal part of it for you, at least make sure that someone has thought about all these things, either in concert, or before your P-Shot®, or it could be a concerted effort.

When they come in, you do the blood testing and a P-Shot®, too. Then, when the blood work comes back, you replace things so everything's happening at the same time.

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[14] **In the U.S.**: Under the Anabolic Steroid Control Act, prescribing HGH without a proper diagnosis can be charged as a **felony**.

- Up to **5 years in prison** for a first offense
- Up to **10 years** for a repeat offense
- Significant fines and DEA investigation

[15] "Release No. 11-103."

Why the Official Numbers for the Incidence of Sexual Dysfunction in Women Hide the Women Who May Most Need Your Help

I love this one.[16]

Talk about semantics: to be counted as having sexual dysfunction as an accurate diagnosis, the woman must be psychologically bothered by her symptoms (decreased libido, pain, dryness, decreased orgasm, decreased satisfaction).[17]

And most of the studies tell you that the incidence of female sexual dysfunction is higher in younger women than in postmenopausal women.[18] [19] [20]

And I've always said, well, that's just because younger women are more psychologically bothered by it, but symptoms are present more often in older women. It does not take a genius to generate that suspicion, but no study has discussed it until now.

This study shows my suspicion is correct, but you will find it between the lines.

I'm going just to read a few of these sentences because they are so key to our O-Shot® procedure.

"Prevalent but frequently overlooked"

We don't overlook it because we're brave enough to talk about it, and it definitely affects the quality of life, psychological wellbeing, even of her children.

One study showed that if a woman has sexual dysfunction, her children are more likely to suffer depression. So they want to examine the relationship between sexual dysfunction, depression, anxiety, and stress premenopause during pregnancy and post menopause.

"We had 300 women who presented with sexual dysfunction symptoms."

This is where the semantics came in. They have the symptoms, but that doesn't mean they got the diagnosis. They have symptoms of sexual dysfunction. So they're seeing them for something else and they're doing a survey and they have these symptoms.

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[16] Kırat, "Sexual Dysfunction in the Life Cycle of Women."

[17] Mimoun and Wylie, "Female Sexual Dysfunctions."

[18] Lindau et al., "A Study of Sexuality and Health among Older Adults in the United States."

[19] "Obstetrics & Gynecology."

[20] Mitchell et al., "Sexual Function in Britain."

But remember ***they could have all the symptoms in the world with the female sexual function index in the dirt, but if the woman's not psychologically bothered by it, she's not going to get the diagnosis of female sexual dysfunction***.

But anyway, they measured FSFI, and then they measured depression, anxiety, and stress scale. And when you look at the numbers, they're shocking. It shocked me. I didn't think I could be shocked about anything related to sex.

But these numbers shocked me.

Okay. So here's your little chart. In the premenopausal woman, female sexual function score was range from two to 35, but ***22 was the median***. Pregnancy was 24. I think pregnant sex is fun and apparently some women do too. But then ***post-menopausal median was 4.4***!

That's a rock. That's as frigid as a freaking Popsicle.

4.4.

I don't even know how you do that.

So anyway, it proves the idea that yeah, a lot of these women who are suffering the symptoms of female sexual dysfunction are just living with it. They're not even being diagnosed because they've resolved themselves to live.

They're content living single or living an asexual life, or there are a lot of other options. But the bottom line is the FSF score in the postmenopausal part of the group was just freaking shockingly low.

Okay. So you can look at the rest of that. ***But the main thing I think that does is remind us that women are not being counted. Postmenopausal women are not being counted because they're not complaining***, they're not bothered by it.

Back when I did weight loss, I would warn my new patients, "As a side effect, you're going to get a sex drive."

"Oh, I don't want a sex drive. I'm living alone and like being alone," some women would answer.

Then, about the time she loses 30 pounds, she comes in grinning with her boyfriend, who's 10 years younger than her, and she didn't want that until it came about, but then she was happy about it.

And so I don't really know what you do about that, except just to know that the numbers are hiding people. ***When you see female sexual dysfunction incidence is higher in younger women just realize it's not counting the postmenopausal women because they are denying psychological stress due to it. But when you identify it and make it better, most of them find their life to be happier—and this paper shows that to be true.***

Why Vestibular Glands Matter

I've become obsessed with anatomy, which is weird for an internist I guess.

But it's been shocking to me. I've had gynecologists text me and say, "Exactly what is the clitoral body?"

Because they hear me say you should inject the clitoral body, not the glans clitoris, when you do an O-Shot®. In my workshops, I've had male patients injecting their female wives, the wives of the students, and I see that they sometimes don't understand the anatomy of their wives.

And I used to be shocked by that until about two years ago. That paper came out that we've talked about here ever since. It came out showing that out of seven medical schools in Chicago, only one was teaching the anatomy of the clitoris. And out of the seven medical schools in the Chicago area, only one was teaching how to do a history and physical and a woman that's got sexual dysfunction.[21]

One.

So it's really not a, I suppose that we don't know the anatomy. And when I dive into studying it, which I've been doing with fairly consistent persistence for the past four years now, there are a lot of blank spaces and some really exciting lack of knowledge wide open for someone to think about.

For example, exactly what does the ischiocavernosus muscle do in the female?

In the male we know it helps with and there's some pleasure from the contraction, but does it have another function? And if it's stronger, would it help sex? Questions like that.

And this one gets into the vestibular glands, and they're right there.[22]

There's a nice picture showing they're at 5:00 and 7:00. And embryologically. It's supposed to be like Cowper's glands. That little pre-cum that drips out of the meatus of penis to lubricate things.

And so it's similar for the female, and it makes me wonder, well, maybe we should modify our O-Shot® by adding an extra half a CC or quarter of a CC in that general area to wake up the vestibular glands. I don't know. I haven't tried that yet. But you're not going to hurt anything by injecting it and it could be an interesting modification to try.

All these variations need to be, I think, studied. There's going to be people studying variations on our O-Shot® for the next 50 years I think. And that's one that could be thought about as adding extra there.

Routinely, I've done my injections just into the anterior vaginal wall and into the body of the clitoris, unless there's something specific going on like a dyspareunia, there's something going on in the posterior

[21] Codispoti et al., "Female Sexual Medicine."

[22] Perelmuter, Giovannetti, and Tomalty, "Review of the Vestibular Glands."

fourchette or there's a trigger point in one of the pelvic floor muscles or there's a lichen sclerosus or something going on.

But I've not thought about just routinely adding something there. I don't think it's that useful to routinely inject the lateral wall of the vagina. There's just not much there. But maybe I'm wrong. Of course, in the anterior wall, you've got the urethra and the Skene's glands, and when you do the body, the clitoris, you're hydrodissecting the corpus cavernosi bilaterally and all sorts of good things happen.

But I thought this picture was intriguing and I want to think more about that. They give you some nice list of studies if you want to think about it as well.

Penile Implant Great for 95%; what about the 1 in 20 that are not so happy?

We've got amazing urologists in our group: urologists like Meir Daller taught me one of the coolest tricks ever for doing the O-Shot®. The way you can move the labia majora to expose the anterior vaginal wall. A brilliant urologist who did some of the original studies with Viagra. I just can't list them all. You've got George Ibrahim, who was a faculty member at Duke and a fantastic urologist. Many in our group. You got Joe Banno up in Chicago. I just can't name them all. So I don't want to bash penile prosthesis. I think when it's needed, it's needed.

I think we have every reason ... Well, not every reason. We have a lot of reasons that are talked about in this paper. We have many reasons for not going there until we must. Yeah, it's true. Around 95% of people who'd get a penile prosthesis are happy with it, which sounds wonderful. But remember, 5% of the population don't like it, and 5% is the same as the number of people in 20. If you're going to splay my penis, I don't like those odds. I don't like a one in 20 chance that I won't like it.

And so they go into some of these for device infections. When they looked at 103 of these studies, the rates range from 3% to 14%, predominantly under about 5%, which would be one in 20.

So I just point this out. It's a nice review of things that can go wrong. It's been about a year ago, we went over a couple of good studies about some of the problems with prostheses. Not from people in our group.

But when some of our critics say, "Oh, you're charging $1,800 for a shot," I reviewed again how much it costs to get an hour-and-a-half massage at the Marriott near my home here on the Gulf of America. So it's a nice Marriott, but it's $450 for 110 minute massage. And if you throw in the foo-foo water and hot rocks on your ass and stuff like that, it pumps it over $680.

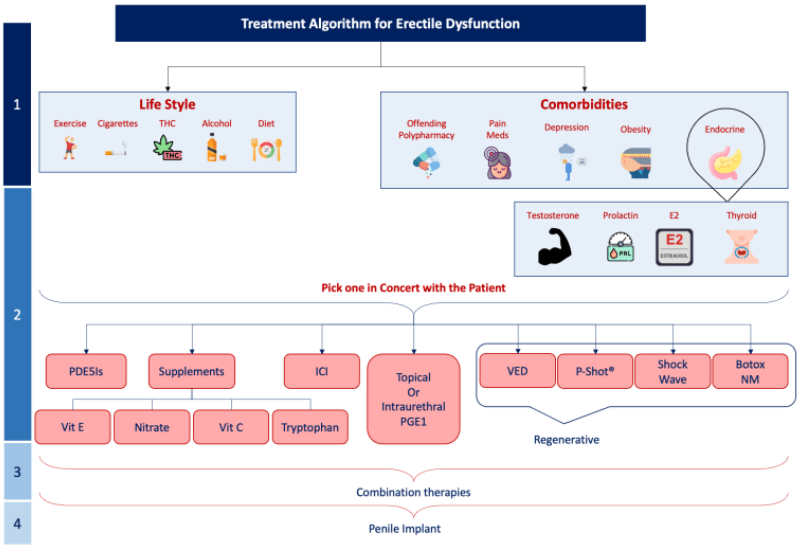
And that's a six-month course. You don't get called at night. You don't have to have an FDA approved device and do phlebotomy know how to handle blood. And I'm not knocking it, they deserve it. Some of those ladies are magicians, they make people happy and they deserve every penny. And they're working and it's muscular and they all get back problems and stuff.

But on the other hand, to say that we don't deserve ... When you have to spend some time talking with people and understand how to handle blood and how to do a history and think about the anatomy and

go to school that's much longer than six months to be qualified to do it, we deserve every penny of that. I would never say that there was resistance to doing something that would delay the need for penile prosthesis for a profit reason.

But it aggravates me that someone would want to skip something that might make things better. Because now we have, I think, five different double-wide placebo-controlled studies showing that our P-Shot® might make things better and skip straight to the $10,000 plus prosthesis that has about a one in 20 chance that you're going to not like it and want it out of there. So again, I love the idea of it. I think probably eventually most men, if they live long enough, are going to want one. I don't know. I know that there are some that are 95 and still going at it. Maybe I'll be one of those lucky ones. I think that it's another reason for doing our P-Shot®, the standard treatments do nothing to reverse or arrest the progression of the etiology for erectile dysfunction.

The PDE5 inhibitors don't. The Trimix doesn't. But Shockwave and our PRP has the potential to reverse the etiology at least within the penis, not iliac disease, but at least within the penis we have the potential to do that. So hopefully by doing it routinely every year or so, there'll be fewer of us needing these. The other thing is that the urologists who do offer the P-Shot® tell me they wind up doing more prosthesis because if it doesn't work, then the patient feels like, "Oh, I've tried everything, so let's go ahead and do it." And more people come to them. Same thing with the gynecologists in our group who do mid-urethral slings. They do more of them because by offering a non-surgical ideas, some people wind up doing great with our O-Shot®, but those who don't feel more happy, they have a surgeon who tried something non-surgical first that maybe someone else didn't offer. And then when it works, they love them and when it doesn't work, they're more inclined to go ahead and get the mid-urethral sling. So I put this here just so you'll know and I'll slow down and put this into the handout section before I turn off the webinar.



So let me just stop and think, okay, what could you do with this from a marketing standpoint? We're almost done. What could you do with some of these? Well, especially if you're a urologist, I would send out this article, a link to it and say, "I do these and most of the time it works. 95% of the time it works. But in my practice, I like to try something non-surgical first to see if we can make things work." I know some of our urologists have told me that by doing the P-Shot® first, if they do have to go to the prosthesis, it's healthier tissue, they get better nerve preservation, better wound healing. And so if it turns out we're eight weeks in and it hasn't helped you, maybe we do it a couple of times, if it hasn't helped you, it goes to the prosthesis. And we'll have a more likelihood possibly of a better outcome

with the prosthesis and we'll give you every chance to not need one. So all of these articles actually could be used in some way for marketing.

The Pumpkin Plan for Soul and Pocket Book Satisfaction

And maybe it's time actually, I stop and talk about ... I'll come back to the research. This book here called The Pumpkin Plan: A Simple Strategy to Grow Remarkable Business. You'll find it on Amazon. This is one of those books I recommend that you don't read it. Buy the book for a reference, but listen to it on the Audible because the author reads it. And I love books when the author reads it, and especially if the reading is relatively dry and something I'm not having fun reading.

But this author, he's an experienced entrepreneur who's made millions and lost millions and made millions, and he has become prominent for having simple ideas that you can implement in your business. And The Pumpkin Plan, the metaphor is that ... I'll give you a spoiler, but the metaphor is that there's a subculture of people who try to grow pumpkins literally as big as a car, and one of those seeds can cost a couple of thousand dollars for a seed. And if you're one of those people where you're trying to grow a giant pumpkin, what you do is you plant the seed and then after the vine starts to make pumpkins plural, you look for the one that looks the healthiest and the biggest and you pluck the others off so the vine is just supporting that one pumpkin. And then that's how you grow a gigantuan pumpkin.

And his point is that most people when they do a business, they won't do that. And I'll come back and apply it to the doctor business. They'll keep the patient that's a problem patient because the doctor thinks they need the money. They'll keep doing things they don't really like doing because they think they need the money. And so they're nurturing all the little pumpkins that are aggravating them. And the big pumpkin that gives them the most soul satisfaction and probably helps their bank account the most, doesn't have the nourishment to grow. So when people have come through my courses over the past 15, 16 years, one difference I see is some will go back and literally make extra millions of dollars and some will go back and just really not implement anything and drop out of the group.

It was really interesting during COVID because we had people who grew their business like crazy and others who went broke in the same-sized town offering the same sorts of things. So what's the difference? One difference is that those who do well with our group, they go all in and they nourish that big pumpkin. So if you're really into one of our procedures, let's say the O-Shot®, because it changes lives and pays well, and it's good soul satisfaction for you and your patient, and people are crying because their marriage is changing, and you like doing it.

Okay, so then read about it, read everything about it. Read all the references on the O-Shot® website and talk about that in your emails and your social media if you're still doing that and with your patients and you put one of our posters up and you're wearing an O-Shot® t-shirt that we sell, and you have an O-Shot® coffee mug that we sell and you're handing out brochures and you're handing out our book and you interview the people who are grateful because they got better. You interview them for videos and social media. In other words, you're still doing the other things. But here's the trick. And listen to his book because you'll get a lot more detail. I'm just giving you the basic idea. But he'll give you really good details to help you implement this idea.

Then as that pumpkin starts to grow and you're doing more O-Shots®, you realize you do, when O-Shot®, it pays quite a bit more than a level four where you have to sit with grandma for an hour and she's on 12 medicines and you get paid 70 cents on the dollar and 10% of it goes to your billing company and then you do one O-Shot®, which pays better than three of those grandmothers.

Well drop the irate grandmother that you're tired of taking care of. In other words, if you're doing this plan, you could literally go home an hour earlier if you wanted and make the same amount of money, or you could stay there for the full day and do another O-Shot®. But it only happens if you're nurturing, nurturing the thing almost without exception. I'm going to say almost even though I don't know of a case. But almost without exception, when people drop out of our group, I go and check and they usually have nothing on their website about the procedure that they signed up for, say the O-Shot®, nothing on the website, nothing on social media, and they're wondering why no one's coming to see them.

Even if you've done one of our hands-on courses, if your patient sees on the directory and finds your name ... I'm talking your patient, and then they go to your website and they can't find where you're talking about it, they're going to go back to the directory most likely and find someone else who's got something on their website about it and they will get on the airplane. It happens all the time. Our doctors talk about people who fly in from other towns where we have O-Shot® providers and they'll get on a plane and fly to see somebody else.

One of our nurse practitioners told me about today, someone flew from two states away to get everything. She got a O-Shot® and a wing lift and breast lift, and she flew from a town where there's two other people. But this nurse practitioner actually had something on her website about it. She's nurturing the big pumpkin. And so listen to the thing. It will motivate you and implement it. Maybe it's not the O-Shot®, maybe it's something I don't even know about. Maybe it's one of the surgeries you do or something else. But nurture that big pumpkin and once it's going, nurture another one and drop off the little pumpkins that are aggravating you that no longer interests you. Okay.

Leukocyte Rich or Leukocyte Poor for Muscle Repair?

So let's see where were. Go back finish. I just got a couple more. A lot came out. This one, I'm just going to throw your way because we've seen this before, but they just looked at leukocyte-rich versus poor, and the leukocyte-rich was better for helping with muscle healing.[23]

Again, just because we're taking care of muscles when we take care of the female pelvis.

Authors Caught with Pants Down

This one really less interesting except that it called out the fact that a mentor of mine told me years ago ... This was back in the '80s. I had a mentor. He is one of those internists that some of you're old

[23] Lin et al., "Leukocyte-Rich Platelet-Rich Plasma Is Superior to Leukocyte-Poor Platelet-Rich Plasma in Improving Muscle Healing by Promoting Angiogenesis."

enough to remember when people smoked in the hospital and he smoked and he was not very healthy, but he could diagnose people. He trained with Harrison like the Harrison's internal medicine textbook. And he wasn't quite of his generation, but he was half a generation away and he could diagnose people. Everybody knew he was the wizard.

And I remember him shaking his head one day and saying, "Charles, there was a time when you could believe everything in the New England Journal. Now half of it's just political BS."

So, this paper I'm bringing up, because we reviewed the original papers, I'm showing the letter. We reviewed this paper that showed that PRP plus HA worked better than PRP alone for osteoarthritis. The letter to the editor called them out that one of the main papers they talked about had not been published yet. So I don't know what you do with that, but they fudged it a little bit.

Autonomic Nerves Matter Too

So this one I've put in here because it's a colon, it's a gastroenterology ... Excuse me. It's a colon surgeon's version of what we're doing with Clitoxin.[24] There was a paper out almost 10 years ago now that recommended that gynecologists be more aware of the autonomic nerves when they're putting in mid-urethral slings, because some of them affect those autonomic nerves, some techniques more than others. And actually, that paper was part of what led to us coming up with the Clitoxin idea. But this is another version of that showing that ... Most of us don't do colorectal surgery, but showing that if you think about that when you do your surgery and avoid those autonomic nerves, there's fewer incidences of erectile dysfunction post-op. You can dive into the details if you want. But I bring the paper just to make the point that I think you're going to see more discussion about the autonomic nervous system in relation to sexual function.

Back to the female anatomy thing. Remember, out of those seven medical schools in Chicago, only one was teaching the full anatomy of the clitoris. And even then, what's full anatomy? The dorsal nerve of the clitoris was really all that I've seen talked about. But you've got the whole inferior hypogastric plexus and you've got autonomic nerves, afferent and efferent running right alongside the dorsal nerve within the body of the clitoris, which is not usually talked about even when it's so-called full anatomy is being taught.[25]

So I think you're going to see an explosion of research about the autonomic nervous system if I have my way anyway, because I think that's why abotulinum toxin into the clitoral body. I think it's how it's working.

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

[25] Oakley et al., "Innervation and Histology of the Clitoral–Urethal Complex."

What's Next in the Study of Treating Stress Urinary Incontinence in Women Using Our O-Shot® Procedure?

We've covered almost every paper mentioned in here. It's another paper about treating SUI in females with PRP.[26] There isn't a lot of originality in it, but it's basically saying it's calling us out legitimately that if we're going to be treating and doing studies regarding stress urinary incontinence for females, then we should have some protocols. And of course that's part of the reason for our group. We have a protocol. So we've addressed one of the criticisms of the research already and we just talked about one alteration possibly in our protocols, but they've evolved. Sophia Lubin told me something, my wife taught me something. Multiple people have taught me things that have become integrated into our procedures.

So they evolve with our experience in the research. But there's some ideas about how we should be thinking about the research moving forward. And most of it involves around protocols in this paper, protocols with how we're making the PRP.

But I think we have to be very specific about where we're putting the needle as well. That's why we spend a million dollars a year shutting down people, one reason claiming to be part of our group because they're just squirting PRP, who knows where. And even if you make the PRP in a quality way, if you don't put it in the right place, it just doesn't do anything useful. So this was just pointing out I think, reassurance for why we exist.

Another Way to Isolate Platelets

And this one I put in here because this is not ready for prime time, but it's an idea about, I've seen one other device like this 20 years ago, someone brought me a device where you use a micropore filter device to repair your platelet-rich plasma. And something like this could be on the way. This particular device is not ready for prime time, but it's some of you who are one of the biomedical engineers like I am ... I actually did that for a while in school, but decided to go ahead and go to medical school. But if you're a want-to-be ... Like, I'm a want-to-be singer, it's not good for anybody but me. But if you're into some of the devices and the mechanics of it, this is a beautiful paper that talks about a particular way that you can basically filter out the platelets. I don't think it's ready for us to use yet, but it's fun to think about.

An Email You Could Send

I promised you three different ways to make money.

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[26] Ishfaq et al., "Critical Appraisal of Evidence on Platelet-Rich Plasma and Stem Cell Therapy for Stress Urinary Incontinence."

One is you could take that this paper right here about women, and if you put a link to this paper, your email could be straightforward.[27]

It could be, wow, so many women, this new study shows that so many women past menopause are suffering in silence with their sexual dysfunction, and they might be content to live that way, but they have some things that are not working as well as they could. And this paper shows that even though the sexual dysfunction gets diagnosed more in young people, post-menopausal women are really having a lot of symptoms, probably more than the 40% that's quoted. And we've got some new ways to help with that so come see us. It could be that simple.

And why does that work better than 10% off to get an O-Shot®? It works better because it's news. It's news. So it's a reason for your letter. Here's some news about female sexual function that just came out. And not only is it news ... See it was published May the 27th.

Not only is it news, but it shows that you are reading as a physician and up to date, which your patients want to know that you are.

So a little simple. That's one email you could send.

5-Notes Expert Marketing System for Physicians

This one about I mentioned how you could talk about the penile implant study, which is ... Really, you could use any of them. This is curious because most people don't know, many doctors would have trouble pointing at the vestibular glands. And so something like that, Hey, the female anatomy is really much more elegant than a simple tube as a receptacle for the penis in a place for babies to pass through. And there's some functionality going on and thought you might find this paper interesting.[28]

And when we do our O-Shot® procedure, we are revitalizing the tissue of the vagina.[29] So if something's not working right, might want to come see us. So that sort of thing. You could take really any of these papers report just what you find interesting about it and then mention that you might have a help.

I'm going to send you something in the chat box that my wife Alex showed me today that is huge. So one wrote a really nice article about the P-Shot® only thing I didn't like about it is they didn't ... Putting it in the chat box. They got it wrong as they often do about where to go. But it's still a really beautiful article. I'll put a link to it in the chat box, and it's called Breaking the Stigma: Why The P-Shot® is Gaining Popularity.

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[27] Kırat, "Sexual Dysfunction in the Life Cycle of Women."

[28] Perelmuter, Giovannetti, and Tomalty, "Review of the Vestibular Glands."

[29] {Citation}

And I love articles like this where it feels like you're missing the party.

And so that's such an intriguing and seductive title, right? Breaking The Stigma: Why The P-Shot® is Gaining Popularity. In other words, everybody else is doing it, so why aren't you?

And here's the reasons why. So it's a very helpful article. Like I said, its only downside is that it doesn't link to our directory. It links to some other paper about PRP in the penis. So you just shoot it out and say, "I'm a licensed provider of the P-Shot®," if you are, "and here's why people are loving it."

So it's in the chat box if you want to get that link. It's another one you could send out. Okay. I think with that we'll call tonight.

I hope that was helpful to you. Have a great week. I'll see you next Tuesday.

=> Apply for *Online Training for Multiple PRP Procedures* <=

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Tags

PRP, platelet-rich plasma, O-Shot, P-Shot, sexual dysfunction, erectile dysfunction, female sexual health, male sexual health, testosterone therapy, prolactin, DHEA, growth hormone deficiency, vestibular glands, clitoral anatomy, urinary incontinence, penile prosthesis, regenerative medicine, sexual medicine, hormone optimization, pelvic floor muscles, red blood cells, leukocyte-rich PRP, shockwave therapy, marketing for physicians, medical practice growth, The Pumpkin Plan, RegenLab, FDA approved PRP, autonomic nervous system, stress urinary incontinence, micropore filter, patient education, medical protocols, journal club, hormone replacement therapy, patient satisfaction, medical email marketing, practice management, physician burnout prevention

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