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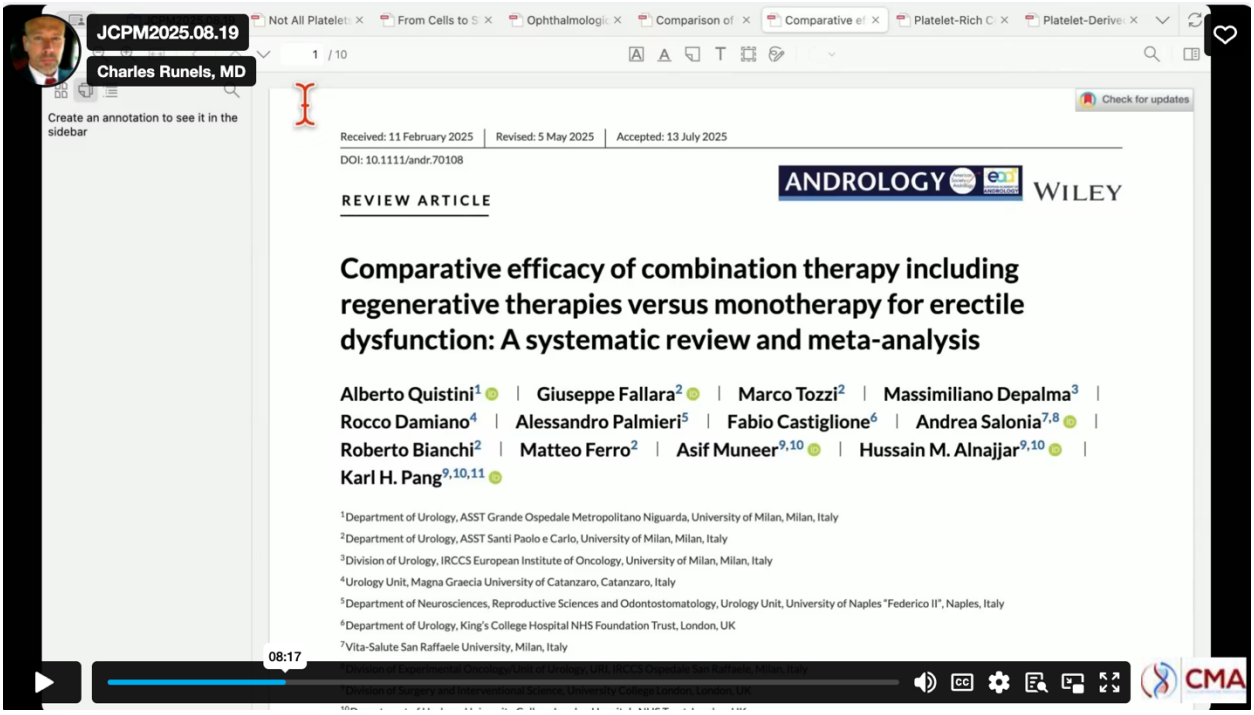
The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of August 19, 2025, with Charles Runels, MD.

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



Topics Covered

- Platelet-Derived Extracellular Vesicles for Psoriasis
- **PRP for Lichen Planus**
- Combination Regenerative Therapies and PD5 Inhibitors
- **Twelve Interventions for the Treatment of Diabetic Foot Ulcers (including PRP)**
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- **PRP vs. Exosomes vs. Minoxidil for Androgenic Alopecia**
- **P-Shot® then Priapus Toxin®, or Both on the Same Day?**
- **How to Improve the Deliverability of the Emails You Send to Your Patients**

Charles Runels, MD
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Transcript

Welcome to our journal club. As usual, when you scroll through PubMed, you see at least three pages of new articles using platelet-rich plasma and other regenerative therapies. I picked my top ones, but sometimes, I have trouble limiting them! I get so excited!

Platelet-Derived Extracellular Vesicles for Psoriasis

We'll start from the bottom up, where someone looked at platelet-derived extracellular vesicles for psoriasis.[1]

I have seen this over and over again. Amazingly, dermatologists don't think about it more often, but psoriasis, eczema, and, of course, our ladies and men who suffer with lichen sclerosus—all are helped with PRP; and the research supports the idea.

So I won't belabor it to tell you it seems to be working. But now, instead of showing that it works, the research is becoming more specific, and it's not just about the growth factors in the platelets but some of the extracellular vesicles in the plasma. We have those who are trying to harvest exosomes from the platelet-***poor*** plasma.

So there's a lot of work going on about what exactly is doing the work instead of just how many platelets can you cram into a small volume. You'll start to see more of this with... I know the most dramatic picture I've seen is one of our gynecologists who sent a picture of a woman who was disabled with eczema who just happened to show up for a Pap smear or something, and he had just attended our workshop about PRP helping lichen sclerosus, and the results were super dramatic. I'll see if I can pull those pictures up here shortly, but many miracles are happening.

PRP for Lichen Planus

This is a review regarding lichen planus. Once again, we've covered this one before, so there is just more evidence that lichen planus, not just lichen sclerosus, responds to platelet-rich plasma, even in

[1] Wang et al., *Platelet-Derived Extracellular Vesicles Alleviate Psoriatic Inflammation via Mitochondrial Transfer to Macrophages*.

cases that are resistant to steroids.[2] So, it's a very difficult problem that's also autoimmune, and I'm just mentioning another paper that came out.

Now, why do I show you these?

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We've talked about it. I'm going to show you some new stuff in a second that's exciting, but that actually blows up some of the talk about drawing lots of volume and cramming as many platelets as you can in a small space. This is important not only for reassuring us in what we do but also **for giving us news to talk about with our patients.**

The first part, reassuring us what we do: Remember, there is nothing ever proven.

There's no finish line.

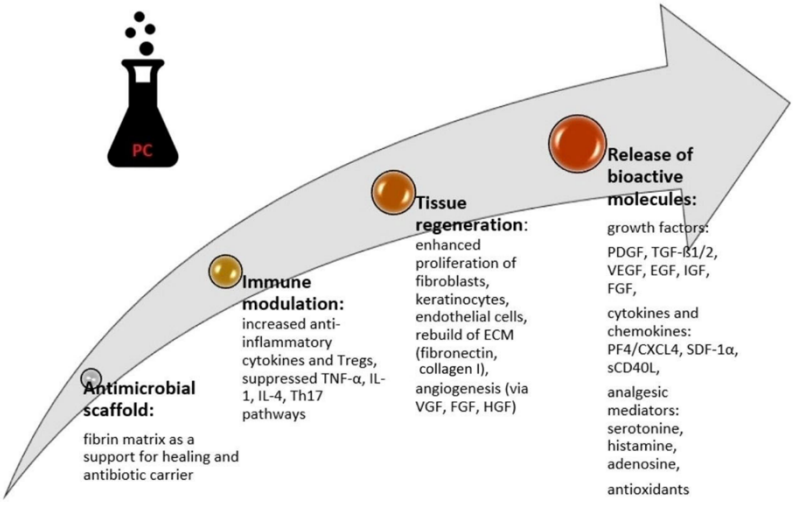

Figure 1. Biologic actions of platelet concentrates.

Figure 1. From ´Slebioda, et al

This used to bother me. I would think, "Oh, we have 20 papers. This is proven."

No, it isn't.

There is never a place where a scientific principle is proven. You just collect more and more supportive evidence until it is finally accepted or someone else blows it up.

I remember when we, as residents back in the '80s, the status quo was still telling those suffering with diabetes to avoid stuff like potatoes because they were bad for you. And they're not. Potatoes are a low-glycemic food. So they've changed diet recommendations and many other things in medicine over the years, as something that was widely accepted was blown apart by new research.

Last week, we talked about the man who died in the asylum when he suggested that gynecologists wash their hands, and the mortality rate of mothers dropped 20%. But he was chastised. He lost his privileges and was actually committed to an asylum, and died there at the age of 47.

[2] Ślebioda et al., "Platelet-Rich Concentrates in the Management of Lichen Planus—A Comprehensive Review."

Then, Louis Pasteur came along and demonstrated the germ theory.

So big changes in medicine happen, but oftentimes the data collects and it collects. And like Planck said, really nothing changes until the old people die off.

Planck, the great mathematician, said, "Medicine and science change one funeral at a time. And when the old people die off, the new people don't have to change their minds. They just grow up learning the new stuff."

That's how medicine changes, which is why it takes 20 to 40 years for a new idea to take place. You must wait for the old people, like me, to retire and for the new people out of medical school to read the research, and they don't have the bias of the old stuff.

So, the bias is that if you've got lichen sclerosus or lichen planus, you slap cortisone on it, and everything else is just voodoo until you have stacks and stacks of papers.

But now at least a dozen of them say, "Hey, this works as well as steroids. Maybe you should try it."

Yet our colleagues are mostly not trying it. So, we'll have to wait for most of us to die off until it becomes adopted.

Combination Regenerative Therapies and PD5 Inhibitors

Okay, this one was interesting. Andrology is a nice journal, and they looked to see which regenerative therapies work better and what works well when combined with the PD5 inhibitor.[3]

They listed shockwave but did not include any of the studies with platelet-rich plasma!!

But if you have a shockwave machine, this is a great article to share with your people because it shows that if you combine it with your PD5 inhibitors, that combination is very dramatically effective. Of course, we know that to be true already, those of you doing this.

But this gives you a very recent article out this month showing that to be the case. You could send out a link to this. It's open source, so you could give them a link to the article. It's in your handout section, so you could download it.

You could shoot that out as a link and say, "Hey, this just came out, and it shows that you're going to have a better erection if we do shockwave. And you can combine it with your PD5 inhibitors."

Remember, if you do a shockwave treatment or do our P-Shot® and they throw away their Viagra or their Cialis the day you do the procedure, ***that's two things changing at the same time***. One decreasing erection, and the other increasing, and you're not sure what's going to win out in that. And

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[3] Quistini et al., "Comparative Efficacy of Combination Therapy Including Regenerative Therapies versus Monotherapy for Erectile Dysfunction."

your P-Shot® takes, really, three weeks to start to work with full effect in three months. So, ***if they throw out their Viagra the day you do the shot or the day you do your shockwave, it's very likely they're just going to think you made them worse.***

So it's important, I think, to tell people, "Just keep doing whatever you're doing, taking your Viagra, Cialis. And then at about three weeks out, you might start to notice that you need less of it."

And if you're on a low dose, you might throw it away. Most likely, you'll cut your current dose in half."

Which seems like, "Well, is that really worth doing?"

Yes, it is. Because without doing the P-Shot® or the shockwave, eventually it just quits working.

Sometimes, if they're doing TRIMIX injections, it can become ineffective just in a matter of months.

Always take pride in the fact that none of the medications, none of them, actually reverse or even slow the progression of the neurovascular disease causing erectile dysfunction. None of them. Not PD-5 inhibitors, not your TRIMIX, certainly not your penile implant.

But we do.

With our P-Shot® and with our shockwave, we are slowing the progression, even potentially reversing the neurovascular disease, causing it, the ED, within the penis itself.

Not iliac disease, not decreased VO2max, if they're out of shape and have congestive heart failure. We're not fixing that.

But assuming they're getting adequate blood flow to the penis, which most men do, we can reverse that. So I think we should be making the case for our P-Shot® and shockwave to be first-line therapy, not to use after your PD5I starts to be less effective. Why wait until it progresses? We should be doing our stuff early on.

But assuming they're already on it, this is a nice study you could shoot out.

Remember, one of my main rules to never forget about marketing is that people do not want to be advertised to, they do not want to be marketed to, they do not want to be sold, but they love to read letters.

So, a personal letter or a personal post, if you like to play social media, that says something like, "Hey, I thought you or someone you love may want to know that I read this paper today. It's just out that shows that, yes, there is even more research where they looked at multiple studies. It's a meta-analysis. Systematic review."

People can understand that. "Multiple scientific studies show that if you throw in a shockwave together with your PD-5 inhibitor, it's going to work a lot better than if you just use that alone, and you may be able to decrease or throw it away."

Twelve Interventions for the Treatment of Diabetic Foot Ulcers (including PRP)

OK. This study: 12 interventions for the treatment of diabetic foot ulcers. They include everything.

You may know that I ran a hyperbaric oxygen therapy at Spring Hospital back during my emergency room days, and it's an involved thing. You show up with your diabetes and your foot that you're trying to salvage, and we put you in a hyperbaric chamber where you sit in there and breathe, and we achieve a high enough... At three atmospheres, we can get your oxygen level so high in your plasma that you wouldn't even need your red blood cells to survive.

That's how high, so we can hopefully help with the anaerobic infection that might be in your foot and help you heal the wound. It's a lot of trouble and a lot of expense, but it's worth it if you save your foot.

But now, here's a study comparing that, and that didn't really come out on top. Amniotic membrane stem cells came out on top, which you should be careful and probably not to use in this country. You can see that they're in China, so they don't have to worry about our FDA. You have to worry if you say the wrong thing, you'll be in jail, but you don't have to worry about the FDA. You can do stem cells over there.

However, platelet-derived growth factors are also at the top of the list. And remember, if you're treating wounds and you're still taking insurance, you have potentially a gold mine because this is now covered. Treating diabetic wounds with platelet-rich plasma is on-label using a Regen Lab kit. They went to the expense of getting on label. And I'm not even going to say how much you get paid because it's enough that I'm afraid somebody's going to find out and stop it.

But I'm telling you, you can get paid a noticeable amount of money because what's a foot worth?

Really?

I just had cataract surgery. That doctor deserves every penny. And everybody gets that. They don't understand thinking, making a diagnosis, saving grandma's life, because you diagnose something and you write a prescription, she gets down the street to the drugstore. That's a hundred-dollar visit, even if it saved your life, because you picked the right heart medicine.

But everybody understands when you help grandmama or granddaddy see again, which is what happens when you get your cataract surgery. They also understand it when you save a foot because there's an ulcer that's not healing. The alternative is somebody taking out a saw.

So it pays well, and it is on the label for a Regen Lab kit. You can find the phone number on our regenlabusa.com, but you can also find the contact info on our membership websites. Let them know you're in our group, and they'll take good care of you. As far as I know, that's the only kit where they've gone to the expense of proving to the FDA that it is on the label. And here you have a paper showing that it helps.

Now, most of us don't treat wounds. I don't treat chronic wounds anymore, but it still carries over. I think when you're thinking about things like, okay, yes, lichen sclerosus is an autoimmune disease. It causes changes in the vasculature, and you get this horrible itching.

The pruritus is maddening. It tears and bleeds when you try to have a bowel movement. Sex is something you can't even think about without hurting. Because you can't even wear tight jeans.

But let's say that you had a magic wand, which your PRP can be like a magic wand. But let's say that you have a magic wand, and you just instantly made the lichen sclerosus[4] go away. ***You're still left with tissue that's cracked and torn and needs to heal***.

And here you have it, it's nice that it's all in one package (attenuate the autoimmune system AND promote healing). Still, you have this paper showing that platelet-derived growth factors help very-difficult-to-heal wounds in places with little blood flow, like the foot of someone suffering from diabetes.[5]

It's beautiful that you have something called fear. ***By using a modified O-Shot®, you can actually both down-regulate the autoimmune response, helping to attenuate or shut off the process of lichen sclerosus, and simultaneously promote wound healing so that the tissue gets healthy again***. So I think that's where it applies.

And the same thing might apply if you're dealing with, say, repeatedly tearing of the posterior vaginal, old episiotomy scar that keeps tearing and bleeding.

A Narrative Review of the Ophthalmological Complications of Aesthetic Injections

All right. In this article, they review... This is also in your handouts. A narrative review. I always think that's a really beautiful way to say we're just going to talk about stuff we read today. And that's what we're doing, right? A narrative review of stuff we read.

But it's a narrative review of things that can go wrong with aesthetic medicine.[6]

It's worth at least studying this list. Let me scroll down to it here. I love this list. Ophthalmologic complications can be severe and irreversible. This is the sort of thing that would ruin not just your day, but also your career/your life. So I just don't do anything that can make this happen.

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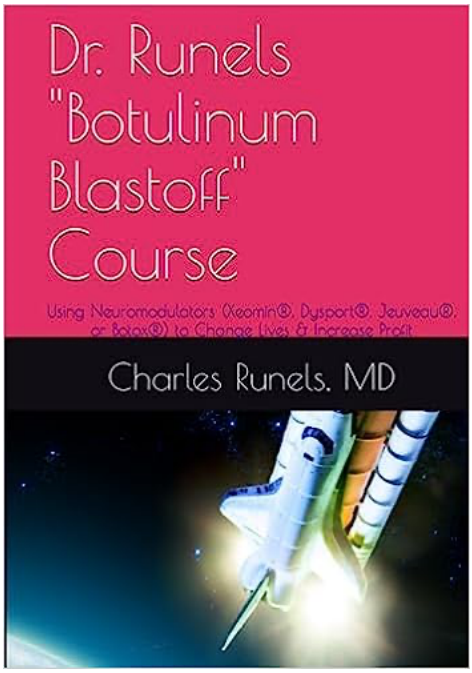
[4] Yes, lichen sclerosus is spelled with a "u."

[5] Hu et al., "Comparison of the Efficacy of 12 Interventions in the Treatment of Diabetic Foot Ulcers."

[6] De-Pablo-Gómez-de-Liaño et al., "Ophthalmological Complications of Aesthetic Medicine Procedures."

When I teach how to inject fillers, I just tell people, "Don't go there. This is a place where something bad can happen. Don't go there."

Retinal artery occlusion is horrible. For those of you who have done my hands-on workshops, I make it really simple to stay out of trouble.



It isn't complicated.

You just know the few areas where you don't stick a needle, and it's the glabella, the tear trough, medial tear troughs, near the nasolabial fold are your main things. We just don't need to be playing there with filler.

And then they say, "Small aliquots less than 0.1 milliliter per injection."

And those of you in my course know that everywhere I inject it, it's almost always 0.05, a half of a 0.1 milliliter injection.

That's why I love the JUVÉDERM Ultra Plus syringe, even though I don't love the company. I still buy it because they have the best syringe, which is long and skinny and makes it easier to inject 0.05 milliliters accurately. And with a short fat syringe, like a Reston syringe... It's a great product, but because it's short and fat, it's hard to do the smaller aliquots accurately.

And then they talk about training and anatomical knowledge.

It isn't complicated. If you haven't had filler training, if you're still confused by your filler training, just come to my workshops or someone who was trained to teach by me, and you will not be confused when you're done. Of course, informed consent, but we don't want to have to rely on that to keep us out of trouble. Just do not inject the dangerous places.

And then, of course, your complication kit, your Hylenex, is in the fridge at all times, and you know what to do with it: inject, massage and praying, a warm compress, and some aspirin. But I've only had to do this once, and it was when I broke my rule.

I used to teach people that you could mix a small amount of HA, one-tenth of a ml, 0.1 ml of HA to 0.9 ml of PRP, put it in a syringe, swish it around, make an emulsion with it, and use it without worrying. Then I had something happen: I injected a nasolabial fold in a woman, and then the tip of her nose started to blanch. I had the Hylenex, squirted it in there, and everything resolved. She enjoyed a beautiful outcome.

But the point is, if you have one drop, ***if you have any amount of HA in your syringe with PRP, you still have to treat it like an HA.***

Except for that, I've never had a problem when I was injecting HA of any kind. I use my Hylenex to take extra filler out for someone who has overfilled under the eye, sometimes the mouth or other places.

It talks about burns from different IPL and such. And of course, botulinum toxin, unless you inject pregnant women, so you're going to get blamed for something that you probably didn't do, but you're going to get blamed for it, or someone with myasthenia, you're just not going to have a problem.

The LD50 is literally so high that you'd have to inject a bottle of Botox per pound of body weight IV push to approach the LD50. So, for a one hundred-pound woman... If you do the math on it, which I've done, you'd have to take a hundred bottles of cosmetic Botox, mix them up, and push them IV at the same time. And so you're just not going to have a major problem with doses of cosmetic Botox or with Clitoxin® or Priapus Toxin®.

Having worked as a chemist and an ER doctor, where I'm supposed to know about poisons, I spent a week reading the literature about what it takes to get hurt from botulinum toxin before we ever rolled out the Priapus Toxin® or the Clitoxin® procedures.

Okay. Also, you can see that PRP injections have also caused some problems. And that same study... They always quote these same studies, which have been around for a decade, but they fail to mention... They do say that these were cosmetologists, but they leave out the part that in the cases where vision problems happened with PRP, they were people who possibly mixed the PRP with an HA.

They leave it vague in the paper, but, for example, in one instance, it was in a hotel room with the cosmetologist, and some unknown filler was used along with it.

So, I'm still not convinced that PRP alone is the cause of blindness. This is ***seven instances out of twenty years, and millions of kits are sold every year.*** Multiple companies now sell over a million kits a year. We have fewer than half a dozen cases where something tragic happened around the eye, and it's mixed up with people getting treated in a hotel room with some unknown filler.

So I'm still not convinced that PRP alone can cause a problem, but I guarantee you it can if you mix any amount of HA.

You think about it; inject it into an intravascular space when doing a P-Shot®. Technically, the corpus cavernosum is an intravascular space. And we've done easily over a million P-Shots®, and no pulmonary emboli, no necrosis ever, because we are injecting PRP. And yet you can cause pulmonary emboli by injecting an HA into the corpus cavernosum, and that has been documented.

So I don't think you have to treat PRP like an HA unless you mix an HA with it, but I'll leave it for you to decide what you're going to do with those six cases.

Worst-case scenario, you just wouldn't squirt it in the tear troughs or up near the nose. But if you use my technique of injecting PRP alone, which I teach, even in the tear trough, you're out of danger of getting tangled up with causing an embolus.

PRP vs. Exosomes vs. Minoxidil for Androgenic Alopecia

In this study, all three worked, but the authors thought exosomes worked better than PRP for the scalp; of course, both work.[7]

And I still believe in the US being really, really careful if you're injecting exosomes. I just do not like things that get me crosswise with the FDA. I just want to talk with them unless I have something new that I invented, but I don't want them tracking me down.

If you are working under an IRB, that's great. But if you are practicing in your office and you're injecting exosomes, whoever's selling them to you... I'm not saying don't do it. Just make sure whoever's selling them to you gives you a piece of paper and they tell you that you can show that to the FDA and you'll be in no trouble at all.

Then you take that piece of paper, give it to your attorney, and say, "Does this keep me out of trouble?"

Unless you're doing that, I would be very careful.

The Age of Your Platelets is NOT the Same as YOUR Age

This was the highlight of what I read this week. We can cover it pretty quickly, but this was freaking amazing.[8]

This is really the new thing, at least this week. Because what they point out in the papers in here... This is open source, so you can download it and read it. I love this paper because it expands upon the idea that platelets age and become less effective.

To this point, there's been a lot of emphasis on just how many platelets and large volumes of blood. How much can I harvest?

So you can draw 60 milliliters of blood and break it down to two to five, and that's great. I'm not saying that's not a thing. And it's actually been shown to be needed in the orthopedic injections.

But what they have shown here is that ***another thing to be considered is not just the number of platelets but the senescence of the platelets themselves, not of the person, but of the platelets themselves***.

They give you a little diagram here about how a platelet ages. And so when you harvest platelets, how old are the platelets?

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[7] Darwish et al., "From Cells to Strands."

[8] Costa et al., "Not All Platelets Are Created Equal."

In their timeline, it's over seven to ten days. You have mostly old ones or you have some young platelets. And there's some practicality to it. Here's where they just compare the functionality.

Of course, if you're over 65, like me, then your platelets won't be as functional as when I was 17. But that's not the only thing. They make the case that even an over-80 person with the right circumstances in health may have younger platelets overall and more functional platelets than a 19-year-old, depending on the person's health and other factors.

So first, they give you this nice chart of what happens with old platelets versus young platelets. And remember, this is not the age of the platelets because of the age of the person, but ***the age of the average platelet in the blood that you just harvested*** that you're about to inject. And so what can make the platelets tend to be older is oxidative stress, and most of the things that you would think of that would make you less healthy anyway, cardiovascular disease, autoimmune disease, and, of course, just aging in general.

So here they talk about strategies. So you know this. What can you do about it to make the platelets healthier?

One of the people in our group, Jeff Piccirillo, used to be in our group; he's doing other things with weight loss now, but he wrote a little book called Perfect PRP, where he explored this. This paper takes it even further. We talk about, and I recommend, the book, antioxidant supplements, nutritional optimization, and exercise.

We've looked at studies in our journal club before. If you just moderate, just go for a walk or treadmill for five or 10 minutes before you draw the blood, you'll increase the number of younger platelets.

But if you have more time, like, say, "Go walking every day for the next week and then let me draw your blood," you'll have younger platelets.

And they actually make the case that the higher the volume of the blood draw, the more likely the platelets are to become senescent.

And then they make a big point. This I haven't explored. Some of the people in our group are doing this photo modulation. They make a very big point about, "Oh, the system's treatment."

So they're talking about the system, not just one thing. But they make a big point, I'm getting to it, about activation.

"Calcium chloride in particular induces controlled platelet activation by providing extracellular calcium-triggering growth factor release without compromising membrane integrity."

They even talk about combining it with autologous thrombin. Regen has a kit where you can make autologous thrombin. I have not done that, combining calcium chloride with thrombin. I have to explore that more. They give a paper there for reference.

This helps explain why we get less now, because people are being more consistent about it. But I have had quite a few calls, especially five, six, or ten years ago, where people would say, "Oh, my O-Shot®'s not working."

I would find out that the drug rep who sold them the centrifuge told them that they don't have to activate with calcium chloride.

=>Hands-on Botulinum Blastoff Course<=

After they talked with me, they'd start activating and get great results again.

We haven't done this study O-Shot® without calcium chloride O-Shot® with calcium chloride, but here's a paper that looks at the science and shows you why that is tremendously helpful to activate the PRP with CaCl. They give you a little diagram.

Okay. This was my favorite paper of the week.

And they give you some ideas, pre-conditioning prior to the procedure, basically telling the person, "We're going to get a better result if we do some things to make your platelets healthier and younger before we draw your blood."

And they, of course, mentioned avoiding non-steroidals, smoking, and good nutrition. T

hey even mention vitamins. This starts to sound like your grandmother talking to you about how to be healthy. It is so amazing how some of those old-fashioned things, like staying outside and eating your vegetables, start to show up in this really esoteric and, I think, beautiful biochemistry and physiological explanation of your platelets.

Okay. So that was my favorite paper. Let's see if there are any questions, and then let's call it a day. Okay. Here are a couple of questions.

P-Shot® then Priapus Toxin®, or Both on the Same Day?

"I have a new patient who uses TRIMIX now. Wants to do a P-Shot® and the Priapus Toxin®. Do you recommend it together or one at a time? To see which one is working better?"

Okay. That's a very good question. Think about it. You've got a penis that doesn't work like you want it to, and the implications of that to your family, to your life.

The best strategy, I think, is to tell people that this is not chemotherapy, where every strategy we choose could risk your life. You could die from our therapy. In that case, maybe you want to do one thing at a time or be really careful not to do more than you need to do.

But we're talking about things that are so benign, platelet-rich plasma, that has a regenerative effect and neurotoxin at a dose half what you would use to treat migraines with. So these are benign treatments.

Now, put yourself in the patient's place.

They want to be well yesterday. So if their budget allows it, my favorite strategy is to tell the person, "Listen, let's do what we can to get you sexually functioning as best as we can, as fast as we can, and then let's taper things off and see how little we can get by with."

So I don't see, unless there's a reason, budget reason, if it's me and my penis isn't working, and my marriage is strained, or I'm living alone. I can't start a relationship because I will have to tell the person, "I can't keep up with you in the bedroom."

I want to be well yesterday.

Always offer people your best thing. Assume they have unlimited time and money and offer your very best rather than sneak up on them. And if they can afford it, great. Then you can move things around, maybe do something for free. Do part of it now and part of it later. But assume, especially with sexual function, which can be so life-changing, that they want your best and offer it to them. And there's no medical reason. Actually, there should be some synergy to offering the two together.

How to Improve the Deliverability of the Emails You Send to Your Patients

Let's look at this other question. Great question. One more about marketing.

"I send emails to my clients, and most of the time, they go to the junk email, even when I send them to myself. I've talked to many developers, but there's no solution. Do you have any for me?"

So yeah, that's the never-ending thing. I don't know what you mean by most. But if truly most, as in over half, are going straight to junk, then it could be you've been tagged somehow.

Here's a quick list of ways to make sure that things get delivered. And make sure whoever's sending your email has a good reputation. If you're working with a company that has a reputation for allowing junk to get through, then you're going to have trouble getting your stuff through.

I'll put it another way. Let's say you're the king of Google, and you get to decide whose email goes through when somebody sends an email to somebody's Gmail account. Well, there's no king of Google, obviously, but there's an algorithm that acts like the king of Google.

Now, there are different companies that send those emails: Constant Contact, AWeber, Infusionsoft, Salesforce, MailChimp, Ontraport. Those are some of them. There are others. There's off-brand where there's spa software. I mean, some companies will sell you a junk list of email, and then they'll send it to people.

All right. If I send... I use Ontraport as the main thing I use, and I teach you how to use it in my 5-Notes. Do that course and you'll just blow it out of the water.

But let's say that I'm using some company, and they're allowing junk to get through. Google is going to ban that company. If you send out... The number is one in a thousand. If you send out an email to a thousand people by Constant Contact, and two people... Not one. If one, they'll let it slide.

But if you send a thousand emails through Constant Contact and two people mark it spam, you get a warning, and next time you'll lose your account, like, boom, they won't do business with you anymore. Because Constant Contact has to keep its reputation up with the Googles of the world. I don't know. What's the other places? You have Gmail, Yahoo, all these different companies that have people with inboxes. And those major inboxes, they will just ban Constant Contact. If they kept letting more than one in a thousand go through that are marked as spam. They would ban the whole Constant Contact, all of their customers. So instead of letting that happen, Constant Contact will ban you if you get more than one in a thousand marked as spam.

So if truly the majority of your stuff is getting marked as going to junk... Now, there's getting marked as junk, and then there's getting put in the junk folder. So there are two different things. But that's the first thing. Make sure you have a good provider. My favorite is Ontraport. I teach you how to use it. I even dumped some emails and gave you some templates in that course.

The ***second thing is that, of course, you never buy email.*** You never buy them. And you only send emails to people you know. They're your patients, whatever.

The third thing is you give people the chance to opt in. So when they sign up for your list, or even if they give you their email in the office, it's because they're a first-time patient. You can make the first email and give them the option to opt in.

Once they opt in, that helps, but it's still not the best. Although it helps tremendously, the best is if you can ***get them to reply.***

So if you send an email and say, "Would you answer me," with whatever you want to know... "Hey, you just had your Botox. Would you click reply and tell me what you think about it?2 If you can get that, that really helps your deliverable rate.

There are other things. For example, wherever you send an email, it should have a spam filter-grader on it. ***So, before I shoot an email with Ontraport, it grades it. It gives me a grade***. And if it's over a specific number, you know it will go to spam.

And so I'll edit it back. Usually, this means I must change words. ***For example, instead of saying erectile dysfunction, I'll call it male bedroom problems. Or if you see an email from me and I call it a pencil, I'm using that metaphor to keep it out of the spam folder.***

Part of your question could relate to this. There are multiple ways to clean this up, but part of it could relate just to the subject matter.

We're talking about sex, which the providers don't like, and about PRP, which they don't like. And you're a doctor, which they don't like.

The cool thing about it is that if you get your person to opt in, then they cannot or will not. I guess they can always change their policy.

But at this point, the only provider that's censoring people from content and saying, "No, we will not allow this to come through" is MailChimp. If you use MailChimp, dump it because they're censoring both for political reasons. We had a person lose their account for talking about PRP, so ***dump MailChimp.***

But the others are not censoring. ***In other words, if you have an opt-in patient, you could send them a picture of a penis that's crooked from Peyronie's disease. You could call it ED and talk about erectile dysfunction. And if they've opted in, they're going to probably get it, especially if they've double opted in.***

So, one opt-in would be the first level, where they put their name and email in a form on your website. The second opt-in would be the first email, where they get it, and they click to confirm that they want it. We've all done that before. Some of you've done it for my email list.

So I always like to give the option of single or double opt-in, because some will double opt-in. And then you're most likely going to get through.

If the spam filter gets it, they still haven't really censored it because we all know you can look in your spam filter. And even now, you're right, I will sometimes, not as much as I used to, but sometimes I would land in the spam filter in Google, and I would just have to drag it out. So I drag it out of spam filter and mark it as not spam. So you teach your people to do that.

Your goal is a delivery rate of around 30 to 50%. Most of my stuff gets much higher than that. With our group, we get over 50% delivery rate. And you want to get at least a 10% click rate. And so if you can get 35% delivered...

Let's face it: even your mother will not read all your emails. She's busy that day. She didn't look at her computer that day. Or when she did, she was focused on paying the light bill. So you don't expect everybody to read every email, but those are good numbers to shoot for.

There's a whole science to just that, and I go into it much deeper in my course, 5notes.com, which no one has told me didn't help them as far as profitability and functionality of their practice.

And mostly, what I like about it is if you learn how to use the email, you will see more of the people you want to take care of. Don't send an email about treating lichen sclerosus if you'd rather not treat it. But if you would like to take care of women or men suffering from lichen sclerosus, and you start sending emails about it and talking about the research, they're going to show up at your office.

The beauty of it is that you start to see more and more of the people you most want to care for because of the soul satisfaction it brings you. Those are two great questions. Thank you, Arena.

Thank you. Have a great night. Bye-bye.

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