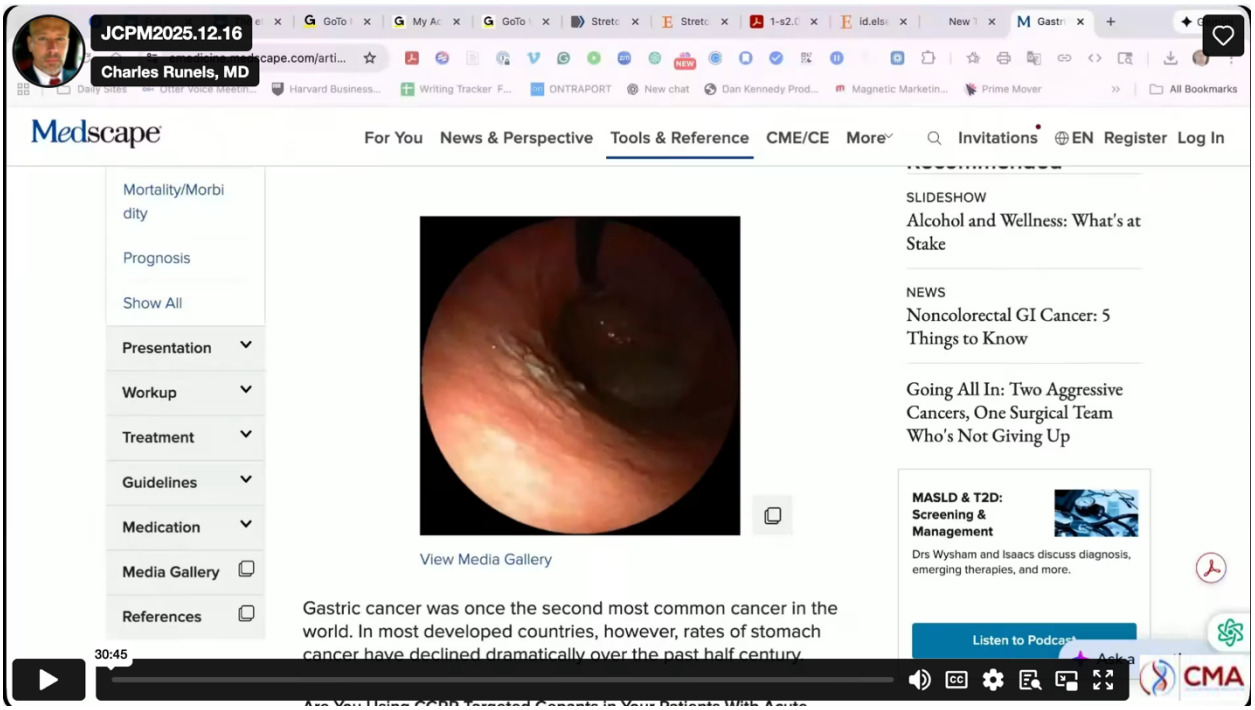
JCPM2025.09.16

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of December 16, 2025, with Charles Runels, MD.

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



Topics Covered

- The Shocking Prevalence of Female Sexual Dysfunction
- A Review of the Treatment of Stretch Marks
- PRP vs Magnet for Sex and Stress Urinary Incontinence
- PRP Alone or In Combination with Shock Wave for Erectile Dysfunction
- Charges for our Vampire-CMA Procedures
- Can I link to the Main P-Shot® Page?

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Transcript

Welcome to our Journal Club. I'm following up on an excellent question from last week with some review articles about sexual dysfunction in women. We also have a review article about treating stretch marks, which are super common, of course, in women who've had children, but especially these days with the new weight loss drugs, it's a very common thing that's happening, together with volume loss in the face. So there's an ever-increasing need for our Vampire Facelift® and for our Vampire Facial® techniques with microneedling for the stria that happens after weight loss.

And then, as we've done for the past few weeks, I will provide you with a marketing kit that includes two emails referencing the research.

The Shocking Prevalence of Female Sexual Dysfunction

Okay. Let's start with this one as a follow-up to the question last week. The numbers are staggering.. And look at these numbers. 20 studies were included in the review article, and the prevalence of female sexual dysfunction ranged from 20 to 95%.[1] [2] [3]

And I'll get to the actual study that shows what we discussed, namely that there's an inaccurate counting that occurs in women who are past 50 to 60 years old. So we'll get to that. Estimated between 8 to 91% in 16 of the studies, arousal disorder, 9 to 91%, how about that range? Orgasm disorder 8 to 93%. Lubrication 9 to 99%, and pain 8 to 99%.

So why are those numbers all over the map?

I think it has to do with what we discussed last week, specifically the definition.

And I think this is huge to remember when we're in a clinical setting, because what often the scenario goes, that someone comes to you for lack of energy or stress incontinence, something that has the

[1] Mitchell et al., "Estimating the Prevalence of Sexual Function Problems."

[2] Jaafarpour et al., "Female Sexual Dysfunction."

[3] Heshmatnia et al., "Prevalence and Correlates of Female Sexual Dysfunction and Sexual Distress in Reproductive-Aged Women."

energy or the fatigue and myalgia and general malaise that happens with hypothyroidism and hormonal problems, and you rule out all the bad stuff, the serious life-threatening cancer and such, and then you replace their thyroid and their testosterone and they get better. They came to you for the fatigue, told you they weren't interested in a relationship, but then, after you treat their hormones, things spark up. They show up with a new boyfriend or new husband or a renewed relationship with their current husband. But they were not distressed about their sexual dysfunction. They just wanted the fatigue to go away.

I'm sure if you've done this for long, you've had women tell you, "I do not want to have a sex drive. I'm happy."

And you tell them, "Well, if I make you better, then one of the side effects of being healthy is just like you get healthy, your appetite goes up, your energy goes up, you sweat more."

It has actually been proven that when you adapt to heat, you sweat more, not less. And as you get healthier, you're going to probably want to do the thing that healthy people often want to do, which is breathe and have sex. But before, even though she had a lack of libido, dyspareunia, and anorgasmia, she didn't complain about it, so she was not counted.

So look at this. This one reports similar numbers, with less than 20 years old at 75%, and 22% in people under 20, and 75% in those aged 40 to 50 years old. And that makes sense. It goes up, and that refutes what I just told you. However, we then find the graph on the other paper. So this one, they were correlating the incidents with morbidity, other problems. And now, on this side are men, and on this side are women. Lack of interest in arousal, difficulty in reaching climax, dyspareunia, one or more of these.[4]

Now, age 16 to 24, pretty high. Experienced one or more of these, 16 to 24.

But look at women, we are on the women's side. 65 to 74, low, low, low, unmeasurable.

And why? So why are they not counted?

Because they are not bothered by it, they don't get counted as having dysfunction unless they're psychologically bothered.

There is nothing else I know in medicine where you can have a physical complaint, if my elbow hurts, or I have high blood pressure, which is measurable, or I have a penis that will not become tumescent, which is measurable. If I have those things and I'm not psychologically bothered, I still have tendonitis, erectile dysfunction, and hypertension, whether I'm bothered by it or not. But the woman does not have anorgasmia, decreased arousal, dyspareunia, or sexual dysfunction if she's not psychologically bothered.

[4] Mitchell et al., "Estimating the Prevalence of Sexual Function Problems."

So these were the numbers. I talked about them and I was not able to give you guys references last week. So I put these together. We looked at them, but I didn't have them to give to you. So I'm going to click and drag them before we hang up today.

A Review of the Treatment of Stretch Marks

Then I have three papers. This first one has to do with stretch marks and they review treatments for it, including cocoa butter and olive oil. How about that? And laser, of course, non-ablative lasers. And then they include platelet-rich plasma. And they talk about subcision, PRP, things we know what it contains. Microdermabrasion, but they don't really talk in detail about the microneedling, talk about subcision, but there's no substantial discussion of that.

So it's included, but the pearl is that, probably a year or two ago, we covered a paper.

If you're going to treat postpartum stria, stria of the back, or stria of the abdomen from rapid weight loss, and sometimes in teenagers from rapid weight gain, from a young male who suddenly has a growth spurt from his testosterone and puts on a lot of muscle, that can cause it too. When that happens in those areas, it requires a deeper setting on your microneedling device, or one and a half to two and a half millimeters to have an effect, but those studies have been done. This is a recent article that you could use, as it was published fairly recently, so you could reference it in an email.[5]

Laser + PRP vs. Laser + Magnet for Sex and Stress Urinary Incontinence

This one was fascinating to me, and I'll re-post it in the download section for you to discuss. But the thing that got me about it is that the commonality in the two groups they looked at was that they looked at women with stress urinary incontinence and compared either a vaginal laser plus a pelvic floor, like an Emsella machine, or a laser plus PRP. They looked at incontinence and at sex. The first important result is that both groups improved; however, the group that received the PRP showed a greater improvement in the incontinence scores. So you can see the laser plus PRP, pre and post laser plus the magnet pre and post, and there was a greater improvement in the PRP.

So the ICIQ scores dropped from about 14 down to five, five and a half in PRP group and a chair group that dropped to seven.

Now, if you look at the protocol, they injected mid-urethra. They did not inject the clitoris, and then they injected on either side of the urethra. I see that in a lot of the papers.

And what is it about the anatomy they know that I don't know? Because the urethra is where the urethra is. And ***the urinary sphincter is not lateral*** to that.

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[5] Algarra Sahuquillo and Martín-Gorgojo, "Stretch Marks."

It seems to me that it could have just as well been squirted on the wall. And not that it hurt anything, but I don't see what's helping. I'm not sure why that keeps appearing in the literature. As you know, we put a full 4 cc in the anterior vaginal wall and a cc in the clitoris, or more in the clitoris. More than that in the anterior vaginal wall, just beneath the urethra, could cause overflow obstruction. We've had a couple of cases where someone went overboard and caused that.

Even with their protocol, which is less robust and well-thought-out than ours in the stress incontinence arena, the PRP outperformed the magnet, with this commonality being the use of a laser. So, where it gets interesting is with the sex side; they reported a large improvement in FSFI scores in the chair, but no improvement in the PRP group.

This is the first time I've seen that where people said it just did nothing. So here we are, FSFI scores, and you can see laser plus PRP pre and post, it's almost just a rubber stamp of the same. And then, with the laser plus the chair, FSFI went up dramatically. So what's that all about? It seems to counteract what we discussed.

So if you stop there, you might say, "Well, PRP really doesn't help sex with women."

But when you look at the protocol, the conclusion doesn't really follow because they did not inject the clitoris as we just talked about. And the PRP was not all put in the anterior vaginal wall near the urethra, but it was split between the midline, where the urethra is, and on either side. So, I think it just proves our point that the protocol matters.

We have other studies that have come out, some that we've published[6] [7] [8] [9] and some others outside of our group have published, where we do see significant improvement in sex when you do both, and putting it beneath the urethra makes sense with incontinence, but on either side really doesn't make much sense for sex or for incontinence.

Remember, one of Dr. Grafenberg's big ideas that he published back in the '50s was that he thought the most erotic part of a woman's body is the urethra.[10] He thought every millimeter of a woman's body was erotic, but the most erotic part of a woman's body was the urethra.

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

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

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

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

[10] "Ernest_Grafenberg_1950_The_role_of_ureth."

So some of the PRP may have been biologically wasted. And what I take from this paper is not that PRP fails to improve sex, but that if you put it away from our neurovascular targets that are responsible for arousal, the urethra and the clitoris, you may not see the same improvement. However, they still demonstrated that it helps with incontinence.

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And it reinforces our point that protocol matters, where you put the needle matters. So, I think this is still worth showing to patients. And certainly they didn't do both together, but it makes sense that there might be a synergy between the two.

PRP Alone or in Combination with Shock Wave for Erectile Dysfunction

This one we've seen before. I bring it up because I wanted to give you guys a strong paper to refer to in an email. We covered this one about the time it was released several months ago, but it focuses on PRP alone or in combination with shockwave. It doesn't look at, and this is a meta-analysis, it doesn't look at shockwave alone. So, it's just two arms, but there's definitely a synergy. Comparing one with the other, shockwave alone versus PRP alone was not done. However, if you have a shockwave device, research shows that PRP helps the outcome when added to shockwave.

Of course, the idea is that always, always, always, of course, to be honest, but completely honest, especially when completely honest is to everyone's benefit. So it's not enough to say that PRP combined with shockwave has synergy. It's also worth noting that ***we have the only protocol that has been in use for over a decade, with real-world experience demonstrating that it is effective without serious side effects.***

So this is the gist of it. But again, when you download this, I'm going to put it in your handout section before I hang up, when you download it to edit it, add your own verbiage to it. Make it sound like you by, as you read it, when something sounds off rhythm or out of tune with the way your brain is thinking, edit it. This is a starting point. If you know a story about a patient that you want to include. Also, it's good to include if someone sends you an email or a letter, you can take that and of course remove the name and say, "

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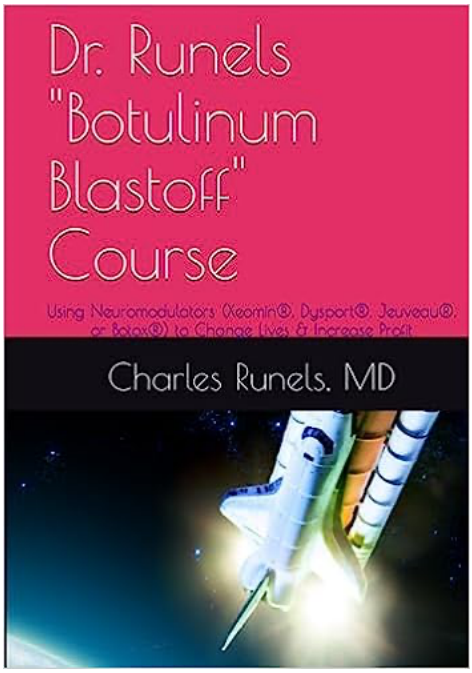
And one patient, name changed for privacy reasons, said this."

And always put your picture at the end. And if you can, something personal about either your training or about every fifth email, something about your family or a story. And you can make almost any story related to anything. So it's probably a topic for another Journal Club.

I've covered it in the past, but a segue like a fairytale where something concrete happens and you take it to a different level. So let's say... Let me just think of something. Always something not tragic, you never want to make something tragic into something that you're profiting from. So I don't know, what do we think?

We're coming up on, we have Hanukkah and Christmas and the New Year, so maybe we could tie it to one of those, to one of those holidays or to the New Year coming and you could tell something about your plans for the New Year and how, I'm just making this up as I go, and you look forward to the fireworks. And if you want fireworks on your New Year's Eve, now would be the time to be doing something like this.

And so if you start, it sounds sort of hokey, but if you actually make it a true personal anecdotal narrative, something like, "I'm sitting with my wife, we're planning the New Year's Eve party," or "The New Year's Eve, quiet at home," whatever, but any narrative that you can put in that's true that relates to what you're talking about, that would take this email and personalize it because right now you're not in it. ***And for your patients to be interested in it, they want to see a sprinkling of you.***



"So you've been thinking about treatments for erections," and now this might get pulled by your spam filter.

So, depending on what service you use, you might have to change that to male private bedroom function, male intimacy, male marriage function, or male marriage performance. Experiment if you have a spam filter warning. I use Ontraport, and it will warn me if there's an email that has ranks over a certain level with spam. And if so, then I know I need to censor what I'm sending out.

"You may have come across platelet-rich plasma. What many patients don't realize is that the results depend on the protocol, not just on PRP. It becomes more important in light of newly published medical research, a meta-analysis reviewed seven controlled studies. There's a link to it. One of the important conclusions was that outcomes varied significantly. And what we know is we have a protocol."

And it goes on why that matters and who may benefit. And then you could send that out.

And then what you hope... Hopefully, you can do something below this. You have a link to your webpage where you explain the P-Shot® on your website, but if not, put a link to the main website, priapushot.com. Okay?

You could almost take this and you could duplicate a lot of it, but you get the gist of it and you could write something similar by saying, "This paper just came out about stria and we have a protocol called the Vampire Facelift® that we know treats scars and striatus, it's a type of scar, and here's research showing that it can help."

And by the way, prescription-strength Retin-A, which is on that list, is vastly underused, which is different from retinol. Retinol is vitamin A, but retinoic acid is just, I think, much stronger and more effective.

And if you look at the science, it causes collagen to be laid down in a more organized manner. On the microscopic level, it restores collagen, which is what PRP does, and that combination is quite effective. So that was on the list of things that helped stria. So I think that combination of microneedling with our PRP or our Vampire Facial® procedure, followed by daily Retin-A at night, is tremendous.

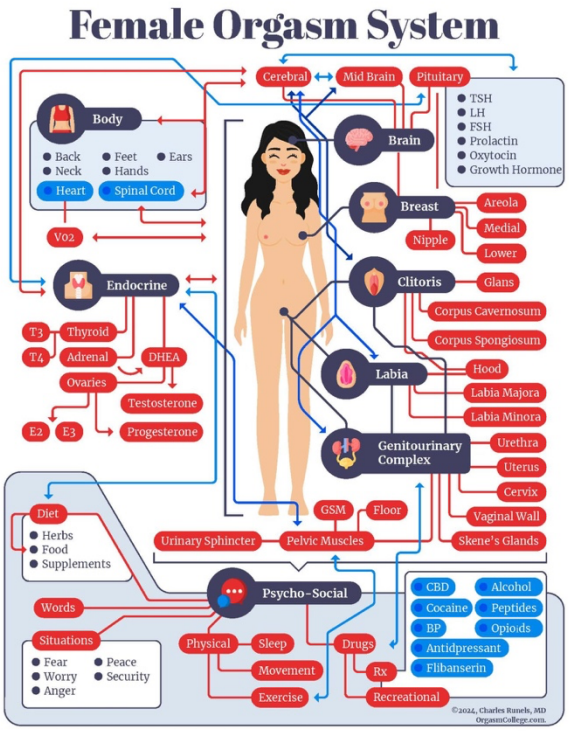
Okay, let me give you these. First, let me look and see if there are questions.

What's my insight on PT-141? So it seems to have here black and white, responses to that. It seems to have, of course, the side effect of nausea, and we have people in our group that use it a lot and with patients, it seems like it's black and white. Even if you give them something, Zofran or something to counteract the nausea, some people love it and some people don't. It's definitely worth thinking about. If you look at the study we just published, it's just over what you usually see in a placebo study. It's around the four range, and it's an improvement in the female sexual function index. And across the board in meta-analysis, most placebos give you about 3.6.[11]

If you look at women who are complaining of sex versus those who are not, and are happy with their sex life, the difference in female sexual function index is about 10, it's the difference from about 20 to 30. So it's definitely worth trying to see if it helps people, but because it doesn't move the needle a full 10 in the studies, it's usually not effective as a standalone.

So try it. I encourage you to try it. There aren't many downsides to it other than the nausea, and put other things with it. Of course, your hormone replacement, just good health. Looking at that whole female orgasm system, you have to think about the whole thing. Do they have hyperprolactinemia? Is their thyroid replaced? And then of course, we have the regenerative therapies with our O-Shot® for the area, but there's a psychosocial component.

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



And so if you haven't seen it yet, definitely take a look at that poster and think about... If you're not looking at the whole system, of course, someone should be looking at the parts that you don't want to do.

Perhaps you don't have time for the therapy part. But yes, it's soundly based, and you don't need me.

You can read the science without my comment, but what you might be asking is, "What's my impression from 2,000 plus doctors reporting to me, what they're seeing?"

And it's a black and white from patient to patient, and even from doctor to doctor. Some people love it. It's definitely not the... doesn't move the needle enough to where people are ubiquitously writing it and seeing full of great effects with every patient, but it's a valuable tool that should be in your toolbox. That will hopefully answer your question.

With our combination of the O-Shot® and Clitoxin®, the needle moved 12 points, and Clitoxin® alone moved the needle eight points, twice what you see with bremelanotide. And so, all the peptides, including growth hormone and insulin, are peptides. Peptides have become somewhat of a buzzword, but we are aware of over 200 peptides produced by the pituitary gland. So we're still on a very elementary school level when you think of it, and you do a profile of 10 hormones, maybe or 12 or 15, that's still a pretty small subset of the over 200 that have been identified.

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I think it's going to be exciting to see how the science advances. And of course, the beauty of PRP is its full of, we're up to probably 40, 50 different peptides and cytokines in there (IGF-1 and VEG and all these different things that are happening in this milieu)[12] [13] which there is no drug that does that. You can't go buy that at Rite Aid or Walmart pharmacy. It isn't made. So it doesn't mean we don't use the thing that comes from the pharmacy if it works, but I think it's right to acknowledge the fact that you're getting a mixture when you use the body's own natural platelet-rich plasma that cannot be duplicated in the laboratory.

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

[13] Pavlovic et al., "Platelet Rich Plasma."

Can I link to the Main P-Shot® Page?

Okay, let's see. Here's another one. Can I link the P-Shot® page?

Oh yeah, definitely. If you look at how our search engines determine what is valuable or not. Let me show you something that I think is very instructive.

Let's see. I've written a few articles for Medscape, and so I know their policy.[14] [15]

I want to show you, rather than tell you, and it answers your question. If you read any Medscape article, that's interesting. Marathon runners have a higher risk of colon cancer. Take a look at the number of links in here: one, two, the first sentence, one, two, three.

The point I'm making is that they do that for a reason. They want the search engines to bring people to their articles. And when I wrote for them, if you go in here, you'll find a few articles that I wrote; they ***want links to other websites***. The Google algorithm, of course, is like knowing gold; no one understands or knows the whole thing. Someone who works for Google may do, but we do know certain ideas, and having links to authoritative, helpful pages works.

It's a very good question I haven't discussed in a while, but there's a common misconception that if you link out, you'll lose someone.

Oh, yeah. See that (see video)?

They're linking within their own website. So you can have... That's the first trick. If you have links, link to another page within your website, and then the search engine sees you bouncing around. However, they also want you to link out, but they want the link to go to an authoritative source.

So within your article on your website or in your email, have links definitely to other pages in your website, but linking to the main page, say for the Priapus-Shot® or the O-Shot®, the main page for our organization, the search engines see that as, oh, this person is taking someone to what's considered to be the original, one of the authoritative pages, and so they give higher value to your page.

Just a few little simple ideas like that can make it so that you rule an area.

Just for fun, in the past, I've bought something that was brand-named, and one of them was a cream that Allergan was making. To prove that I could, I made it so that my website would come up before the company's website.

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[14] Medscape, "Don't Fear the Vampire Facial. Just Keep It Safe."

[15] Medscape, "The Female Orgasm Should Be the Twelfth Body System."

And that is doable, but to have your page, say for O-Shot or P-Shot, be the top of the list for a three- or four-state area, it doesn't take much. Another way is to drive traffic to that page, which you can do for free by sending emails that direct people there.

So, the short answer is that it helps your SEO if you have a link to our main page.

And if you're doing that and your patient is reading that, the chances of them going somewhere else are practically minimal. It's more likely they're likely to read the main website, see that others are doing it, see the research there, see the legitimacy of it by that crowd endorsement, and then to be more encouraged to go see you because of that. So it does help. Let's see what else. There was another question. Yeah, but you'll never see a Medscape article without multiple links.

Charges for our Vampire-CMA Procedures

What are the charges for the other procedures? I'll give you the quick answer and then I'll tell you how to be more sophisticated, or more effective would be the right word about it. So we have a minimum that you should charge. You should charge more if you're in a big city, if you have credentials or experience, or just because you think it's worth more, should be your standard price. We have a price list out there. It's usually on every website, and we have a master list... That it's a good question, I need to make that master list more available. But the short answer is the minimum we suggest advertising for the O-Shot® is 12, I need to increase that to 15, but it's still at 12.

In the beginning, PRP was so expensive that I charged more for the P-Shot® because it just costs so much more to spin the blood. I mean, it's not as expensive now, but so 1,500 is what most people are charging. And then repeat treatments because you have to do less history and physical, is more on the 950 to 1,000 range.

Some people charge quite a bit more than those prices. If you've known someone a while and your history... it's a longstanding patient, if you don't have to start from scratch with your history and physical, it's acceptable to charge them the 997 on the first visit. But an unknown patient coming in for a history and physical, it's not just a shot, and telling you why that price is justified. That's still two or three nights in a nice hotel to change someone's life. So when I'm trying to think what's the value of something, when the first person I trialed a P-Shot® to, he's recommended we charge $150,000. He said, "That's what it's worth. I know people would pay that much for a penis that's a little bigger and works better without having to take medicine." And I said, "Yeah, but I want it to be where everyone can have it." And even when I was mopping floors as a janitor, which I did for a while, I couldn't afford a new set of tires or to fix the transmission on my Ford Pinto, which I had at the time.

So if you price it in that range, it makes it where you're being compensated adequately for your time. And I think it helps to remind people of that. So when someone says, "Oh, $100," and what they're thinking is comparing it to a $25 copay. And I'll remind them, "Oh, well, that's less than a good set of tires. So if that's what your marriage is worth to you, less than a good set of tires, maybe I'm not the right doctor for you." And I'm not being sarcastic. I'm being honestly truthful about who I want to take care of.

And it's 1,500 for the Vampire Facelift® or one syringe of Juvéderm, 600 is the minimum for the Vampire Facial® that you're advertising, and if you do something less, we all give things away for free, just don't advertise it, because if someone discounts it on 4th Avenue, and then someone on 6th Avenue discounts it down to their price, you're in a bidding war and no one benefits, including the patients because we bid the price down to where we can't afford the materials.

It's 1,800 for the first P-Shot® and then drops to a $1,000 range for repeats. And the hair minimum is 600 per procedure. And if you add the toxin in, you should charge somewhere around an extra 800 to 1,000 because that stuff costs a lot of money. And if you do a wing lift, it's an extra 1,000, 800 to 1,000, most people get that as an add-on to the O-Shot®. A Vampire Breast Lift® is 1,800. So those are the short answers.

However, I know you've done research and have specialty training, and you're in a substantially sized city, so you should consider increasing those prices.

And then, if you want to offer a discount, you can reduce it back down to our minimum suggested price of $ 1,500.

I think that's all the questions today.

It was honored to have you on the call.

See you here next week. Goodbye.

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Here's an Email You Could Send

1. If you are licensed to offer the procedure, copy and paste one of the following messages into a new Word document. (click to download)<=
2. Then edit it so that it sounds like you.
3. Add a story or a personal observation if you have time.
4. Then, fill in the information with your phone number, etc., and send it to your patients.

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Tags

female sexual dysfunction, prevalence studies, diagnostic criteria, psychological distress requirement, Female Sexual Function Index, FSFI, arousal disorder, orgasm disorder, dyspareunia, lubrication disorder, stress urinary incontinence, platelet-rich plasma, PRP therapy, O-Shot®, P-Shot®, Clitoxin®, protocol-dependent outcomes, injection technique, clitoral injection, anterior vaginal wall injection, urethral anatomy, Grafenberg theory, regenerative medicine, shockwave therapy, PRP and shockwave synergy, vaginal laser therapy, pelvic floor magnetic chair, ICIQ scores, microneedling depth, stretch marks, striae treatment, Vampire Facelift®, Vampire Facial®, retinoic acid, Retin-A, collagen remodeling, peptide signaling, growth factors, cytokines, hormone replacement therapy, PT-141, sexual medicine research, clinical pearls, marketing kit for physicians, patient education emails, pricing strategy aesthetic medicine, medical SEO linking, authority websites, physician practice growth, Journal Club CME

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