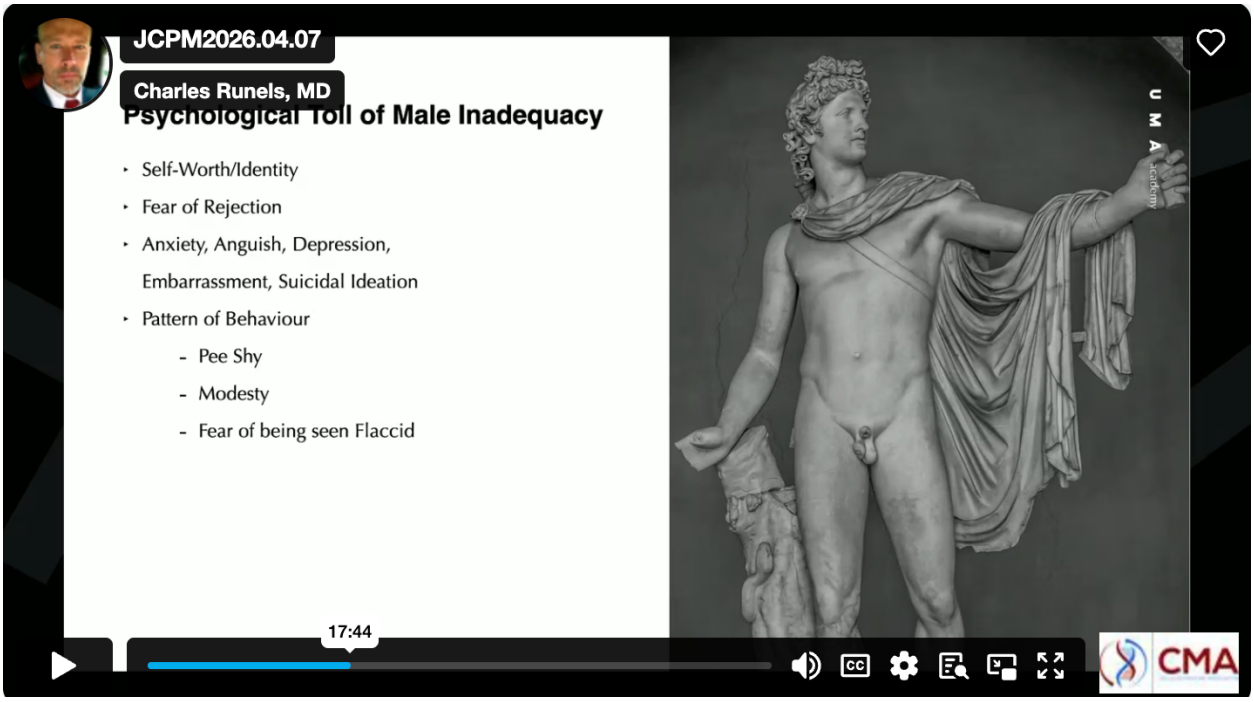
JCPM2026.04.07

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of April 7, 2026, with Charles Runels, MD.

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



Topics Covered

- Welcome and Introduction of Dr. John Leonardo
- Dr. Leonardo's Background and Path to PRP
- PRP Goes Mainstream: Early Days and Growing Awareness
- The Canadian Injector Advantage and Off-Label Teaching
- PRP for Alopecia in Transgender and Gender Diverse Individuals
- Toronto Injectors, Allergan Reps, and Off-Label Teaching
- PRP for Interstitial Cystitis and the O-Shot®
- O-Shot® Going Viral: The Green Journal Article and Judo Marketing
- PRP for Keloids, Scars, Safe Guidelines, and Stress Urinary Incontinence
- Dr. Leonardo Presents: Penile Augmentation — Overview and Background
- Locker Room Syndrome, Penile Retraction, and the Psychology of Male Inadequacy
- Traditional vs. Non-Surgical Options: P-Shot® and Size Outcomes
- Neuromodulators for Penile Relaxation: Before-and-After Results

- Dermal Filler for Penile Augmentation: Product Selection and Safety
- Technique, Volume, and Before-and-After Results
- Glans Augmentation, Longevity, and Long-Term Outcomes
- Potential Complications and Management
- Patient Testimonials and Private Training Information
- Q&A: Botulinum Toxin Dosing — 100, 200, or 300 Units?
- The Autonomic Nervous System, Clitoxin®, and Parasympathetic Tone
- PRP Systems: EmCyte, Anticoagulant Issues, and Recommendations
- Assessing Candidates: Dosing Protocol and Combination Therapy
- The Perfect Triad: Botulinum Toxin, PRP, and Filler as a Subspecialty
- Closing Remarks and Encouragement to Train with Dr. Leonardo

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 and Introduction of Dr. John Leonardo

Charles Runels, MD:

Thank you for showing up at the Journal Club. You're in for a special treat today. Dr. John Leonardo from up in Toronto and other places. He's truly international, has been in our group for quite a while and has his own innovations and ideas about some really important and current topics. I would like to go ahead and bring him onto the call. Then we'll speed read some of these papers with his comments and then he's going to tell you his observations about augmenting not only function, but girth with his techniques using HA fillers, toxins, and PRP for the penis. So, in for a special treat. We've had similar conversations in the past, but never with Dr. Leonardo. So, here we go. Let's start off.

Are you there, John?

John Leonardo, MD:

I am. Can you hear me?

Charles Runels, MD:

Yes. Would you mind just starting off with our history together and your history as a physician?

John Leonardo, MD:

Sure.

Charles Runels, MD:

I know a lot of people already know you, but some don't. So, take it away and let them know where you've come from and what you've been up to.

Dr. Leonardo's Background and Path to PRP

John Leonardo, MD:

Sure. Yeah. So, I was originally from the United States and lived in New York City for about 20 years, and that's where I did all of my medical education and finished residency in anesthesiology. I'm still board-certified in it.

And I worked in the New York City, New Jersey area, working with orthopedic surgeons, plastic surgeons, et cetera.

And then I relocated to Toronto in 2013 for a pain management position. And that's when I was interested in implementing PRP in our practice. As early as 2007, I worked with orthopedic surgeons using PRP, and I thought it would be a great treatment to offer our patients.

=>About Dr. Leonardo's Next Classes<=

And I found out about Dr. Runels because of PRP.

And I discovered that you can use PRP to regrow hair, to use it for medical aesthetics, and also for improving sexual function. So, in 2016, that's when I took Dr. Runels' course, and my life has changed for the better since then. Dr. Runels is great. He's an innovator in these procedures, and he's helped me help many of my patients with function and appearance.

And he's also helped my career in terms of marketing.

And I attribute a lot of my success to Dr. Runels. So, it's really an honor to be back here as a guest.

PRP Goes Mainstream: Early Days and Growing Awareness

Charles Runels, MD:

Well, thank you. Very kind. And several things about this are obviously you're a brilliant man doing with your background before you ever picked up a PRP syringe, and I'm sure you would've been wildly successful had we never met. But when you came to that class, and think about it, and decade ago, it was so, so, so early on. So, you weren't only brilliant when you showed up that day. You're also very

brave. Now, it's so close to becoming standard of care, at least in some arenas, that I keep thinking one day, it's going to actually be covered by insurance.

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

But anyway, those were the days when, if you spoke to your colleagues, unless they're orthopedic surgeons or dentists, it was unlikely they even knew what PRP was, right?

John Leonardo, MD:

Correct. And even the patients, because I remember at the time when I was starting, I would answer emails and phone calls, and I'm always explaining what PRP is. And then two, three years later, the public was a little bit more aware and I didn't have to do that anymore.

The Canadian Injector Advantage and Off-Label Teaching

Charles Runels, MD:

Yeah. It's like when I started doing testosterone pellets for women and men in 2000, 26 years ago, before Suzanne Summers wrote the first book, nobody knew what the heck I was doing. And then when she wrote that book, I thought, finally, now I don't have to explain it. And even more than that, I'm old enough to remember when I worked in the ER I was an ER doctor, and I would be at a social event, and people would say, "What do you do down there?"

This is a 35-bed inner-city ER with 4 trauma beds, 6 cardiac beds, 4 ortho beds, and the rest.

They'd say, "What do you do down there? Treat sore throats and stuff?"

And I would say, "Yeah, that's all I do."

And then the ER TV series came out, and suddenly I didn't have to explain what I did anymore.

So, we've been caught up in some scientific and cultural revolutions. So, I don't want to take up too much. I want you to be able to teach people what you want them to know. Before we do that, though, several really nice papers came out. I just want to speed-read through those and your comments. Let's do that real quick, and then I'm just going to stop so you can take it away.

PRP for Alopecia in Transgender and Gender Diverse Individuals

So, this first one, we've had so many papers about PRP for androgenic alopecia. This is the first one I've seen that covers that idea for transgender and gender-diverse individuals.[1]

---

[1] Ramos-Rodriguez et al., "Characterization and Management of Androgenetic Alopecia in Transgender and Gender-Diverse Individuals."

We have people in our group who use some variation of our O- or P-Shot® when they do gender-affirming type surgeries, but I haven't seen this talked about, and it's pretty much a rehash of the other ideas, but applied to this very particular population with a different mindset.

Have you had any experience with this in treating alopecia? I have not. Years ago when I did a lot of hormone replacement, I did some hormone transition stuff, but I didn't even know about PRP back then. So, have you done this before? Any experience with this?

John Leonardo, MD:

I treat a lot of alopecia, but not really for the transgender community, but I would think that all the science still applies. It's hormonal.

So, you control the hormones, particularly DHT. If you can reduce those concentrations, then the hair follicles flourish.

Toronto Injectors, Allergan Reps, and Off-Label Teaching

Charles Runels, MD:

Just a comment, before we go much further, comments about where you live [Toronto].

I don't know if you remember, but when I first decided, because a patient complained, she looked old after she lost weight with me way back, literally 20 years ago, 2006, I found out the top Allergan account was in Toronto. Cosmetic botulinum toxin came out of Canada, as we all know from Dr. Carruthers and her husband, and I went up there; his name was Mark Bailey. He and his nurse practitioners were doing around 75 million in injectables a year, and the man was a wizard. And what I found was in Toronto, because there's no FDA, the Allergan reps can teach off-label.

I heard an Allergan rep lecture for a full hour about her nuanced tips about using Juvederm, which we did not have in the US yet, in the mouth, just on the mouth from the rep. And so, what I found was if you're not an excellent injector in Toronto, you'll starve because the level... It was almost an inside joke that in the US, we were sort of hacks compared to the Canadians. You don't have to say too much about that, but am I right? Overall, Canadians are really good injectors. Would you agree with that?

John Leonardo, MD:

I think they're good injectors, but they're great injectors everywhere. And back then, things must have changed, because I think it's close to the US model in terms of being on-label and teaching.

Sometimes, I will speak for a company, and I have to tell the audience what's on the label and, "Well, this is how I do things."

So, then I kind of step aside saying, "Now this is off label. This is how I'm doing it."

Charles Runels, MD:

Interesting. So, it has changed. Yeah, this was way early. As you know, cosmetic botulinum toxin Botox was approved in 2002, and offered to primary care in 2004.

I picked it up in 2006.[2]

We still just had Restylane in the US, no other fillers. And so, yeah, I'm dating myself. That's definitely something. It definitely sounds like it changed there.

PRP for Interstitial Cystitis and the O-Shot®

This one I just want to bring up, because there was actually two reviews out in the past month showing the effects of PRP injected for interstitial cystitis. The one I keep hoping someone will do in our group, I think it needs to be a gynecologist or urologist, really, for the highest impact, is that you really don't have to inject into the bladder directly.[3]

For some reason, we're seeing amazing results for IC with just our straight-up O-Shot®.

The reason that's important, more than intellectually, is that it would allow primary care physicians to treat this problem. Most family practitioners and internists like myself would not be eager to do intra-vesicular injections.

Charles Runels, MD:

I would encourage anyone on the call who wants a low-hanging fruit, just grab 20 people with IC and just do the straight-up O-Shot®, and they will get better.

O-Shot® Going Viral: The Green Journal Article and Judo Marketing

This one, I put this here just to show you guys: I put out a press release that came out today, and I'll put a link to it in the chat box there.[4]

As you know, a couple of weeks ago, a Green Journal article supporting our O-Shot® was published, a very high-impact journal.[5]

---

[2] Medscape, "Should Primary Care Physicians Offer Cosmetic Procedures?"

[3] Simões et al., "Intravesical Platelet-Rich Plasma Injection for Refractory Interstitial Cystitis/Painful Bladder Syndrome."

[4] Association, "New Study Supports PRP for Female Sexual Function; O-Shot® Protocol Cited."

[5] Clarke et al., "Vaginal Injection of Platelet-Rich Plasma for Sexual Function."

And they referenced our original paper about the O-Shot®,[6] and it made the popular press.

It bled over into MSN and Daily Mail as the O-Shot® was shown to be helpful to women who want better sex.

There's a type of marketing I call judo marketing or vampire marketing. Either way you want to call it, the idea is that instead of spending a lot of money to bring a lot of attention, you look at where the attention is already, and you go there.

You get tapped into the flow.

Well, right now, once again, the O-Shot® is going viral because of that study and the popular press picking it up.

So, I wanted to tap into that and make it easy. Let me show you guys where it is. It's a great one to refer your patients to, since it is going viral now. Let's see. Here it is right here. Way too slow. I'm going to sit there and watch that wheel turn. I'll put the link in the chat box and just take my word for it. When you go to this link, you'll find it ties together the Green Journal article.

The Press release states that our O-Shot® procedure supports the idea that just squirting PRP any way you want isn't always the best practice, and it includes a link to our directory, right?

So, this is a great one to show if you want to put a link to it on social media or write an email about it. This is a great one to show your people because it is complementary. It's not too often we get one, an article in the Green Journal.

Hey, John, are you seeing the actual paper, or are you just seeing a list of papers?

John Leonardo, MD:

I'm seeing a list of PDF files.

Charles Runels, MD:

PRP for Keloids, Scars, Safe Guidelines, and Stress Urinary Incontinence

Interesting. Interesting. Okay. All right. Not sure why it's doing that. I'll just drag the PDF file over into the handout section.

I'll tell you, this next one is about using PRP for keloids and scars in the early phase of a traumatic scar.[7]

---

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

[7] Blandón et al., "Platelet-Rich Plasma for Immature Post-Traumatic Scars and Early Keloids."

Very supportive. As always, it ends with saying we need better trials, but it's there.

And then the next one is talking about some guidelines for keeping PRP safe.[8]

I need to get to where you are, John. I want you talking. So, I'm going to just tell about these and then I'm going to turn it over to you.

And then the last one is about meta-analysis. I'm going to go ahead and add a link here because this is probably the most important paper we'll be discussing this week.

So, I'm putting a link to it, and it's open source. It's a meta-analysis showing that ***PRP helps with stress urinary incontinence. Very supportive.***[9]

Of course, some of the techniques are more like our O-Shot® than others, but you could not ask for a more supportive article.

I think I want to turn that over to you now, John.

John Leonardo, MD:

Okay.

Dr. Leonardo Presents: Penile Augmentation — Overview and Background

John Leonardo, MD:

All right. Fantastic. So, UMA Academy is an aesthetic training academy in Amsterdam, and it's run by Dr. Jani van Loghem, and he's pretty world renowned in terms of the aesthetic field, and he's an expert in Radiesse, calcium hydroxyapatite. So, he and I are co-authors along with a bunch of other authors like Sebastian Cotofana and Shino Bay Aguilera. And we wrote a textbook all about calcium hydroxyapatite. So, I contributed the penile augmentation chapter and in its second edition also contributed a chapter on nerve blocks to the face.

So, I created this PowerPoint presentation with UMA Academy. I visited Amsterdam last year and created this. And I just kind of edited this out for today, just so it's a little bit more concise. So, this is all about the penile augmentation and then a little bit about me. So, the background is in anesthesiology. I'm a co-author in this textbook and I've been a member of the CMA since 2016 and I've won some awards and I'm a trainer for various companies.

---

[8] Stern et al., *Platelet-Rich Plasma Therapy: Key Infection Prevention Practices and Strategies for Safety Risk Reduction - CORRIGENDUM*.

[9] Utama et al., "Therapeutic Efficacy and Safety of Injectable Platelet-Rich Plasma in Women with Stress Urinary Incontinence."

So, we're going to talk about why penile augmentation is desired and the available treatment options, particularly the non-surgical ones, PRP neuromodulators, and fillers, and then we'll talk about using dermal fillers for penile augmentation.

Locker Room Syndrome, Penile Retraction, and the Psychology of Male Inadequacy

So, what concerns men sexually? They want to perform well. They want endurance, so treating erectile dysfunction and premature ejaculation is high on the list. And then just sex appeal. How are they perceived as a sexual being? And how do they measure up with their peers? There's something called locker room syndrome, and that's tied in with a hyperactive penile retraction reflex.

All right. So, locker room syndrome is a real phenomenon where guys are actually more embarrassed or self-conscious in front of their buddies in the locker room, their teammates, as opposed to their sexual partners. Because if you are a grower as opposed to a shower, you're suffering from shrinkage when it's cold, when there's a situation of stress or embarrassment. And if you're in the locker room and you're seeing naked, you're being judged when you are shrunken and no one knows the potential that you have in terms of length in the erect state. And that's why guys feel more self-conscious about that because when they're with their sexual partners, of course they see them with their erect penis, which is a lot larger than their retracted penis. So, the hyperactive penile retraction reflex, we can blame the dartos muscle for this. In the penis though, it's actually a layer of connective tissue. There's no muscle there, there proper, but within the scrotum, there is.

But I figured back in 2019, there was a study of injecting neurotoxin into the penis to improve erectile function. And I thought, well, if there's a muscle responsible for retraction, if we target that, then maybe we can address shrinkage. So, there's a psychological toll when it comes to male inadequacy. They question their self-worth, their identity, there's a fear of rejection, there's anxiety, anguish, depression, embarrassment, and even suicidal ideation. I've had patients come in like that. And they exhibit a pattern of behavior where they're pee shy. They won't urinate even at a urinal with a barrier and there's modesty. They don't want to be seen naked ever.

So, if they're going to shower at the gym, they always put a towel around their waist. There's just this general fear of being seen flaccid, right?

Charles Runels, MD:

I have to put one thing in here, John. So, I'm from Alabama and my dad always called them when you're swimming in a cold creek and out in the woods, which you do in the south, if you don't have a swimming pool close and you live in the rural south, you have the bank walkers and you got the waders because the cold water, when it draws it up, you just stay in the water so nobody can see. And then you got the proud guy up walking on the bank. So, I don't know how that goes over in Toronto, but-

John Leonardo, MD:

Absolutely.

Charles Runels, MD:

... you've got walkers and waders.

John Leonardo, MD:

Yeah, absolutely. And Seinfeld, there's that scene with George Costanza where he just got out of a cold pool and he's caught pants down and the lady that's looking at him's got a smirk on her face and kind of laughing. And he's like, "It was cold. The water was cold." So, the growers, they all share that stress and anxiety.

Charles Runels, MD:

That's right.

John Leonardo, MD:

Traditional vs. Non-Surgical Options: P-Shot® and Size Outcomes

So, when you see these patients, they want you to be able to address it. And up until recently, it was just basically normalizing their size, maybe a little bit of psychotherapy or they were put on antidepressants, but patients actually really want you to do something about it and now we can.

All right. So, some of the traditional treatment options were surgical, right? Like the suspensory ligament release. And there's a study in Europe that showed that there's only about a 30% satisfaction rate with this because often there would be reattachment with scar contracture and then you'd end up with a shorter penis and surgery is just highly invasive.

All right. So, now the non-surgical options, the P-Shot®. When I first trained with you, you said that don't advertise about size increase because I think guys will be really disappointed, right? But I conducted a small-scale study with my chronic pain management patients, and I followed them during the course of about six months. And I found that, you know what, they grew bigger. So, in these examples you have on the left gentleman just under six inches and then he's just under seven inches. So, he grew about an inch, the gentleman in the middle, just above five inches and then just above seven inches. He grew two inches. And the guy on the right, just above six inches and then just about seven, all right? So, you can get increase.

And this was just with one treatment with the double spin centrifuge, and this is about four months out. So, I then started advertising that yes, you can improve size and function with the P-Shot®. And in so doing, I found four caveats in terms of treatment failure. The first one being, well, most of these guys in my study were kind of middle age, 40s, 50 score showing mild to moderate ED. And the guys that had absolutely no ED at all, SHM score of like 24 out of 25, 23 out of 25, they didn't really grow that much. And if you think about it, if you improve the circulation with someone who's suffering from ED, that penis is getting better perfusion and it's of course going to be bigger, right?

Second category of guys, they didn't do their exercises with the pump and cylinder. So, you can get some size with the P-Shot® alone. You can get some size with pumping alone, but the combination of the two, that's where you really get the benefit, right? The third category of guys, they never took measurements and photographs of them before treatment. So, every day is your new baseline and you forget where you started from. And sometimes they did grow, but they just forgot. And then the fourth category of guys, on paper, they seem like the perfect candidate, but it's not 100% efficacious.

Neuromodulators for Penile Relaxation: Before-and-After Results

So, there are treatment failures regardless. Okay. And then neuromodulators, okay? So, back in 2019, this is when I developed it, when I saw you in 2022, you had just come up with Botox. And in my experience, it was also size increase and also endurance. And the way that I used it was to turn growers into showers and improving those three categories, erectile function, endurance, and then also shrinkage, right?

So, here are some of my before and afters. All right. The befores and the afters are about two weeks apart from each other for these three patients. So, you see how much relaxation that they have. The gentleman in the middle and the right also got scrotal neurotoxin known as Scrotox and you see the relaxation there as well. And then these two guys, okay, they're looking nice and relaxed. This is the same gentleman in all three views. And then here you can see on the right, it's just the before and after with the neurotoxin, and then he had filler. And so, he's hanging even better because of the weight of the filler and the action of the neurotoxin. And then to the right, this is after he's had toxin filler in the erect state. And you could see that it doesn't change the erect length. It's girthier because of the filler, but the benefit of the neurotoxin is the flaccid length.

=>About Dr. Leonardo's Next Classes<=

And here we have a similar gentleman on the left. It's just the neurotoxin in the middle, it's toxin filler. And then afterwards when he's erect, you see that the length doesn't change, but he's girthier because of the filler. And then this is pretty cool because this is the same gentleman. So, the one photo on the left, you saw that already. That was after his first session, two weeks after. And he comes to me on a regular basis every three months. And for about four years, he came back and I was like, "You know what? You are due for your tox and typically we would think it would have worn off, but you still look maximally relaxed." And the photos in the middle and to the right demonstrate the before and right before he's supposed to get his treatment. So, this is after four years of just perpetual relaxation every three months. And it looks amazing. And this is the same gentleman, different angles.

Dermal Filler for Penile Augmentation: Product Selection and Safety

All right. For dermal filler penile augmentation, we're going to talk about product selection, safety considerations, and I'll mention a little bit about the protocol, follow-up, photos, and potential complications. So, most aesthetic physicians are familiar with HA dermal fillers. Not many people are comfortable with Radiesse or calcium hydroxyapatite. And then this is a side-by-side comparison. HA is dissolvable by hyaluronidase. It draws water, but sometimes it can have a spongy fatty consistency.

Depending on the product and your technique, granuloma formation may occur. Longevity is about 9 to 12 months, but recent MRI studies show it can often linger for years; it's just not really doing its job quite as well as freshly injected. For the calcium hydroxyapatite, it's not dissolvable, but if you make an aesthetic mistake, you can always inject it with normal saline, massage it, or hyperdilute it. It's no longer going to fill, but it will still retain its biostimulatory effects, creating collagen and elastin.

And that's one of the advantages I love about CaHA. It feels like flesh. You have a real fleshy texture to it. And it has a very low incidence of granuloma formation. The longevity can range from 14 to 18 months, sometimes longer. But I prefer a hybrid. I blend the two, and you get the best of both worlds. You get the bulk of the HA to a degree; it's dissolvable. You form collagen. So, you've got that real fill texture and the longevity and the bulk. So, everything that you want out of a filler, right?

In terms of safety considerations, we perform the P-Shot® in the corpus cavernosa, and we should all be aware of where that is. But if you look at the anatomy and cross-section going from superficial, you have the skin, then you have Colles' fascia, which is also known as dartos fascia, then you have areolar tissue, and then you have Buck's fascia. So, I like to sandwich the filler between the superficial and deep connective tissue layers. And when that happens, you get really great results. If you inject too superficially, sometimes the penis can have contour irregularity depending on the properties of your HA filler, or sometimes it could look like a blister or so, particularly if it's really hydrophilic. But if you bear it between these two connective tissue layers, typically it's nice and smooth.

And then this is just ultrasound imaging and different views, transverse views to the left. You can kind of make out the corpus cavernosum, and then the longitudinal views, and you see the little white arrows. We want to inject the filler as deep as possible. And that's kind of where that's keep things safe. I use something called AccuVein. It helps me visualize veins, and I use aseptic technique. We don't want to introduce bacteria with our implant, and I'm using a 22 gauge blunt tip cannula, either 50 millimeters or 70 millimeters. A 22 gauge is a lot safer than 25 gauge. And when I'm using the AccuVein, I see my cannula gliding past veins. It doesn't visualize arteries, but I kind of take comfort in that it's gliding past the veins because the arteries have thicker walls, right? So, if it's gliding past the veins, I'm sure the arteries are going to be unharmed.

And also with a 22 gauge cannula, typically that diameter is larger than the arteries found in that plane. So, it would be very difficult to cannulate an artery there. And then there's safety in that I'm diluting my calcium hydroxyapatite. So, as opposed to injecting it undiluted, it's going to be kind of lumpy and I think more prone to nodules. And then I also have a shockwave device in case things go wrong. And I have an ultrasound device also to help me figure things out in case there's a vascular occlusion.

Technique, Volume, and Before-and-After Results

This is just kind of a schematic of how I do it after anesthetizing the penis, I like to introduce the cannula kind of mid-shaft on both sides. And when I do that, I can access proximately and distally, and I can use the 50 millimeter. I think there's just a little bit more control. The 70 millimeter is fine, but it's a little bit flimsy and sometimes it's difficult to control. All right. So, I like to start off at midshaft. Sometimes when the patient comes back, if they seem to be a little bit thicker more distally, then I can place the cannula

distally and use a longer length to inject proximally, right? So, I'm not always married to that starting point. So, it depends on the indication and where you want the volume because it's a little bit more difficult to place the volume where you've placed your cannula.

So, here's some before and afters. After 10 mLs flaccid, you see that it's bigger, it's thicker, right? And some of the superficial veins are a little bit hidden. It's kind of like when you do the dorsum of the hand, right? A hand rejuvenation. It's similar to that. And erect, you see the difference there. Patient two after 12 mLs, placid and erect. And then this patient, nine months after 13 mLs, seven months after topping it off, you see how he's getting bigger a little bit at a time. You look at his measurements, five inches, five and a half to six. So, it's something that can be built out and topped off a little bit at a time. You don't have to hit the home run all in one session.

Now we're using even more filler, about 30 mLs. This gentleman was about seven inches erect. So, he could handle the 30 mLs and that's the girth that he wanted. If someone has a shorter penis, like four and a half, I think it'd be very difficult to stuff 30 mLs there. And then looking at him flaccid a year after the 30 mLs, he's still thick. 47 mLs is not all in one sitting. I think this is after about three sessions or so, but flaccid and erect, you see the difference that it makes.

And then 54 mLs over 14 months, flaccid and erect. My motto is you only bigger. So, it should look natural. I don't want it to look weird, like some providers sculpt only the dorsum or just the sides, but I want to kind of create more natural contours. So, this gentleman before and then his after with his toxin fillers.

And then we can also augment the glands. Okay.

Glans Augmentation, Longevity, and Long-Term Outcomes

In publications dating back maybe like a decade and a half or so, they use Perlane to treat premature ejaculation. And the benefit lasted for about 5 years, right?

So, this is a great treatment for premature ejaculation. I'm not promising my patients five years. I'll tell them maybe about a year and a half to two years. If they get three years out of it, great. But if I tell them five and it peters out at three, they may be disappointed. But you can augment it also just to increase the size.

It's a little bit more difficult because the shaft, everyone puts their money into the shaft and you've got the tunica albuginea, which is this nice, thick base. And when we augment, we can increase girth outwards. But with the glands, it's just like a three-dimensional sponge.

So, when you're just injecting filler there, you might not get quite the dramatic girth increase compared to the shaft. And then in terms of longevity, I've had three patients come back after the hybrid after 32 months, and all three of them ended up being bigger than baseline. Two of them realized that they were still augmented. The one thought it was all gone, but because of the Radiesse turning into collagen, he

wasn't aware that he was still augmented. Here's one of those gentlemen. And then here's another. This is a gentleman that didn't realize that he was still augmented compared to his baseline, right? And then 32 months after, still going strong.

Potential Complications and Management

Potential complications. There could be persistent swelling. You could be just really conservative in terms of management and just have the patient position the penis upwards to allow gravity to drain.

Often, you don't really have to do anything. If there are contour irregularities, you can target with a small amount of hyaluronidase just to soften the contour. Or they can come back. And I'll tell my patients, sometimes you can come back and we can build around a contour irregularity. So, it serves two purposes, increased girth, and then also just to make it look better. Sometimes, there could be nodules.

Often you can take a cannula and break it up if it's a little bit persistent. But often I'm just kind of injecting with a combination of dexamethasone and Kenalog. If it's a small lesion, sometimes there can be infection.

In the United States, a lot of my colleagues are doing this under sterile conditions. And in Canada, I try to be as sterile as possible, but I wouldn't call it a sterile technique, but I really don't have problems with infections. The only times that's happened were with gentlemen who were maybe construction workers, and they're working outside, and the sweat is dripping into the injection site. Or I've had two patients that had sex prematurely before those entry sites healed. I tell them no sex or masturbation for two weeks, and they're having sex two days later, and they've had infections, but usually covering them with antibiotics should be perfectly fine.

Sometimes, they can have persistent edema. You just numb up the area, use a large bore needle, even just 22 gauges adequate, and then you express the fluid.

There could be filler migration. If that happens, you can dissolve and then treat with your neurotoxin just so that there's less shrinkage and less size variation between flaccid and erect so that you have a much better contour.

And then of course, there's vascular occlusion where you have to run through your protocols.

Since I have an ultrasound, I've had three in my practice, which still accounts for about 1%. It's still rare, but this is a high-risk area. So, I know how to handle it. And I'll take an ultrasound and I'll survey the area and kind of pinpoint where the occlusion is.

And then I use my hyaluronidase, I dissolve it, restore circulation, and everything is fine. My three patients did not have any permanent injury, and two of them came back for more filler because they absolutely enjoyed it.

So, this is an example of persistent edema. So, this gentleman was actually uncircumcised. He had filler and I told him, "You really should dissolve the filler before a circumcision."

But he's like, "No, no, no, no."

No one wants to dissolve their filler. So, of course, he got a circumcision; he had all this persistent edema. And then I just pretty much injected with hyaluronidase, and then I expressed everything, and it looked so much better.

Now, this is not my work. This is when providers are not assessing for shrinkage and they're just going ahead and filling.

So, with my patients, I examine them beforehand and make sure that if they do have shrinkage, they're going to get their neurotoxin prior to the procedure. However, I'm getting a lot of patients flying to me on the same day.

So, I'm doing the neurotoxin the same day, and I'm actually using three vials, just because I want to be aggressive about it in terms of onset of action and longevity, right? But you just basically, if these people come in, you just dissolve, and then you treat them with neurotoxin and then refill when they're much more relaxed.

And then this is one of my cases of vascular occlusion.

All right. Three days post-op, he was developing some necrosis. I took care of the occlusion and I use a product called CO2Lift. It's a topical form of carboxytherapy. It tricks the body into thinking that it's hypoxic. So, it opens up blood vessels and improves circulation. It helped facilitate the offloading of oxygen, and it healed up really well, such that I had him lined up for treatment at a hyperbaric oxygen chamber facility, but, of course, it happened over Labor Day weekend, and it was closed.

And I saw him on Friday, and I gave him the CO2Lift six treatments, and he canceled his appointment at the hyperbaric facility on Tuesday, and he's doing great. He's one of the patients that continues to see me for augmentation.

Patient Testimonials and Private Training Information

So, that's about it. This is just a little comment or testimonial from one of my patients. I wouldn't be anywhere without my patients who approached me back in 2019.

And I don't know, something was in the air that year where patients would come to me and say, "I want you to give me a bigger penis, and I want you to just figure it out and use me as a guinea pig." So, I had a handful of those patients and that's how I developed my neurotoxin protocol along with the augmentation with fillers.

And that's about it. I do private training, and if you're interested, you can go to my website, the QR code leads you to the website, or you can email or call the office and we'll give you information in terms of pricing and you pick what you want: augmentation with fillers, one model or two models. Do you want neurotoxin with the scrotum or the penis or whatever? And we'll take it from there.

Q&A: Botulinum Toxin Dosing — 100, 200, or 300 Units?

Charles Runels, MD:

Very, very encouraging. We have quite a few on the call and some questions that have already popped up. I'm going to ask a couple myself before I get to those. You mentioned using three vials. This actually came to my text messaging a couple of days ago.

Someone had injected botulinum toxin 100 units using our Priapus Toxin® technique and the person didn't get an effect and wanted to know if they should use more. And one of our urologists routinely uses 200 units instead of 100.

When you said you used three vials, were you saying that sometimes you'll use 300 units instead of 100 units of botulinum toxin?

John Leonardo, MD:

That is correct. So, as high as 300 units, I used to do was everyone would start off with a hundred units, but I found that you had maybe 65% of the patients that were really happy.

And it was a tough sell to say, "Oh, you know what? Let's do another vial. Let's do another 100."

But now I'm doing 200 units from the get-go because maybe 85% of the patients are really happy with the results, right?

So, the 300, those are the ones with really severe ED or retraction.

So, I'm either giving 200 units or 300 units. If it didn't work with 300 units, 400's not going to do anything. So, that's my cap.

And I've been doing this for a good six, seven years and no systemic side effects from these patients. And that's like the big fear. And some of my patients discovered that on their own. If they were just hands-off for three days, they got better results.

Charles Runels, MD:

Mm-hmm. So, a couple of things about that. By the way, several comments about people enjoying your lecture. Could you put that page back up? Some of them missed how to find you; it went away.

John Leonardo, MD:

Oh, okay. Sure.

Charles Runels, MD:

Yeah. And if you actually do the LD-50 for botulinum toxin, it works out to where it's about one vial per pound. So, in 180-pound man, you would have to inject 180 vials of cosmetic botulinum toxin to reach the LD-50. [10,11]

So, we're still, the 300 units, as you know, that only takes you to about what you routinely do if you follow the FDA guidelines for treating migraine.[12] It's still not a huge dose.

That 100 units treatment started, as you know, John, it started because those four or five initial double-blind placebo-controlled studies that came out, one with Dysport,[13] two with Xeomin,[14,15,16] one with Botox®,[17] they were using a hundred units.

And the Xeomin people were the only ones who did 50 and 100 and the 100 unit dose, it lasted up to a year, the 50 units were mostly wearing off at six months. So, you're probably going to get longer lasting results with that 300 units as well.

John Leonardo, MD:

So, is that in terms of ED or shrinkage?

The Autonomic Nervous System, Clitoxin®, and Parasympathetic Tone

Charles Runels, MD:

They were talking ED.

Only one of them mentioned, one of them actually did mention, as it wasn't the reason for the treatment, one of them actually mentioned that the flaccid penis was larger, and they postulated that it

---

[10] Stephens and Balls, *LD50 Testing of Botulinum Toxin for Use as a Cosmetic.*

[11] Dhaked et al., "Botulinum Toxin."

[12] Zandieh and Cutrer, "OnabotulinumtoxinA in Chronic Migraine."

[13] Giuliano et al., "Safety and Efficacy of Intracavernosal Injections of AbobotulinumtoxinA (Dysport®) as Add on Therapy to Phosphosdiesterase Type 5 Inhibitors or Prostaglandin E1 for Erectile Dysfunction—Case Studies."

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

[15] Habashy and Köhler, "Botox for Erectile Dysfunction."

[16] Abdelrahman et al., "Safety and Efficacy of Botulinum Neurotoxin in the Treatment of Erectile Dysfunction Refractory to Phosphodiesterase Inhibitors."

[17] El-Shaer et al., "Intra-Cavernous Injection of BOTOX® (50 and 100 Units) for Treatment of Vasculogenic Erectile Dysfunction."

was secondary to modulating the autonomic nervous system, downregulating sympathetic tone, and, therefore, relatively increasing parasympathetic tone.

Priapus Toxin® for ED

And as we all know, parasympathetic tone is what causes erection.

So, yeah, when you came by, and we talked about it years ago, I wasn't really talking about that very much because even though it was mentioned, that was really the clue that led to our Clitoxin® procedure, because after reading that, I dove into the headache literature.

And in the headache literature, they talk about, which he referenced, he gives you the clue. And so, if you dive into the headache literature, they document botulinum toxin migrating along the axon to the caudate nucleus and the trigeminal ganglion,[18] blocking some of the pain fibers, interfering with the signals from the meninges, and downregulating the sympathetic nervous system.

So, you're essentially using the procerus when you inject botulinum for migraines; you're using the procerus as a port to inject the caudate nucleus.

And so, that clue was given in one of those double-blind, placebo-controlled studies.

So, that led me to think, "Well, what happens? What's the anatomy in women?"

And getting out the textbook and spending a year and a half, two years thinking about it, which led to eventually my wife injecting her clitoris when she kept hearing me rave about, if that happens in women, it's going to go to the ganglion lining the lateral vaginal wall, which connects to the midbrain. And so, if it had the same effect, it should increase libido and orgasm in women.

And of course, the one paper we've published so far showed that indeed when you add botulinum toxin to the O-Shot®, you get an increase in arousal and orgasmic capabilities.[19]

So, I think what you're doing, of course, is relaxing smooth muscle with increased blood flow, as you said-

John Leonardo, MD:

Absolutely.

Charles Runels, MD:

---

[18] Ramachandran and Yaksh, "Therapeutic Use of Botulinum Toxin in Migraine."

[19] 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 increasing volume. But I think you're also, and I know you know this, you think you're probably having even a more profound effect on the autonomic nervous system with that 300 units, which is displayed by more flaccid penis, which is basically, you could say the length of that flaccid penis is going to be directly proportional to the relative increase in the parasympathetic nervous system.

So, it's a beautiful lecture, and I love your innovations. I love how you've taken things to another level. And thank you for sharing so generously with us.

For the people on the call, just know that I've seen Leonardo's hands at work and his mind at work. As he mentioned, I've been blessed enough to share a room with him twice now, and I cannot encourage you more strongly to take his course.

PRP Systems: EmCyte, Anticoagulant Issues, and Recommendations

So, one person has asked, "Which PRP system do you use?"

John Leonardo, MD:

I have EmCyte. It's a great dual-spin system. You have it as well. When I first trained with you in 2016, I was using something else, and when I revisited in 2022, you're using EmCyte.

And I was like, "Well, that's what I'm using," right?

And I still stick with it. And there are all sorts of new PRP systems and PRF, and the numbers are better with EmCyte. And when I do hair, it's just a one-and-done treatment. I'm not doing a series of three because I'm using EmCyte, right? The more platelets used, the merrier, the more therapy.

Charles Runels, MD:

Yes. And quite a number of people use EmCyte.

My only caveat with EmCyte is that, at one time, we had a series; it lasted only about six months. We had multiple reports of people having increased pain from that, and the company was kind enough to swap out the anticoagulant because otherwise, it's just a container, right? So, they swapped it out and I would just recommend people... It's a great kit and it's been now, I guess, a year and a half since that happened. But if you have their old anticoagulant, have them swap it out for ACD solution otherwise...

John Leonardo, MD:

Pain during injection or what or...

Charles Runels, MD:

We had about a dozen people who had gone from good erections to flaccid, can't get it up. And women with pretty good sexual function trying to make it better, and now their clitoris is completely numb, like you anesthetized it. Horrible pain during and immediately afterward.

And I talked with the owners and they agreed to swap. I said, "There's nothing in it, but that maybe you got a bad batch of anticoagulant because there's nothing else that could make a bad result." And in every case it resolved, but it was pretty scary.

You can imagine you take a woman and now she can't even feel her clitoris.

But in every case, it resolved. In every case, it was EmCyte and in every case, it was that sodium citrate from that one little timeframe.

And I just told people to swap it to ACD, and the company was kind enough to do so.

So, I bring that up. If anyone's on the call and had that experience, then it was probably a year and a half ago and now I haven't heard that complication for probably about a year. And I think it's a lot of people in our group use it and it's a great kit.

So, you may not have known that I sent that email, probably about a year and a half ago. And so, for those who got it, I wanted them to know that I haven't heard that problem for a while, but the company agreed to swap that sodium citrate.

Regen has sodium citrate, and I've never had that problem with that kit. And when I say that problem, I mean people calling me with that problem, but I mean, we had a run-in about a month and a half ago. We had 12 people, all with that kit.

And of course, you've taken this to a different place from what I normally teach. So, congratulations. I love it.

John Leonardo, MD:

Thank you.

Charles Runels, MD:

Assessing Candidates: Dosing Protocol and Combination Therapy

And we're doing this because I want to encourage people to go see you.

Let's see. Other questions: do you now start with a higher dose, 100 units? I mean, are you starting at the 200 or the 300 level or what do you usually do when they first get your botumlinum toxin?

John Leonardo, MD:

So, I examine them, right?

So, I'll take a ruler, plus, I'd say, "Drop your pants and before you do, most guys are going to fluff themselves, make it look better."

I'll put the ruler up next to it, take a photo, and then I'll track the penis so that it's longer, stretched, and then I'll take the stretched length, and then I'll determine if you're mild, moderate, or severe. And typically, mild to moderate is your sweet spot for any type of therapy. If they're severe,

I'm going to say, "All right, we're going to go with three vials, and the three vials may or may not help you because you're that severe."

The ones with mild retraction may not notice anything.

So, your sweet spot is actually kind of moderate. And I kind of arbitrarily picked a range of 50% to 80% between flaccid and stretch length. If you're in that ballpark, you're going to be a great candidate to address shrinkage.

But it's either 200 units if it's mild to moderate, or 300 if it's moderate or moderate to severe.

The Perfect Triad: Botulinum Toxin, PRP, and Filler as a Subspecialty

Charles Runels, MD:

And I would second your observation that after doing this for more than a decade like yourself, that the P-Shot® alone, you will see growth, but I tell people it's going to be only something in the neighborhood of about 10%.

So, if you have a 3-inch erection, it's not going to be so dramatic where it's more easy to put an inch on a 5 or 6-inch penis than it is on a 3-inch erection. And so, unfortunately, those who want it the most, you're least able to help. But with this filler, of course, you can have a near instant dramatic change. And then you combine it with a toxin.

It really is the perfect triad, isn't it? I mean, crazy how fun it is when you have botulinum toxin, PRP and filler, and now you're doing this combination filler, it really is becoming this high art. I think it's going to turn into almost a subspecialty. In your case, you've made it a subspecialty, but it'll probably take another decade, but eventually this will be a subspecialty of urology.

When I first first started teaching my little workshops now 16 years ago, there was a radiologist that came down from Birmingham. He was an OG that I think mostly just came to see what I was doing because that's my alma mater. And when I finished, he said, "Charles, they're going to take it from you." He said, "We started out," speaking of radiologists, "We were the first to do heart caths and then the cardiologist took it." And he said, "You're going to run through the briars, get criticized, and then 20 years from now, it's going to be only gynecologists and urologists can do these procedures." And I said, "Well, maybe, but if by that time we have thousands of doctors trained, it's going to be hard to put the horse back in the barn, so to speak."

And of course, the other flip side of this is that these procedures can work the way that fillers work in the plastic surgeon's office, where you have the high-end surgeries, like you're working with a urologist, you have the surgeries. And they wind up doing more surgery if you have an injection subset within your office.

So, as an example, I know one of the urologists in our group who teaches penile implants in Chicago at one of the medical schools.

He said, "I do more implants because I offer the P-Shot® procedure."

One of our gynecologists said, "I do more mid-urethral slings because when the O-Shot® works, they love me. When it doesn't work, they know they've tried everything. It's time for a sling."

Any comments on that strategy? And do you see that happening around you?

John Leonardo, MD:

Absolutely. I got a lot of penile augmentation traffic just because of P-Shot®, right?

Guys would come in, I would conduct the consultation, and they would come in under the guise of erectile function improvement. Then all the questions were about getting it bigger, right?

And then now, okay, I can make it bigger and yeah!

Closing Remarks and Encouragement to Train with Dr. Leonardo

Charles Runels, MD:

Right. Yeah. Well, I'm so honored and happy that you came on the call and it looks like we answered all the questions except one was wanting to know if you're... I think the answer that you're still using the anticoagulant that comes with an EmCyte kit, right?

John Leonardo, MD:

That's correct. I don't know if they...

Charles Runels, MD:

They haven't had a problem. So, yeah, so [inaudible 00:53:49], it looks like whatever happened a year and a half, at least for now, seems not to be an issue.

So, I'm so glad you're on the call and we'll have this recording out. And you guys, if you can make time to go see Dr. Leonardo, I promise you he will take good care of you. He's an excellent teacher and magician.

Okay. I think with that, we'll call it a day. Thank you very much, John. I appreciate you, sir.

John Leonardo, MD:

All right. Thank you again for having me. It was an absolute pleasure, and it's such an honor to be one of your providers. You've really transformed my career, and I owe it all to you. That's where it started.

Charles Runels, MD:

You're the wizard, but thank you anyway.

Have a great day, John. Bye-bye.

John Leonardo, MD:

All right, thank you.

=>About Dr. Leonardo's Next Classes<=

References

Abdelrahman, Islam Fathy Soliman, Amr Abdel Raheem, Yaser Elkhiat, Abdelrahman A. Aburahma, Tarek Abdel-Raheem, and Hussein Ghanem. "Safety and Efficacy of Botulinum Neurotoxin in the Treatment of Erectile Dysfunction Refractory to Phosphodiesterase Inhibitors: Results of a Randomized Controlled Trial." *Andrology* 10, no. 2 (2022): 254–61. https://doi.org/10.1111/andr.13104.

Association, Cellular Medicine. "New Study Supports PRP for Female Sexual Function; O-Shot® Protocol Cited." Accessed April 13, 2026. https://www.prnewswire.com/news-releases/new-study-supports-prp-for-female-sexual-function-o-shot-protocol-cited-302735032.html.

Blandón, Virgilio, Alessandro Alvarado, Miguel Borge, Erick Correa, Taylys Leyton, and Sofia Gonzalez. "Platelet-Rich Plasma for Immature Post-Traumatic Scars and Early Keloids: A Scoping Review." *PLOS One* 21, no. 4 (2026): e0345754. https://doi.org/10.1371/journal.pone.0345754.

Clarke, Bayley, Neha Gaddam, Bobby Garcia, Cheryl B. Iglesia, Robert Podolsky, and Alexis A. Dieter. "Vaginal Injection of Platelet-Rich Plasma for Sexual Function: A Randomized Controlled Trial." *Obstetrics & Gynecology*, ahead of print, March 19, 2026. https://doi.org/10.1097/AOG.0000000000006256.

Dhaked, Ram Kumar, Manglesh Kumar Singh, Padma Singh, and Pallavi Gupta. "Botulinum Toxin: Bioweapon & Magic Drug." *The Indian Journal of Medical Research* 132, no. 5 (2010): 489–503. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3028942/.

El-Shaer, Waleed, Hussein Ghanem, Tamer Diab, Ahmed Abo-Taleb, and Wael Kandeel. "Intra-Cavernous Injection of BOTOX® (50 and 100 Units) for Treatment of Vasculogenic Erectile Dysfunction: Randomized Controlled Trial." *Andrology* 9, no. 4 (2021): 1166–75. https://doi.org/10.1111/andr.13010.

Giuliano, Francois, Pierre Denys, and Charles Joussain. "Effectiveness and Safety of Intracavernosal IncobotulinumtoxinA (Xeomin®) 100 U as an Add-on Therapy to Standard Pharmacological Treatment for Difficult-to-Treat Erectile Dysfunction: A Case Series." *Toxins* 14, no. 4 (2022): 286. https://doi.org/10.3390/toxins14040286.

Giuliano, Francois, Charles Joussain, and Pierre Denys. "Safety and Efficacy of Intracavernosal Injections of AbobotulinumtoxinA (Dysport®) as Add on Therapy to Phosphosdiesterase Type 5 Inhibitors or Prostaglandin E1 for Erectile Dysfunction—Case Studies." *Toxins* 11, no. 5 (2019): 283. https://doi.org/10.3390/toxins11050283.

Habashy, Engy, and Tobias S. Köhler. "Botox for Erectile Dysfunction." *The Journal of Sexual Medicine* 19, no. 7 (2022): 1061–63. https://doi.org/10.1016/j.jsxm.2022.03.216.

Medscape. "Should Primary Care Physicians Offer Cosmetic Procedures?" July 20, 2025. https://www.medscape.com/viewarticle/should-primary-care-physicians-offer-cosmetic-procedures-2025a1000ide.

Ramachandran, Roshni, and Tony L. Yaksh. "Therapeutic Use of Botulinum Toxin in Migraine: Mechanisms of Action." *British Journal of Pharmacology* 171, no. 18 (2014): 4177–92. https://doi.org/10.1111/bph.12763.

Ramos-Rodriguez, Daniel, Daniel Sanchez-Baez, Patricia Cabrera-Garcia, et al. "Characterization and Management of Androgenetic Alopecia in Transgender and Gender-Diverse Individuals: A Narrative Review." *Dermatology and Therapy*, ahead of print, April 1, 2026. https://doi.org/10.1007/s13555-026-01735-9.

Runels, Charles, Hugh Melnick, Ernst Debourbon, and Lisbeth Roy. "A Pilot Study of the Effect of Localized Injections of Autologous Platelet Rich Plasma (PRP) for the Treatment of Female Sexual Dysfunction." *Journal of Women's Health Care* 03, no. 04 (2014). https://doi.org/10.4172/2167-0420.1000169.

Runels, Charles, and Alexandra Runnels. "The Clitoral Injection of IncobotulinumtoxinA for the Improvement of Arousal, Orgasm & Sexual Satisfaction- A Specific Method and the Effects on Women." *Journal of Women's Health Care* 13, no. 3 No. 715 (2024). https://doi.org/10.35248/2167-0420.24.13.715.

Simões, Gabriel Chahade Sibanto, Caio De Oliveira, Lucas Mira Gon, Cássio Luís Zanettini Riccetto, and Gabriel Chahade Sibanto Simões. "Intravesical Platelet-Rich Plasma Injection for Refractory Interstitial Cystitis/Painful Bladder Syndrome: A Systematic Review and Meta-Analysis." *International Urogynecology Journal*, ahead of print, April 6, 2026. https://doi.org/10.1007/s00192-026-06515-9.

Stephens, Martin L., and Michael Balls. *LD50 Testing of Botulinum Toxin for Use as a Cosmetic*. no. 2 (2005): 5.

Stern, Rebecca A., Jennifer Andrews, Katherine Bashaw, and Thomas R. Talbot. *Platelet-Rich Plasma Therapy: Key Infection Prevention Practices and Strategies for Safety Risk Reduction - CORRIGENDUM*. n.d.

Utama, Bobby Indra, Arif Bima Al Birru, Kevin Nathaniel Cuandra, et al. "Therapeutic Efficacy and Safety of Injectable Platelet-Rich Plasma in Women with Stress Urinary Incontinence: A Systematic

Review and Meta-Analysis." *Frontiers in Medicine* 13 (March 2026): 1728478. https://doi.org/10.3389/fmed.2026.1728478.

Zandieh, Ali, and Fred Michael Cutrer. "OnabotulinumtoxinA in Chronic Migraine: Is the Response Dose Dependent?" *BMC Neurology* 22, no. 1 (2022): 218. https://doi.org/10.1186/s12883-022-02742-x.

Tags

PRP, platelet-rich plasma, penile augmentation, P-Shot, Priapus Shot, O-Shot, Orchid Shot, erectile dysfunction, male sexual health, botulinum toxin, Priapus Toxin, neuromodulator, dermal filler, hyaluronic acid, calcium hydroxyapatite, Radiesse, locker room syndrome, penile retraction, shrinkage, girth enhancement, glans augmentation, Scrotox, EmCyte, PRP system, anticoagulant, sodium citrate, ACD solution, interstitial cystitis, stress urinary incontinence, androgenic alopecia, transgender alopecia, DHT, hair restoration, Clitoxin, autonomic nervous system, parasympathetic tone, sympathetic nervous system, vascular occlusion, cannula technique, AccuVein, Buck's fascia, dartos fascia, ultrasound guidance, complication management, hyaluronidase, CO2Lift, hyperbaric oxygen, premature ejaculation, Perlane, locker room syndrome, John Leonardo MD, Charles Runels MD, Cellular Medicine Association, CMA, journal club, JCPM, off-label injection, Canadian injectors, Allergan, Juvederm, judo marketing, vampire marketing, Green Journal, O-Shot press release, John Paul Getty, medical practice marketing, physician training, UMA Academy, Amsterdam, anesthesiology, pain management, Toronto

Helpful Links

=>Dr. Leonardo's Next Classes<=

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

=>Next Hands-On Training with Live Models with Dr. Runels (includes marketing)<=

=>Hands On Botulinum Toxin Workshop That Teaches Medical & Cosmetic Uses<=

=> Dr. Runels Online *Botulinum Blastoff Course* <=

=> The Cellular Medicine Association (who we are) <=

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

=> FSFI Online Administrator and Calculator <=

=> 5-Notes Expert System for Doctors <=

=> Help with *Logging into Membership Websites* <=

=> The software I use to send emails: ONTRAPORT (free trial) <=

=> Sell O-Shot® products: You make 10% with links you place; shipped by the manufacturer), this explains and here's where to apply