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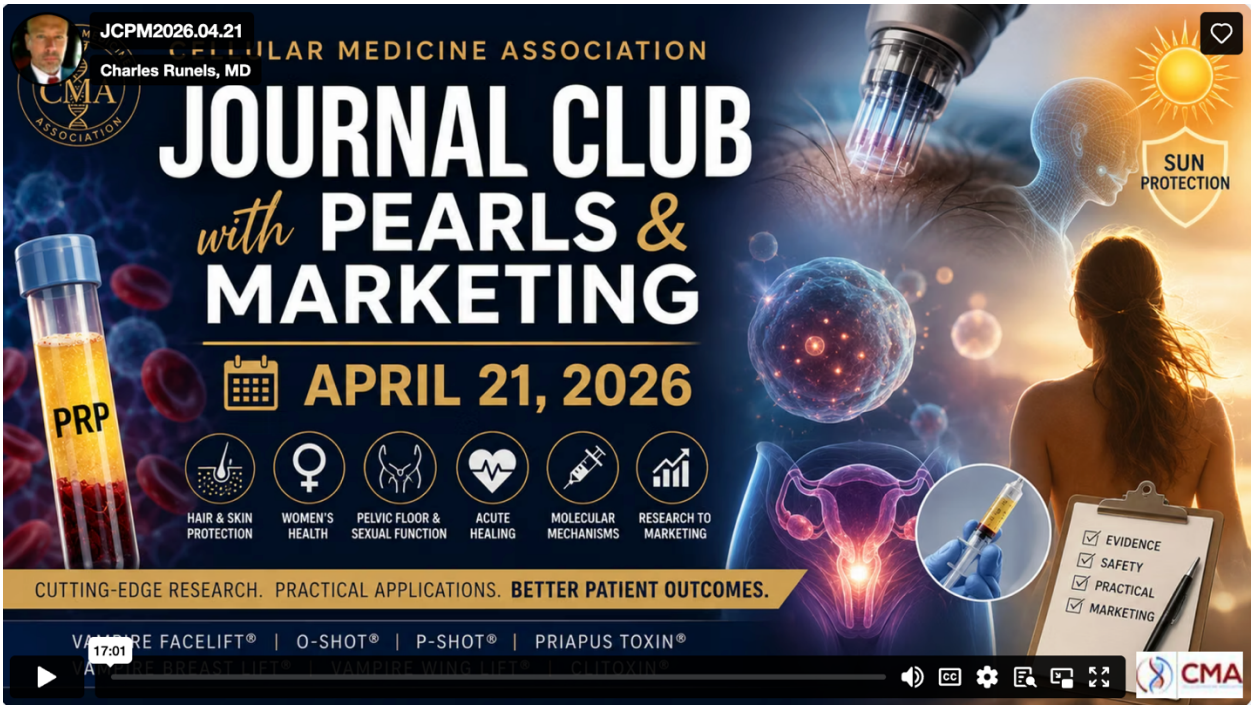
The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of April 21, 2026, with Charles Runels, MD.

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



Topics Covered

- PRP Variability and the "Everything Matters" Principle
- PRP for Hair, Skin Cancer Risk, and Sun Protection
- Green Journal Editorial: PRP for Sexual Function in Women Without Dysfunction
- PRP in the Labor and Delivery Room: Acute Episiotomy Healing
- GLP-1 Weight Loss Drugs and Sexual Dysfunction
- Molecular Mechanisms of PRP: Orthopedics Applied to the Pelvic Floor
- Closing Pearls: Turning Research into Marketing
- References
- Helpful Links

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Transcript

Welcome to our journal club. We have about half a dozen papers today that are really wonderful, and I think helpful, both practically and as an encouragement to what we do.

PRP Variability and the "Everything Matters" Principle

Best I can tell from this paper, they're saying the central problem with PRP therapy is mostly due to the wide variety of how we're making it[1]. We've talked about this a lot. Composition and patient factors are highlighted, with emerging concepts on antioxidant capacity, fiber, and architecture.

Especially, they're talking about ***recipient biology: it matters.***

One way this comes in, from a practical standpoint, is when I get the question, "Should I do the O-Shot® or the P-Shot®, and then we do blood work? Or should we do blood work and then do the P-Shot®?"

And my usual answer is, let's do all of it at the same time, because none of it is dangerous. You can get an infection just doing phlebotomy for a blood test, but relatively speaking, it's all safe.

This paper stresses that everything matters.

We really don't have magic shots. We have very powerful procedures, but they're not magic, and it all matters, and it helps to reemphasize that.

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So if you use this as both educational and marketing, you'd include a link to it and talk about how you take a complete view, because that's what works best.

I promised you a link<=

[1] Kawase et al., "Special Issue 'Recent Progress in Regenerative Therapy Using Blood-Derived Biomaterials.'"

PRP for Hair, Skin Cancer Risk, and Sun Protection

This one was fascinating. I think about it now, I have hair, but I shave my head most of the time. And one of the first things I noticed because I used to have Kenny G hair that was pretty long. If you look around, you can find old pictures of it. This relates to treating hair and the idea of malignancy.[2]

And first, they make the same point that I noticed after I cut my hair: I was just hot from the increased sun exposure.

When I had hair, that was a sunscreen

I didn't realize.

I figured it might be cooler [after the haircut], but no, no, no. If you're walking around with a bare scalp in Southern Alabama, Florida, or other places I like to go where it's hot, you've lost your shade. So obviously growing hair indirectly gives you shielding.

They raise an important point, I think, even though we have no causal data linking PRP to malignancy; actually, the opposite is true. We covered one paper here not so long ago about PRP possibly decreasing the incidence of basal cell carcinoma.[3]

There's no link between PRP and malignancy, but they make a good point. When we inject the breast, we always have a consent form that says, we're going to agree that if you get breast cancer, we didn't cause it. And there should probably be something on our consent form that does the same thing regarding possible basal cell.

And the other thing we mentioned last week is that when you do a Vampire Facial® procedure, you tell people to stay out of the sun because they may experience pigment changes. If you're doing that microneedling together with PRP as part of your alopecia treatment, you might want to have the same sort of disclaimers.

We say, ***keep your scalp out of the sun for a week or so. (It's still good for all skin types, which is wonderful.)***

We've covered several papers on comparisons, and two of them have shown better results with microneedling than with PRP injection for alopecia.[4]

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[2] Spindler et al., "Platelet-Rich Plasma Injections and Scalp Cutaneous Malignancies"; Spindler et al., "Platelet-Rich Plasma Injections and Scalp Cutaneous Malignancies."

[3] Cui et al., *The Anti-photoaging Effects of Pre- and Post-treatment of Platelet-rich Plasma on UVB-damaged HaCaT Keratinocytes*.

[4] Biben et al., "Local Injection versus Topical Microneedling of Platelet-Rich Plasma for Androgenetic Alopecia."

We have an all-encompassing consent form, but I think I need to go back and relook at it. And with this paper in mind, I mentioned that you might get a basal cell. Whether we do this or not, ***research does not indicate that we could increase the incidence. Possibly, we might even decrease it,*** but we're going to agree that if you get a basal cell carcinoma, you won't blame it on us.

But if I were doing this from a marketing standpoint, I would say, hey, you know, hair is a nice sunscreen. ***So, part of the reason for treating your alopecia is not just to look pretty in your pictures. It can help prevent skin cancer.***

And now let's jump to the next one, and we'll be done in under 30 minutes, and I will take questions.

Green Journal Editorial: PRP for Sexual Function in Women Without Dysfunction

You know, we were so thrilled. It's been about a month. There was an article in the Green Journal that discussed using platelet-rich plasma injections for the anterior vaginal wall.[5]

They did not inject the clitoris. So, they did not do our full protocol. They did half of an O-Shot®.

Still, this was a very useful article. These were women with***out*** sexual dysfunction, but they showed improvement in sexual function after the procedure, and they referenced our original article from 2014, which was huge.

So I love that. And I'm glad this is starting to show up in the Green Journal, which, as you know, is arguably the most high-impact journal for gynecologists.

I know my wife, who's a gynecologist, saw a PRP question for the first time in her yearly CME. Unlike some boards, the American College of Obstetrics and Gynecology has a required reading list. It can't just be like when I get my boards renewed in Alabama, I just need to document a certain number of CME hours. I think it's 25. Alex has to read a prescribed reading list and take a test on it. And for the first time, they had a question in a paper about platelet-rich plasma. So it's starting to go mainstream. And I predict that in another 10 years, insurance will be paying for these procedures, or some version of what we're doing.

But the other part we didn't discuss when we covered the paper is that this editorial reference indicates they ***were treating people without dysfunction. And as you know, even though we all know young women with normal function, a high percentage of them will report better sex, sometimes dramatically better***, after an O-Shot® procedure.

But I've resisted promoting it for that reason, because it seems more medically acceptable to be advertising for treating dysfunction.

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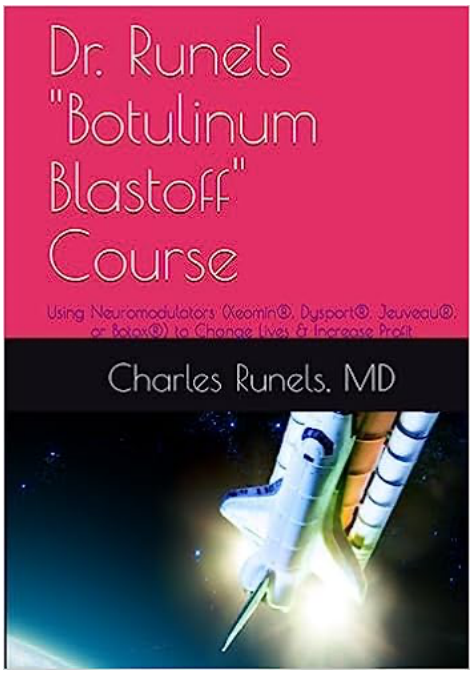
[5] Clarke et al., "Vaginal Injection of Platelet-Rich Plasma for Sexual Function."

We can't advertise giving men testosterone just to make them stronger. That would be a violation of the ethics, and you could lose your license for it—must be treating some sort of andropause symptom by replacing low levels. And so, with that idea in mind, I've tried to stay very conservative and not talk about ***the fact that our O-Shot® can be almost like a sex drug for young women who already have normal function***.



The only time I ever gave any direct information about that was an interview with Cosmopolitan. The European version did an interview and thought that was an appropriate place for that discussion.

But in the medical literature***, I've never broached the idea of using the O-Shot® procedure to make normal better (even though we know that if often does); here, we have a paper in the Green Journal that did exactly that.***

So this was a nice editorial that gives their overview of the idea. It's worth reading through mostly as reassurance that we're on the right track. I didn't see anything new in here that we haven't talked about, but it's a stamp of approval of our path, at least.

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Okay, so let me put that one in. I had to pay for this one, so I'll give you the link, not because I wouldn't want to give it to you for free, but it'd be hypocritical for me to enforce our trademark intellectual properties and steal other people's stuff.

PRP in the Labor and Delivery Room: Acute Episiotomy Healing

Okay, so let's do the next one. I love this article. Pretty sure this one was open source. I'm giving you the link, but you'll be able to download it.[6]

Okay, we've been talking in our group for 16 years. I know it's been at least 15 years since I treated the first woman with dyspareunia secondary to friability and bleeding from an old episiotomy scar.

But this paper is the first time I've seen it discussed in detail for use in the actual labor and delivery room. The idea is to use PRP or a hydrogel. But you could easily just flood the wound with PRP, close your multilayered episiotomy tear, and you should have less infection and better healing, which is the point they're making.

[6] Brezeanu et al., "Lactic Acid-Loaded Hydrogels for Post-Episiotomy Wound Healing."

So if you are one of our providers who's still actively delivering or some of your nurse practitioners who are actively delivering, and you put this on your website and tell them that if there's an episiotomy to be done, you're going to offer them this at no extra cost, only if it's needed, but you're going to make sure they get the best of care and you put in your PRP as a way to help with that healing process. You don't have to use a gel; just inject the tissue and close it. They will love you for it.

It's excellent confirmation that what we've been doing, our ideas about treating this area, are on target. Of course, we've been promoting it mostly as something to do after the scar is formed to help strengthen the tissue. And we've had many studies over 20 years on using PRP to remodel scars, but this is the first time I've seen it written about to this degree in the acute setting of delivery.

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

GLP-1 Weight Loss Drugs and Sexual Dysfunction

If you're dealing with prescribing these drugs, you know that this is a thing, that there are men with or without type 2 diabetes who are having a more difficult time with sexual function when they use the new weight loss drugs.[7] So I know the research in this has been out there. It's been somewhat inconsistent, but this is a real thing.

I took one very low dose of these drugs just because there's some evidence it might help prevent dementia. My father passed away from advanced Alzheimer's. And even at a low dose, to me, I felt like I lost my spark, not just a drop in sexual desire, but being a little bit hungry helps me keep mentally awake. I used to stay awake in the ER for days by eating less than what I needed to satisfy my hunger. Hunger for food and hunger for sex make you roam. If you're a wild tiger, your belly's full, you go to take a nap. If you're a wild tiger and you're hungry or want sex, you start roaming the forest. So, I like a little bit of hunger. And when it went away, I lost some volition.

Anyway, that's what this article is about. Even if you're not prescribing these medications, you're dealing with people who are on them. And I think pointing out that this is a deal and that you have a way of dealing with the side effect with your hormone replacement, if you do that, and with your P-Shot® and Priapus Toxin®, even if they're getting the hormones replaced somewhere else.

So I think that's probably all I should say about that paper. Let me give you a link to that one.

This is a good example of what you hear me talk about: the best marketing is just caring about your patients.

Read about things that will help them either learn what to do better, or to motivate them, or re-motivate them to do what they already know they should be doing.

[7] Tang et al., "GLP-1 Receptor Agonist and Risk of Erectile Dysfunction in Men with Type 2 Diabetes."

This is one very good example where even if you're not prescribing the GLP-1s, you would provide this to your male and female patients to alert them, hey, if things are falling off in the bedroom and you're using one of these medications, this could be why. And so don't let it bother you. Maybe you need to stay on the medication but come see me so I can make sure everything else is optimized. And that could mean going down some on the GLP-1, but maybe that stays the same, and you just do your Priapus Toxin® with the P-Shot®.

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These were people who had failed to respond to PD5 inhibitors in those double-blind, placebo-controlled studies of botulinum toxin injected in the corpus cavernosum.[8]

So if I had someone who was recently impotent, if they had erectile dysfunction after starting a GLP-1, I would even more strongly consider combining our Priapus Toxin® procedure with the P-Shot® so that you get the neurological benefit to help counteract some of the hormonal changes with the GLP-1.

Molecular Mechanisms of PRP: Orthopedics Applied to the Pelvic Floor

I think it's helpful to stay up to date on developments in the orthopedic world.[9] Some of you may be doing family practice or sports medicine, and this applies directly to you. But if you're not, the way the exercise physiologist or sports medicine doctor talks about using these PRP treatments applies to the pelvic floor as well.

If you treat 100 females with dyspareunia, you're going to see some that have pelvic floor pain. So this talks about some of the biochemical and molecular mechanisms, how they relate to multimodal signaling networks and the modulation of inflammation and androgen signaling, all the things that help improve function and decrease pain.

It's out of China, whatever. I don't know when we started thinking that things from other countries (other than the US) aren't as reliable. William Osler warned against that.

He said, "Be careful, you can't discount things just because they did not come from your country."

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[8] 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"; Saadawi et al., "Efficacy of Botulinum Toxin Injections for Erectile Dysfunction and Premature Ejaculation"; El-Shaer et al., "Intra-Cavernous Injection of BOTOX® (50 and 100 Units) for Treatment of Vasculogenic Erectile Dysfunction"; Giuliano et al., "Safety and Effectiveness of Repeated Botulinum Toxin A Intracavernosal Injections in Men with Erectile Dysfunction Unresponsive to Approved Pharmacological Treatments."

[9] Chu et al., "Descriptive Analysis of Platelet-Rich Plasma Injection Therapy in Chronic Musculoskeletal Pain."

And I don't think we're guilty of that, but some of our colleagues may have a bias against research from Asia for some reason.

Closing Pearls: Turning Research into Marketing

Okay, so I think I will stop there.

Let's see if there are any questions. Many smart, amazing people on the call. Thank you for being here. Always grateful to see familiar names.

The way to turn research into a video is just to use your Camtasia app or whatever you like to film your screen. I like Camtasia and use it like this: Pull up the paper you're going to talk about, film your screen and your face while you talk about it, point things out, and then post the video wherever you like to post things, your website, or even your social media. And you just turned research into marketing, so people can see both how smart you are and where to go for treatment and know what you offer.

Remember what one of my gurus, David Ogilvie, said:

If you teach the person about their disease, they will trust you to treat their disease.

So that's what I'm giving you: information you can use to teach people about their disease, what you do, and why it works.

I hope that was helpful. I'll see you next week. Thank you so very much for being on the call.

=>Benefits of the Cellular Medicine Association<=

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Tags

PRP, platelet-rich plasma, PRP variability, PRP composition, recipient biology, O-Shot®, P-Shot®®, Priapus Toxin®, Vampire Facial®, Vampire Wing Lift®, Clitoxin®, alopecia, microneedling, basal cell carcinoma, sun protection, consent forms, breast cancer consent, Green Journal, Obstetrics and Gynecology, anterior vaginal wall PRP, sexual dysfunction, female sexual function, FSFI, ACOG CME, mainstream PRP adoption, episiotomy repair, labor and delivery PRP, acute wound healing, hydrogel,

scar remodeling, GLP-1, semaglutide, weight loss drugs, erectile dysfunction, PDE5 inhibitors, botulinum toxin, corpus cavernosum, hormone replacement, dementia prevention, Alzheimer's, exercise physiology, sports medicine, pelvic floor pain, dyspareunia, multimodal signaling, modulation of inflammation, androgens, research bias, Camtasia, video marketing, David Ogilvy, patient education, physician marketing, Cellular Medicine Association

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=>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 <=

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

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

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