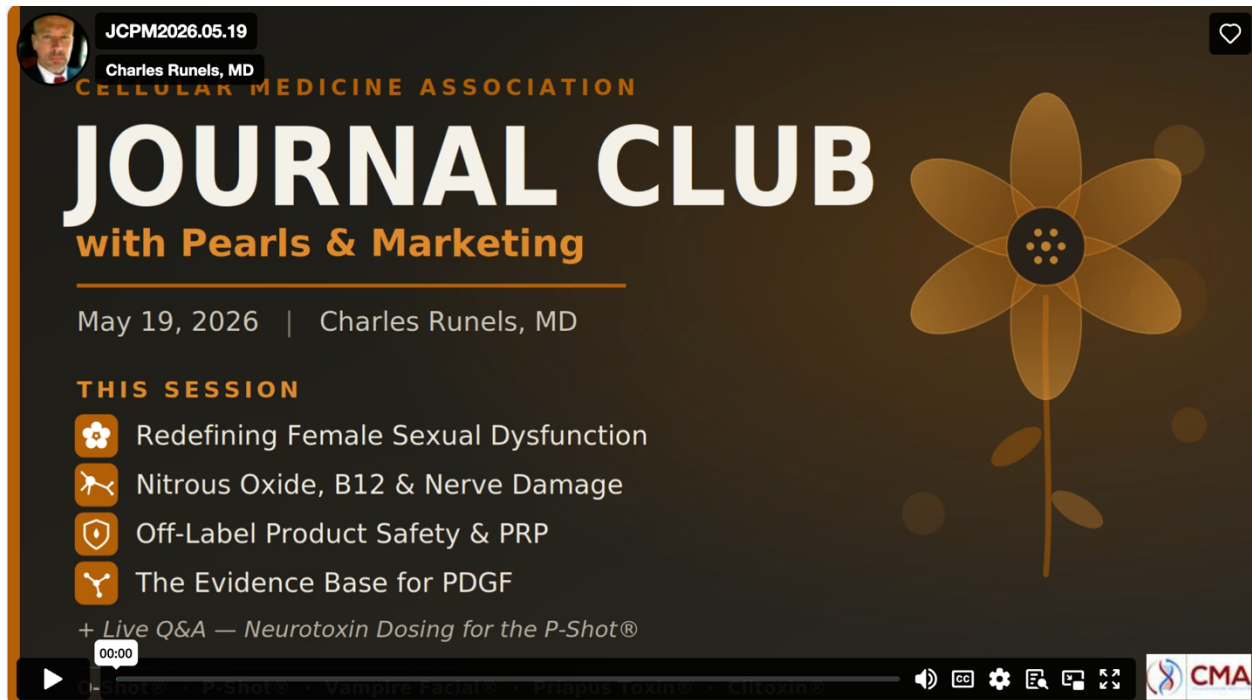


# JCPM2026.05.19

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of May 19, 2026, with Charles Runels, MD.

>> [The video of this live journal club can be seen here](#) <<



## Topics Covered

- It's All About Words: Redefining Female Sexual Dysfunction
- How the Definitions Relate to Our Procedures
- Nitrous Oxide, Vitamin B12, and Demyelination
- Pearls & Marketing: Writing a Letter That Teaches
- A Warning About Topical-Only Products Used Off-Label
- The Other Side: The Strong Evidence Base for PDGF
- Practical Pearls from Today's Papers
- A Note on Teaching and Protecting the Protocol
- Adding Providers in Your Office to the Directory
- Q&A: How Many Units of Neurotoxin for the Penis?



**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

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### **It's All About Words: Redefining Female Sexual Dysfunction**

We have four papers I'd like to cover today. This one, I think, is probably the most important one that came out, and it's all about words.<sup>1</sup>

I used to look at these papers, and I'd think, "Oh, well, don't people have better things to do than just come up with new names for things?"

The people in the places of strongest influence have, over the 20 years or so that I've been keeping up with sexual medicine in a detailed way, changed the definitions on multiple occasions. But there's one thing that's bothered me the most, and I think others, and it's that *you must be distressed if you're a female to be counted*.

*(If you have ED and are not distressed about it, you still have sexual dysfunction; but if you are female and have dyspareunia or anorgasmia and are not distressed about it, by definition, you do NOT have sexual dysfunction.)*

And this matters a lot, of course, because when you're doing research, if you're trying to show a new treatment for female sexual dysfunction, and it has to do with a psychological change, that is a more difficult measure (than a physical change). And distress can be worsened by increased sex drive. In other words, you could have a treatment that improves sexual libido or desire or even improves orgasm, and it would be disapproved if you went by the strict definition and the increased desire increased distress.

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And if you don't have psychological distress, you do not have dysfunction, even though you might have dyspareunia or be unable to have an orgasm. So this article wasn't open source, so I wasn't able to give you the link, but I'll copy and paste [the DOI](#) into the chat box. It's in the Journal of Sexual Medicine Reviews, and so I can't give it away, but I can tell you the main things that I think will be helpful to you.<sup>1</sup>

They're shifting away, it seems, from this old idea that it's either psychological or biological. And talked about this forever, but if you go way back to see the extreme case of it, I remember training in the '80s. It was thought that eighty percent of men with sexual dysfunction had purely psychogenic problems.

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<sup>1</sup> Trost et al., "Definitions, Classification, and Epidemiology of Sexual Dysfunction."

It's sad to think how many men were counseled that their problem was psychological. And then when PDE5 inhibitors came along, now we know that really eighty percent of ED is secondary to neurovascular problems.

And unfortunately, it feels to me like that same mentality has been lagging and persistent in the female research. If you look at the three FDA-approved drugs to help women with sex, you have flibanserin and bremelanotide, both of which primarily affect the brain. So, we might not be calling it purely psychological, but our main FDA-approved treatments are psych drugs. The third one is a DHEA cream. And even flibanserin is still not indicated for women over sixty-five. Well, a lot of women have a lot of fun after sixty-five. So, I think this paper addresses that — they're all interacting simultaneously, and they stress that we should be thinking about it.

We talked about these numbers, not so long ago, I guess maybe two months ago, in our journal club. But the incidence of symptoms of female sexual dysfunction is around 90% of women. But then, when you include distress, it drops. If you include distress in the definition, the prevalence, not incidence, the **prevalence** drops to around 40%, but that's still significant.

And surprisingly, it's more common in younger women. But not surprisingly, when you consider that you have to be distressed and maybe women who are through having children and maybe living alone, they may not be as distressed about it, so they may still have symptoms. There are some controversial or emerging definitions emerging.

This whole thing about desire is that they've had different definitions or with the semantics. Again, some— in some ways this feels like a word game, playing Scrabble or something, when you think, really, does it matter?

What really matters is when two people get together, do they have enough fun that they want to buy groceries and live in the same house and make a family, or go on vacation, or do they feel loved and connected, or do they at least have a good time or not and feel separated, depressed, and broken?

And the definitions matter because they determine where research funding is spent and whether a drug or a procedure can be approved. So we're in the process of going through the mechanism to get a new study published, and semantics matter a lot. So there are these new ideas about female cognitive arousal disorder, female orgasm illness syndrome, hard flaccid syndrome, and restless genital syndrome.

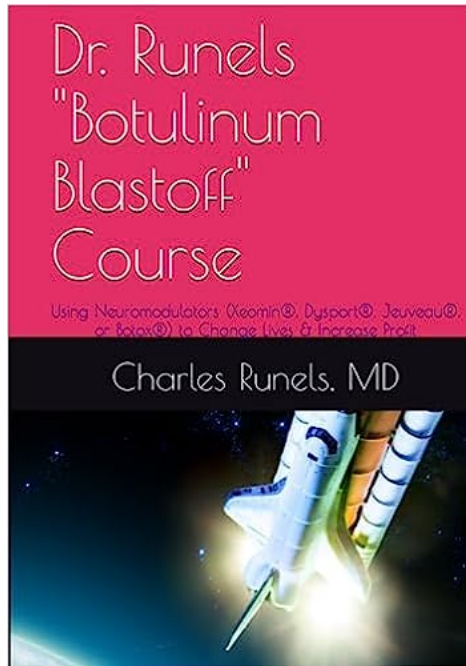
, To me, restless genital syndrome is just being a teenager, but they have a different definition. Genital dysmorpho-phobia. So th-these are all new ideas that I think you're going to see coming out, and they— I-it's worth reading this paper. Again, I wish I could just dump it into your chat box, but I'd be breaking copyright law.

So I'll— I put a link to it in the chat box. Let me do that. And so you can go— at least go to where the paper is. But that's really the summary of it, I think you're going to see more discussion about that problem with defining it only if you're psychologically distressed.

And now, how does that relate to our procedures?

## How the Definitions Relate to Our Procedures

If you've done this for any length of time, you know that you'll see people who come for one thing, who would come for weight loss, but they'll say, "I'm not interested in having sex."



And they come back three to six months later, with a new lover, and now they want everything you have.

So, as far as our procedures go, the most nitty-gritty way I see it happen is when someone comes in and says they're there for... They won't even say sex. They'll say they're for an O-Shot® because of urinary incontinence.

What do you do with that?

They'll say, "I'm not interested in the sexual function. I just don't want to leak."

And you'll give them an O-Shot®, and they'll come back with a new lover or smiling, with a deeper relationship with their spouse. And then the question has come up frequently: if they are there just for incontinence, do you still inject the clitoris?

And I think you do because you have—you actually have some crossover histology, and you have erectile tissue surrounding the urethra of a female.

And you also have, especially now that we have our [Clitoxin®](#), you have autonomic signals coming from the clitoris, both for sexual function and incontinence or s- or urinary function. So I always treat both. And then, of course, this may not be a good enough reason on its own. There are people who will use the incontinence as a, an alibi to get the O-Shot® when they're really interested in sexual function.

But I think probably the biggest take-home from that paper is that they—you'll, you'll see some cleaner endpoints. Hopefully, we'll migrate to a place where you don't have to have psychological distress to be counted as having dysfunction because, as a woman, it means there's less money, and it's harder to get new drugs approved. And you may see some of these new terms start to be used, like restless genital syndrome and genital dysmorphophobia.

## Nitrous Oxide, Vitamin B12, and Demyelination

This next one is interesting because it concerns nitrous oxide.<sup>2</sup> I personally think that nitrous is just pleasant. It's just pleasant. And it's tempting to just have a little shot of nitrous every day just because it makes you happy.

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<sup>2</sup> White and White, "Nitrous Oxide Abuse Prevalence, Mechanisms, Treatments and Prevention."

But when you look at the research, you see problems with vitamin B12 function, and in one study they showed demyelination at a greatly increased rate in people who were using nitrous regularly.<sup>2</sup>

So if you're using it or treating someone who used it, that's the take-home. If you want to do a screenshot of that, that's sort of the paper in a nutshell: you can have all those things you're seeing there, gait disturbances, limb paresthesia. I don't think anybody worries about frostbite, but it's possible.

The main things are plasma homocysteine levels, methylmalonic acid, and B12 function. And so they give you some ideas for treating it: a B12 shot once a week for several weeks and taking folate. Pretty easy, fun things to do anyway, B12 and folate.

I think it was [Demi Moore who wound up in the ER once with a near stroke from doing nitrous](#) with her lover.

They talk about how prevalent it is. Something you should know is that it became prevalent when you could order it as part of your kitchen utensils to make whipped cream. [So you can grab—you can buy these canisters not just at smoke shops but also on Amazon.](#)

So this one is worth reading and knowing about.

## **Pearls & Marketing: Writing a Letter That Teaches**

I call this journal club with pearls in marketing. So, how could you make this part of how you end up with the people you want to treat in your office? So, if you're interested in treating sexual function, why would you want to do that? Not only is it incredibly rewarding for your soul and has a positive impact on families, but it's also one of those categories where the insurance coverage for treatments can be minimal. Our procedures are now strongly supported by research, yet they're not covered by insurance.

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That puts you in that sweet spot where you can be both a very good physician and do things that people who only take insurance do not do, and make profits that help you pay for the patients you might lose money on. And our procedures, of course, are very safe when using platelet-rich plasma.

So, if you want to treat sexual dysfunction, how does this paper figure in?

Remember the three rules about marketing.

***First, the best marketing is to teach the sufferer about their disease. Teach them about the disease, and they trust you to treat it.***

***The second principal worth making a poster about is that it's not the patient's responsibility to know what you know how to do: It's your responsibility to teach them.***

***The third thing is that people don't want to be advertised to, but they love to get a letter that shows concern and teaches them how to make their life better. So you could write a letter about this one. Real simple.***

It could be, “Hey, there’s a new paper that just came out.

This is common, and you or someone you love may be doing it frequently. You should know the possible side effects of it and know that there are other ways to have fun.”

You know, I have to go through the side effects. It could be quick. You could mention some of these things that could happen.

And put a link to the article.

Yes, I always talk to my patients as if they are physicians. I don’t talk down to them. And then you put a link to the article.

Basically, you write a letter as if you’re writing to your sister, your brother, your niece, your nephew, or your mama. That’s what you do.

And then you would say, “But there are other ways to have fun, and if you come see us, I can help you out with that. We have our O-Shot® procedure.”

Some of you are probably prescribing oxytocin, which is a nice one that makes people feel happy, and you don’t stroke out from it, and whatever else you’re doing.

## **A Warning About Topical-Only Products Used Off-Label**

This next one was a letter, an open-access letter.<sup>3</sup>

The main thing that caught my eye here is that, just like the PDGF exosomes, other things are happening, and now you have people selling products that might be labeled for topical use only.

And I’ve had this happen more than once, but the drug rep who sells it to you winks and says, “But you could use it IV, it’s sterile.”<sup>3</sup>

And they would get and tell you that, but just don’t talk about it on your website.

That worries me because, of course, if anything goes wrong, you must go start selling shoes and your license goes in a scrapbook instead of on the wall.

But he mentions it here and talks about PDGF and how it relates to PRP.

But the main thing, we’ve covered that in the past, and this one is open source, so let me throw it in there now into your documents, because this is one you could actually give to your patients as a warning.

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<sup>3</sup> Torres et al., “ ”

You could send a link to this one and say, “Hey, if you see somebody offering this, be careful because we do things the right way and not everybody does.”

And then you, you give them this paper, and the ones who read it will come see you and give you lots of money and trust you to do the right thing when you’re taking care of them. See if I put that in there.

Yes. Okay. So that one’s in your material section, and then the last one, and then I had one question I wanted to cover.

## **The Other Side: The Strong Evidence Base for PDGF**

This one is also open source, [so I’ll put it in here](#).<sup>4</sup>

Also, it’s in your, in your handout section.

And so this is the flip side of how wonderful it is, and their main point is you’ve got thirty plus years of research, one hundred and forty plus published human clinical studies, over fifteen thousand patients, and four FDA-approved PDGF protocols. So there’s, there’s reasons for it. It’s mostly wound healing, and of course, anything that has to do with wound healing can often be adapted to what we do.<sup>4</sup>

I’m not using these products, but some of you are, I know, and I wanted you to have both the good side and the warning, the positive endorsement and the warning about its use. And even if you’re not using it, something to know when your patients ask. And again, if you are using a product for topical use, definitely just use it for that, because they’ll get you.

We do have a few people who have had to go... have been investigated by the FDA, breaking rules they don’t really have to break. So I think the practical pearls to remember from these papers, and then I have one quick note on a question, and we’ll call it a day.

## **Practical Pearls from Today’s Papers**

This from the Tross paper is the, uh, distress is changing the prevalence estimates. And when you take that out, it’s much more prevalent than people think. And especially on the female side, it’s true—the people tried to squeeze it into three to four categories, but we’re going to have these other categories that will be talked about, and we’ll discuss them in upcoming journal clubs.

I love the restless genital problem. I think I like having restless genitals. But anyway, we’re going to talk about some of those in future journal clubs.

Nitrous oxide abuse is pretty common and so know some of the bad downsides of it and how to treat it. If you’re going to do it yourself or tolerate it in others, just make it rare.

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<sup>4</sup> Younan et al., “Recombinant Platelet-Derived Growth Factor in Tissue Repair.”

The things they talk about that could happen, to me, the most dangerous is not frostbite. It's that if you don't have an urge to breathe, if you don't have high CO<sub>2</sub>. So if you blow off your CO<sub>2</sub> and your lungs are just full of nitrous, you do not feel the urge to breathe, but you don't have oxygen either.

You have a low O<sub>2</sub>, decreased respiratory drive, and it could lead to a stroke. And reading between the lines in the news, I don't know what happened with Demi Moore, but I, I think some sort of TIA could be possible, so you've got to be careful with it.

And then injectable PDGF: do only what the FDA has approved for what's on the bottle in your hand, and know that this science is fairly mature, but mostly for topical, and I think using it in one of our procedures is not the thing to be done.

Okay. So I had one question that I'll cover: One of our providers wrote in that he had been asked to teach a clinic, and I just want to mention that we need more teachers and the right way to go about it for the best results and for the best second income.

## **A Note on Teaching and Protecting the Protocol**

We have [a list of upcoming classes and teachers that's been on display for the past 15+ years](#), we promote our other teachers, and we pay them.

We don't take money from them. We pay them to teach.

If you're going to teach, though, we ask that you let us know, as we have a separate training program for teachers.

And if you teach A, A teaches B, and B teaches C, and we don't know about it, I promise you C will be doing something significantly different than A. So we need to have some control over what's being taught and a way to keep track of who is being taught. If someone is taught and we don't know about it, and they start advertising under our trademarked names, there's a good chance they will lose their website or social media account.

We're still averaging 2.5 websites or social media accounts that go away per business day over the past 2+ years. We had another quarterly report with our attorneys in Israel, BrandShield.com, and without that, we would have people doing crazy, stupid things and calling them an O-Shot®, a P-Shot®, or a Vampire Facelift®.

And, sometimes they've done it even with our enforcement, and two people are in prison now for doing something stupid and calling it a Vampire Facial® when it was not. They're not one of our people. And other things have happened. So we want to support your students and support you if you want to teach. But, if it's done without us knowing, then some bad things can happen. In the same way, and this is the last point, I'll open up for questions, and we'll call it a day.

## **Adding Providers in Your Office to the Directory**

If someone in your office wants to do the procedures, we want them to do them. We need more people offering these procedures. But we need to know who they are. We had something as an example. We had someone show up to see my wife, who's in our group, and a gynecologist. She'd had a procedure from another provider, not from the provider in our directory.

The provider had taught her extender, but the extender had done something painful and ineffective. And we didn't even know the extender was injecting. But the extender was taught by the provider, who was taught by us. So even if we tell A and A tells B, if we don't know about B and B's not on our membership site, and B wasn't taught by us, there's a very good chance B will do something different that will be less effective or even dangerous.

There's no problem if you want someone else in your office to provide the procedures if they have a proper license. Just call our office, and we'll get them trained up using either hands-on or online training. Get them tested, make sure they understand everything, and put them in the directory. And we don't even charge extra for that person to be on the directory.

We have a training fee, but it's very reasonable. And then you'll have two listings in the directory, and we will know that that person knows our protocol and won't have someone else subjected to something painful and ineffective, and it will be called something it's not. Okay. Let's see if there's questions.

## **Q&A: How Many Units of Neurotoxin for the Penis?**

Pete says, "The previous journal club mentioned using up to 300 units of neurotoxin in the penis. How many do you use? Does it require Botox specifically, or can you use Xeomin or Dysport?"

Okay, great question. And, by the way, we just installed another AI bot on the membership sites to answer questions. I didn't like the other one.

It was giving stupid answers and going outside our website to find answers that were just wrong. Remember, we have over 900 videos and millions of words. Hundreds of conversations over the past decade and a half on our websites. Not just me rambling with some sort of monologue but talking about research and interviewing multiple doctors in our group.

And what we did have was just a plain old search bar, and when you put it in there, or you might get—say you put in this question, you just put in Xeomin or botulinum toxin and ED. You might get, even though that's only been something we've talked about for two or three years, you might get a dozen different journal clubs or pages, and each one of our journal clubs is about three thousand words.

So you might have an equivalent of a textbook to read to try to find your answer. Even though it's highlighted, it's work. So I installed the AI, and I asked it a few questions when I put it in. It seemed like it was performing. Then, about a week ago, it gave me a stupid answer, so we got rid of it, and we have installed another, much smarter, more expensive version.

We have a, a new AI bot that will give you a smart answer.

I'll give you the answer, but in the future, check out our new AI and let me know if you think it's working. If it's broken, I want to know so we can fix it.

Now, the answer to your question. And the reason for that number, as you know, the Xeomin, Dysport, and Botox people all did studies.

The Xeomin people, best I can tell, were the only ones who had a follow-up study, and 50 units were starting to wear off at 6 months, but 100 units were persisting at 9 months to 1 year. We don't have longer studies for the Dysport. I don't know if there's a study like this yet with Letybo.

But a hundred units, if you do the math on the LD50 and from my years as an ER doctor and three years as a chemist before that, I do have some fascination with poisons and what it takes to kill somebody or hurt them with a poison. And of course, most things we use as medicines could be poison, but especially botulinum toxin.

So I spent some time, embarrassingly too much time, reading about the LD50 and toxicity of botulinum toxin medically and for other uses. And then when you do all the calculations on it, the LD50 is literally if a man weighs 180 pounds, you will have to have 180 100-unit bottles of botulinum toxin or Botox, cosmetic Botox, 180 bottles and do an IV push to reach— approach the LD50.

Of course, we don't do that, but that— I like that big safety margin. Now, to answer your question, if 100 units was what was done in the study, then it's the official starting recommended dose for Priapus Toxin®. And now, even with Clitoxin® in the clitoris, we bumped it to 100 units. But with migraine or its frequency to use more than 300 units, and even the face it's al- it's common to use 500 units or— So 300 units every— even if you're going every three months, which you won't be for ED because remember it lasts longer, up to nine months.

But if it works, there's a good chance you'll get six months to a year out of it for 300 units versus just cosmetic use, maybe you might be going 450, 500 units every three months. So 300 units is still a reasonable amount, and that's the first thing I wanted to address: it's not a scary amount, which I'm sure you probably know.

But for those who don't, I wanted to put that in perspective. And now as far as how I do it, and, and this may change, right?

And our science is changing. But I start with 100 because in the study, 40% of men who were not responding to LD50s at high doses, the highest dose, those men, 40% of them started to get erections again at 100 units.

I don't start at 50 because I don't— I like starting with what's going to last longer, and Daxxify is also one you can use. But I like starting at 100, and if it wears off soon or they have no results, maybe I'll add to it or bump it up to 200 or 300. You heard one of our providers talk maybe a month ago that he does an analysis of the person in the flaccid state, and if they have a, a penis that's turtling and, and not as

noticeable as another that might be more s- more, noticeable in the flaccid state, you might start with 300 units.

I usually start with 100, but this is where the art and the clinical come in. There's not a firm guideline on it. There was an article out this week that I did not put in here that came out regarding testosterone levels, cardiac dysfunction, and they mentioned that some with type 2 diabetes and obesity, even when young, have low testosterone levels.

It's associated with that, which we, we knew, but another study documented that. So if you have someone that you suspect is m- a more difficult case because of body habitus and history, there's nothing wrong with starting at 300 units. But personally, I start at 100 units, combine it with a P-Shot® and then, uh, give it eight weeks. If after eight weeks they're not improved, I'll consider repeating either or both and increasing the dose.

So hopefully that answered your great question, Pete. Thank you.

All right. That's all I see in the way of questions, and I hope that was helpful to you. And, uh, and, uh, by the way, you realize every journal club we do, y- there's a half a dozen ideas for new studies, so that would— could be a study for one of us.

Could be the one you need to do, Pete.

All right. Y'all have a great week, and thank you for honoring me by being on the call. Hope that was helpful to you. Bye-bye.

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## Tags

female sexual dysfunction, distress criteria, sexual dysfunction prevalence, psychogenic vs biological, flibanserin, bremelanotide, DHEA cream, PDE5 inhibitors, erectile dysfunction, female cognitive arousal disorder, female orgasm illness syndrome, hard flaccid syndrome, restless genital syndrome, genital dysmorphism, O-Shot®, Clitoxin®, urinary incontinence, clitoris injection, erectile tissue urethra, crossover histology, platelet-rich plasma, PRP, nitrous oxide, whippets, vitamin B12 deficiency, demyelination, homocysteine, methylmalonic acid, folate, gait disturbance, paresthesias, stroke risk, topical-only products, off-label IV use, PDGF, exosomes, FDA-approved PDGF protocols, wound healing, regenerative medicine, patient education marketing, trademark enforcement, BrandShield.com, provider training, directory listing, Priapus Toxin®, P-Shot®, botulinum toxin, Botox, Xeomin, Dysport, Letybo, Daxxify, LD50, neurotoxin dosing, testosterone deficiency, type 2 diabetes, obesity, Charles Runels, Cellular Medicine Association, JCPM

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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](#)<=

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