# JCPM2026.05.26

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of May 26, 2026, with Charles Runels, MD.

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


## Topics Covered

- PRP for Post-Prostatectomy Urinary Incontinence
- Treating Acne Scars — Stromal Vascular Fraction vs. PRP
- PRP for Osteoarthritis — Composition Over Platelet Count
- Preparing PRP — Androgenic Alopecia, Buffy Coat vs. Apheresis
- Defining Female Sexual Dysfunction — A Two-Year Consensus Review
- Hypoactive Sexual Desire Disorder
- Female Genital Arousal Disorder
- Female Cognitive Arousal Disorder
- Female Orgasmic Disorders
- Female Orgasm Illness Syndrome
- Sexual Pain–Penetration Disorder
- Persistent Genital Arousal Disorder

**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

Today is May 26th, and we have some wonderful papers regarding sexual function. That's the main emphasis of today. There's a beautiful review article that came out, a work of 2 years in the making, which I think is very helpful. But let's start with this one regarding platelet-rich plasma injections in men with post-prostatectomy urinary incontinence.[1]

## PRP for Post-Prostatectomy Urinary Incontinence

I've had people ask me about doing a regular P-Shot® in someone who's had prostate surgery to help with incontinence, and it somehow seems to me that it's the wrong place [the corpus cavernosum] and not likely to help if you just do a standard P-Shot®. But surprisingly, I've had multiple people in our group who have had prostate cancer and suffered the problem and then treated themselves, who told me it helped.

But the P-Shot® is not what this paper is about. This paper is just an injection directly into the urinary sphincter. And they found it helped, but it usually took three or four injections to work. And although most primary care doctors would feel more comfortable performing a standard P-Shot® rather than injecting the urinary sphincter, it's not that big a deal.

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

Another important aspect of this paper was that it discussed ***increasing sphincter muscle volume.*** Sphincter muscle volume is important, of course, for the indication talked about in the paper, but it's also important because we've talked repeatedly about how it could be that when we do our O-Shot® procedure, when injecting into the anterior vaginal wall, we may be improving sphincter function and possibly increasing sphincter muscle volume in the female urethra.

So that's a paper just waiting to be done

This, I thought, was anecdotally interesting, in that the incidence rates vary widely from 2% to 92% depending on the definition of incontinence! Two to 92!

---

[1] Yang et al., "Therapeutic Efficacy and Predictive Factors for a Successful Outcome after Platelet-Rich Plasma Injections in Men with Post-Prostatectomy Urinary Incontinence."

My working definition of incontinence is that if it's interfering with your hygiene or your activities.

So if you're having to wear a pad, that's hygiene. If it's causing you to not be able to focus because you have to go three times to the bathroom when you're trying to have a business meeting, or you've quit doing gymnastics if you're a young person, or quit your job if you're working as a long-haul eighteen-wheel driver, then that's incontinence.

This next one talks about treating acne scars with either stromal vascular fraction or PRP.

## Treating Acne Scars — Stromal Vascular Fraction vs. PRP

And stromal vascular fraction to me is a more difficult process. But they did a study where they did PRP by itself, stromal vascular fraction by itself, the two combined, just undermining with nothing else, and then graded.[2]

So here's your group one: stromal vascular fraction (see video).

The next was SVF with PRP. The third was PRP, and the last was the control group.

The groups were equally matched. But it's somewhat confusing because if you look at their conclusion, they conclude that the combination when used as an adjuvant to subcision represents a superior result to the monotherapies or subcision alone.

But now look at the groups: two is everything combined. Three is PRP by itself.

Two is everything combined, SVF and PRP. Three is PRP by itself.

And if you look at this, there seems to be a reversal: with moderate scarring, the patient thought that PRP by itself was better than the two combined. But then, when you looked at the horrible scars, the two combined were better.

Same with this one. When looking at more severe scarring, the two combined worked better. But then, with moderate scarring or mild scarring, PRP alone worked better. I'm not sure why it is that relationship would change.

Improvement in color: Why would it be that with severe, a different method, the two combined, worked better than PRP by itself, and ***PRP works better with the moderate***?

It's encouraging to me that, if you have less severe scars, you do just as well or better with PRP alone.

But notice ***in all the groups, they did subcision***. That's an important part of the process. We have some videos on the membership site that demonstrate this, but the way I like to do it when someone

---

[2] Abdalla et al., "Synergistic Effect of Platelet-Rich Plasma and Stromal Vascular Fraction in Atrophic Acne Scar Management."

has a lot of scars like this, just a quick overview, is I'll ask the person, they know their face. I'll say, "Point out the ones that bother you the most."

And they'll have some deeper ones. So for this man [see video], perhaps it's these two on his cheek, or maybe that one. And then I'll take those and I'll subcise them and inject PRP as I'm doing it, and then I'll inject ***intra***dermally in that one and others.

And then, ***this is the part they didn't mention***: I'll microneedle the whole face with PRP, then bring them back in four to six weeks and do it again. That was not one of their groups, PRP with microneedling. But we have multiple studies that talk about that.

And also remember, we have studies that show PRP is actually inferior when combined with microneedling, to microneedling combined with 10% trichloroacetic acid, TCA solution. The gradient is that vitamin C serum works better than saline. PRP beats vitamin C serum, and TCA solution beats PRP.

So where stromal vascular fraction falls in that spectrum, I'm not sure. But if you look at their study, depending on the severity, it might vary, but they all work.

## PRP for Osteoarthritis — Composition Over Platelet Count

All right, the only reason I put this one in here is that they talk about measuring the effectiveness of PRP for osteoarthritis, and they find that it's the composition, more than the platelet count, that seems to be predictive in this study.

And so, they measured IGF-1 and other factors, and the factor most strongly correlated with treatment was IGF-1 or somatomedin C. And this is dear to my heart because, of course, that's one of the growth factors in PRP, and I did some clinical trials with growth hormone.

It's also how you measure the effectiveness of growth hormone deficiency treatment, since growth hormone is pulsatile in adults. You can't just do a growth hormone level. But when you secrete growth hormone from the pituitary gland, it triggers somatomedin C, also called IGF-1 or insulin-like growth factor 1, to be produced mostly by the liver.

And when that is low, all sorts of problems happen, including depression, alopecia, poor wound healing, and poor bone healing. Twice, someone came to my office while I was still involved in growth hormone research with malunion of fractures after multiple surgeries.

One had already undergone six operations for a fractured humerus proximally, all of which had not healed. They were going to try once more at UAB in Birmingham and then amputate if there was no healing. She came to me, referred to by all, of all things, by the cashier at the health food store. Her IGF-1 was almost zero.

I told her to delay the surgery for six months; we replaced her growth hormone; the seventh surgery worked.

Growth hormone has been shown to be more effective for osteoporosis than Fosamax (osteoblasts are lazy without growth hormone), but it's risky to prescribe it these days because of the legal repercussions.[3]

The same thing happened at least once more: I saw a woman in my office with a rash who I noticed had an unrelated external fixator on her left radius. After multiple procedures, it just wouldn't heal.

And I said, "What's that about?"

I treated her rash, and she told me the same story; she had a low IGF-1; I replaced her growth hormone, and everything healed.

So, bone healing is highly dependent on growth hormone, and without systemic growth hormone, you can provide somatomedin C locally by injecting PRP. That's the take-home from this. And that, measuring that is something that, in this study at least, showed it was one of the primary determinants of effectiveness for osteoarthritis.

Hopefully, we can one day return to prescribing growth hormone without worrying about going to jail.[4]

## Preparing PRP — Androgenic Alopecia, Buffy Coat vs. Apheresis

There's more than one way to isolate PRP. I've seen a micropore filter. Most of us are using a centrifuge.

---

[3] Human growth hormone occupies a unique legal status among prescription drugs in the United States. Unlike most off-label prescribing, federal law (21 U.S.C. § 333(e)) provides criminal penalties of up to five years' imprisonment for knowingly distributing HGH for uses other than treatment of a disease or recognized medical condition authorized under federal law.

A further complication is that adult growth hormone deficiency is not diagnosed by a single universally accepted test. The insulin tolerance test is often described as the "gold standard," but other stimulation tests—including GHRH–arginine, glucagon stimulation, and macimorelin—are also discussed in endocrine guidelines and reviews. Because federal law treats hGH differently from ordinary off-label prescribing, this diagnostic uncertainty matters legally. Under 21 U.S.C. § 333(e), hGH distribution for human use is criminalized unless it is for treatment of a disease or other recognized medical condition authorized under federal law and ordered by a physician. Therefore, even a physician acting in good faith could face regulatory or legal vulnerability if a reviewer later disagreed that the patient's testing adequately proved adult growth hormone deficiency or that the indication met the statute's "recognized medical condition" requirement.

Bottom line: write a prescription for growth hormone for adults and, unless the person has pan-hypopit, your license and your freedom become subject to the whim of others even though research documents that often the anterior pituitary fails with head trauma and other insults and leaves the posterior pituitary intact.

[4] Perls et al., "Provision or Distribution of Growth Hormone for 'Antiaging.'"

There's also an apheresis process. And these authors just looked at the treatment of androgenic alopecia, the buffy coat-derived method, which involves centrifuging and harvesting it.

They used a double centrifuge versus apheresis.

***And then their conclusion was that while the buffy coat gave a higher recovery rate, both methods improved hair density, and there was no difference between the two.***

And ***platelet number alone did not determine efficacy***. So that was reassuring to me, and it's probably the third time we've covered a study showing that, in androgenic alopecia, platelet count was not the primary determinant of effectiveness. And of course, the take-home is that if you have a single-spin centrifuge and you're treating alopecia, you're probably going to do as well as with a double-spin.[5]

## Defining Female Sexual Dysfunction — A Two-Year Consensus Review

This is a forty-page paper that we introduced last week.[6] This week, I thought it would be helpful to highlight the section on females.

There are three different ivory towers making up words and their definitions; they show all three opinions for each sexual dysfunction.

Let's go through them.

The organization doing this paper (one of the three) is the *International Consultation on Sexual Medicine Panel on Definitions and Epidemiology.* They had a bunch of experts who got together. Not only did they talk about it, but they also had people send them emails, which they discussed, and that's how they came to their conclusions.

They also point out that, ***among male definitions, distress is not a criterion of definitions/diagnosis***, but the concept of distress is not only relevant, but it's a required part of the definition for female sexual dysfunction. And that we'll get back to that. But that's hugely important because it changes the numbers.

And this is where they talk about how they came up with everything [see video]. And they admit that their opinions are not based on studies, they're based on their discussion about those studies.

They decided, their definitions, that they would define men and women by what you see when you unzip someone's pants.

So the current document divides definitions of women and does not attempt to identify those that do not fit a binary structure.

---

[5]Buffy-coat (double-spin centrifuge) versus apheresis PRP for androgenic alopecia. [Full citation and DOI pending.]

[6] Trost et al., "Definitions, Classification, and Epidemiology of Sexual Dysfunction."

Several surgeons in our group perform some of the transition surgeries and apply our techniques (O-Shot® and P-Shot®).

So I thought that was interesting how they decided if you're a girl or a boy.

And they give you so many summaries here. ***This is a great reference paper if you want to dive deep into one of the problems.*** This is a Herculean effort.

Holy smoke. No wonder it took two years after the meeting to get this to press, because they think about the definitions of all sexual dysfunctions of both men and women, and they don't just cover definitions; they cover incidence rates, which come up a lot in our discussions.

## Hypoactive Sexual Desire Disorder

Hypoactive sexual desire disorder. You're going to have a lack of motivation for sexual activity. And they all say you have to have it for at least six months, which is interesting because after six months without motivation for sex, by that time, your spouse may be gone, or you might be getting a lot of packages from the UPS man because that's a long time.

But that's what it takes to be counted as the definition. So lack of motivation for sexual activity, *decreased or absent spontaneous desire, no thoughts or fantasies, decreased or absent desire to erotic cues, stimulation. Loss of desire to initiate or participate, including behavioral responses, avoidance, or failure to seek out situations.*

Hypoactive sexual desires combined with clinically significant personal distress. So you can have this combined with the others. If you're grieving, you don't say, "Just because you're sad, you don't have it." You're grieving, and maybe that's causing it, but you've got both. Okay, let's see what else I noticed about this one.



Oh, so most of these, they determined that they had a lack of desire by looking at the desire domain of the female sexual function index. And then they looked at the female sexual distress scale to see if they were distressed about it. That's how they arrived at the numbers.[7]

The prevalence, this is pretty shocking, actually. The prevalence was ninety-two percent in one study. ***Ninety-two percent of partnered women, but only twenty-six percent with distress***. Isn't that interesting? So you have ninety percent have low desire for six months, but less than a third of them are distressed about it.

In the unpartnered group, eighty-seven percent had the symptoms. Only about 7% or 8% were worried about it. Interesting, huh?

---

[7] Try out our female sexual function index calculator here: https://oshot.info/fsfi-calculator/

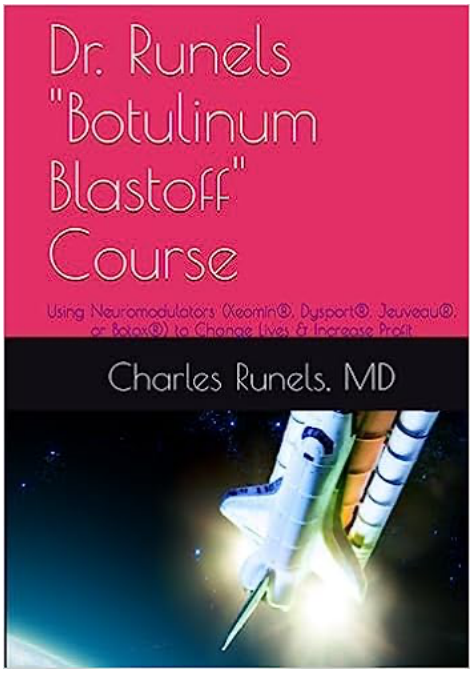
So if you have a partner, you're about three times as likely to be worried about it.

And then if you look at the younger ages in this other study, three age groups, in the age range of 18 to 39, that's still one in five. One in five. In 40 to 65, it's 30%, about a third of them. And by the time you make it to 65, it's 15%. So that's a prevalence, in another study.

They found a prevalence rate of 39% in Australia and 13% in Iran. Persian ladies are less distressed or more desirous than Australian ladies.

As relating to our procedures, I still think testosterone is the primary treatment for desire. Desire is mostly in the brain, of course. On the other hand, with women, there's a different sort of situation: with men, you have arousal, plateau, orgasm, and then a refractory period, and there's a response that has little to do with the last sexual encounter.

With women, this is not me making this up; these are the studies that show this. With women, you get




arousal, and then if there's no... Let's say this is baseline [see video]. If this is blocked somehow, there's frustration, the man's got premature ejaculation, or the woman, for whatever reason, can't reach orgasm, or she has pain, then she drops to a different level.

And so now the next time she has sex, it takes more. There, there's a memory here. Where the guys, not so much. Whatever happens here, they're ready to go the next time around. But for the woman, it becomes more difficult. She's starting at a lower baseline. Of course, if this problem persists, she eventually just quits trying.

On the other hand, if she has a great response, and then she never quite makes it back to the baseline. In the next encounter, it's easier for her to become aroused; there's a positive feedback loop. It's easier for her to reach the same level or higher, and, eventually, she's up here, as I say, writing the next book of the Bible.

She's having visions.

And so looking at these conditions, if you have hypoactive sexual desire disorder and you just give her an O-Shot® and she's had this experience, it may not be enough unless this drop [see video] and this blockage here were, say, from decreased sensation and you now cause neurogenesis, and then the next time around, even though she's starting lower, things are working better.

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

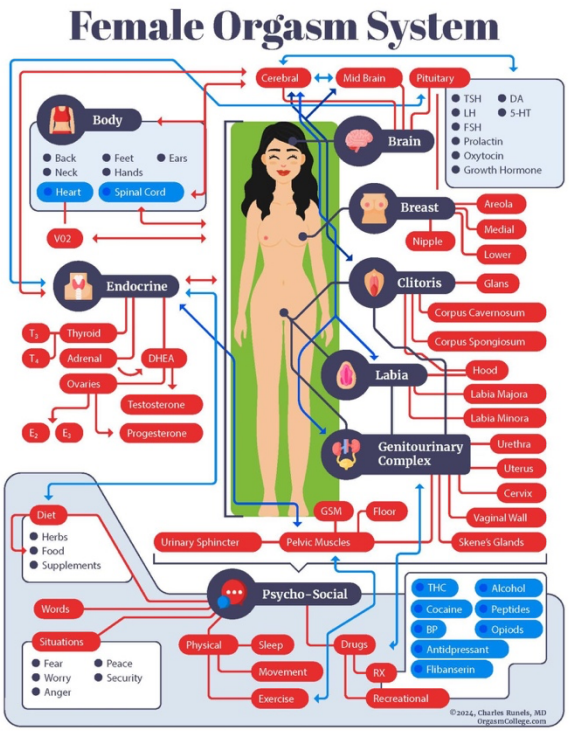
Or she had dyspareunia, which blocked it, and this time, even though she started lower, there's less dyspareunia, and she can more easily get back up here where she was. But she will be starting from a

different place. The thing I love about testosterone and our Clitoxin® procedure is that they seem to act centrally to take this baseline back up here, maybe even up here somewhere.

## Female *Genital* Arousal Disorder

Okay, let's examine the next one:[8] Female genital arousal disorder. So with this definition, persistent or recurrent inability to attain or maintain arousal, the keyword here is "genital."

So, because there's another diagnosis that's not the genitals. Genital arousal disorder. It's characterized by the inability to maintain adequate genital response.




That's key. So it includes lubrication, engorgement, and sensitivity. The flower's not engorged. And, again, it has to go on for six months. And it could be a vascular injury. They give you some of the etiologies. But of course, you guys have seen my female orgasm system poster, and this problem could be arising from many things, from narcotic use to a pituitary adenoma with hyperprolactinemia.

This paper does not give an exhaustive list of etiologies. But the point is that it has to do with actual genitalia. And you must exclude the vulvovaginal conditions of atrophy, infection, inflammatory disorders, vestibulodynia, clitorodynia, lichen sclerosus, all that. So she has to have it without these.

It's useful to review these definitions because having a better vocabulary means you think more discerningly about diagnosis. We think with our words, right?

And, "She's not having fun in the bed versus really figuring things out and helping you both diagnose, figure out etiology, and help you be more thoughtful and effective in choosing your treatments—that's what definitions of words can do.

Always, of course, remembering the whole systems analysis idea.

[8] Trost et al., "Definitions, Classification, and Epidemiology of Sexual Dysfunction."

Okay, this was an interesting number. In Australian women, lubrication occurs in twenty-one to twenty-eight percent of women. And for this, our orgasm shot, our O-Shot® is the bomb. It's the bomb. And look at that. That is one in five to one in four women who we could help because they have dryness.

Their genitals are not responding. Their mind might be, but their vagina and labia are not, and the clitoris is not. And this is low-hanging fruit for us, for the lubrication.

Also, remember we showed that when we added botulinum toxin to our O-Shot® procedure, it helped even more. Persian ladies here had less response, or more; a higher prevalence. And by the time you get to Swedish women, who ranged in age up to 65, it was up to half of them.

A lot of people need O-Shots®!

And remember, we have two papers- two really strong papers published now that show we can help these women even if it's secondary to being without hormones after having breast cancer treatment.[9] This is one of the problems where we can really change lives.

## Female Cognitive Arousal Disorder

In this one, you're just not aroused. They say they modified it by taking out a word.

They took out the word "various."

These people worked so freaking hard. This was arduous. Took years of their life. I'm so grateful to these authors, but that's the kind of detail they go into. With the ISSWSH definition, the International Society for Women's Sexual Health, they define it as characterized by difficulty or inability to attain or maintain mental excitement associated with sex, problems with feeling engaged or mentally turned on.

And here it goes, "may experience in various combinations."

May experience female cognitive arousal disorder or female genital arousal disorder independently or in various combinations.

And their contribution was they took out the word "various" and made it, "May experience female cognitive arousal disorder or female genital arousal disorder independently or in combinations."

Which I think an English teacher would agree with: "various" is somewhat redundant. That's the kind of work that someone has to be persistent enough to bear the tedium and get it done (I would never survive one of these meetings).

And they changed it from "at least six months" to a "minimum of six months."

---

[9] Hersant et al., "Efficacy of Injecting Platelet Concentrate Combined with Hyaluronic Acid for the Treatment of Vulvovaginal Atrophy in Postmenopausal Women with History of Breast Cancer."

Whew!

Female cognitive arousal disorder: look at the prevalence of this problem: between 22% and 80% of women aged 20 to 79, 15% of Portuguese women, 36% to 43% of US women aged 48 to 68!

Oh, a lot of people are not getting too excited.

And for that, we have to remember this: even if you have good hormones, you can get blocked here [see video] and have a negative feedback loop. But I still think a good testosterone level is probably better than our procedure for most people at helping with cognitive arousal disorder.

Although I don't know, now that we have our Clitoxin® procedure, that may have changed. Remember, we could —in our study —have used Flibanserin and Bromelain tide as a placebo.[10] I know those are out there, but remember: ***Flibanserin is still not indicated for people over 65***. You must take it every day. You're not supposed to drink with it.

And if you take it every day and go to all of the trouble, the average is at one extra sexual encounter per month And the boost in female sexual function index was not dramatic. Women were almost twice as responsive to Clitoxin® as to flibanserin. And bromelinatide is great if you don't mind taking something for vomiting along with it, and you're ok with an effect that is only slightly better than a placebo.

Again, these are useful drugs, but they're both CNS drugs, which is why I think they're more likely to affect the cognitive arousal disorder. But we're thinking perhaps our Clitoxin® procedure is also affecting the midbrain or cognitive function by modulating the autonomic nervous system via axonal transport to the ganglion lining the vaginal wall, which is connected through the vagus nerve to the midbrain, the center of arousal, and affects the genitalia for a synergistic effect.

## Female Orgasmic Disorders

I think female orgasmic disorder is self-explanatory, but it can be defined by a decrease in intensity, ability, or frequency.

And for this, I think our O-Shot® can be very helpful for frequency. If a person is completely anorgasmic and has been their whole life, I think that's more of a job for sexual therapy and testosterone. But if she can have an orgasm and they're just not as strong as they were, or she'd like them to be stronger then the O-Shot® is the bomb.

The last Green Journal article that talked about a procedure that was only ½ an O-Shot® (they left off the clitoral injection), they were treating women with***out*** sexual dysfunction (young women without

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

sexual dysfunction) whose orgasms still improved with the injection of PRP in the anterior vaginal wall (without even injecting the clitoris). So they did half of an O-Shot®.[11]

## Female Orgasm Illness Syndrome

Female orgasm illness syndrome: you just feel bad after an orgasm, for lots of reasons.

It can be central or peripheral, everything from diarrhea to migraine caused by having an orgasm. That would be a bummer, and it's all too common, given the prevalence. And that, I think, is usually more hormonally treated and sex therapy than with our O-Shot®.

A good rule of thumb is that with our procedures, you're making the tissue, the local tissue, healthier when you use PRP.

Not so with botulinum toxin. You may be affecting the central nervous system if you put it in the right place.

But with our PRP procedures, the O-Shot®, the P-Shot® alone, without adding the botulinum toxin, you're affecting local tissue.

So if the etiology is somewhere else, it's less likely to be helpful. And I think when someone who's having central nervous system problems after an orgasm, we're not likely to help with that with and O-Shot® procedure.

## Sexual Pain–Penetration Disorder

Sexual pain penetration disorder, this is another one where we shine. I don't know why. I hope we will figure it out. But for some reason, even those without an obvious diagnosis often see near-miraculous results.

Of course, if someone's got a trigger point, you could inject it and make it better, and the differential diagnosis for this is huge. But for some reason, we get a high success rate, which is a straight up O-Shot®, and I'm not sure why.

## Persistent Genital Arousal Disorder

Persistent genital arousal disorder, this one is very difficult to treat, and I don't have any idea whether our O-Shot® will help it or not. I really don't. But these poor ladies and men who have it actually are so miserable, they have a higher rate of suicide than people in chronic pain.

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

It's a horrible problem. So, persistent genital arousal disorder can be all sorts of unwanted sensations, but there's no pleasure from it. It's just psychological and social torment.

Okay. I think we'll stop with that. I hope that's helpful.

=>Benefits of the Cellular Medicine Association<=

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

## References

Abdalla, Marwa S., Mary S. Karras, Marwa Zohdy, Shaymaa E. El-Mongy, and Mohammed H. El Fahar. "Synergistic Effect of Platelet-Rich Plasma and Stromal Vascular Fraction in Atrophic Acne Scar Management: A Mechanistic and Clinical Pilot RCT." *Aesthetic Plastic Surgery*, ahead of print, May 18, 2026. https://doi.org/10.1007/s00266-026-05871-7.

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.

Hersant, Barbara, Mounia SidAhmed-Mezi, Yazid Belkacemi, et al. "Efficacy of Injecting Platelet Concentrate Combined with Hyaluronic Acid for the Treatment of Vulvovaginal Atrophy in Postmenopausal Women with History of Breast Cancer." *Menopause* 25, no. 10 (2018): 1. https://doi.org/10.1097/GME.0000000000001122.

Perls, Thomas T., Neal R. Reisman, and S. Jay Olshansky. "Provision or Distribution of Growth Hormone for 'Antiaging': Clinical and Legal Issues." *JAMA* 294, no. 16 (2005): 2086–90. https://doi.org/10.1001/jama.294.16.2086.

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.

Trost, Landon, David Rowland, Cindy Meston, et al. "Definitions, Classification, and Epidemiology of Sexual Dysfunction: A Consensus Statement from the Fifth International Consultation on Sexual Medicine 2024." *Sexual Medicine Reviews* 14, no. 2 (2026): qeag028. https://doi.org/10.1093/sxmrev/qeag028.

Yang, Chia-Cheng, Yuan-Hong Jiang, and Hann-Chorng Kuo. "Therapeutic Efficacy and Predictive Factors for a Successful Outcome after Platelet-Rich Plasma Injections in Men with Post-Prostatectomy Urinary Incontinence." *International Urology and Nephrology*, ahead of print, May 20, 2026. https://doi.org/10.1007/s11255-026-05200-6.

## Tags

platelet-rich plasma, PRP, regenerative medicine, sexual medicine, female sexual dysfunction, O-Shot®, Orchid Shot®, P-Shot®, Priapus Shot®, Clitoxin®, Vampire Facial®, post-prostatectomy urinary incontinence, urinary sphincter injection, stress urinary incontinence, sphincter muscle volume, acne scars, atrophic scars, subcision, stromal vascular fraction, SVF, microneedling, trichloroacetic acid, TCA, knee osteoarthritis, IGF-1, somatomedin C, growth hormone, bone healing, wound healing, androgenic alopecia, hair restoration, buffy coat PRP, apheresis PRP, double spin centrifuge, platelet count, ICSM, ISSWSH, ICD-11, hypoactive sexual desire disorder, HSDD, female genital arousal disorder, female cognitive arousal disorder, female orgasmic disorder, female orgasm illness syndrome, sexual pain penetration disorder, dyspareunia, persistent genital arousal disorder, lubrication, arousal, testosterone, flibanserin, bremelanotide, female sexual function index, female sexual distress scale, vagus nerve, autonomic nervous system, Charles Runels, Cellular Medicine Association

## Helpful Links

=> 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) <=