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The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of June 9, 2026, with Charles Runels, MD.

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

Topics Covered

- How We Prepare PRP: Filtration and the Variability Question
- PRP for Anal Fistula: Preserving Sphincter Function
- PRP and Filler for the Lips in Scleroderma — and the Origin of the Vampire Facelift®
- A Critical Review of Cellular Therapies for Erectile Dysfunction
- Traps with the O-Shot®: First, Relax — It's Safe
- Choosing the Right Candidate (the O-Shot® Is Not a Magic Shot)
- The Female Orgasm System Poster
- Consent and Protection
- Use the Patient's PRP — Not Exosomes or Birth Products
- Drug Reps, Cheap Centrifuges, and the Paperwork You'd Show the FDA
- Injection Technique: Seeing the Field, Targeting Beneath the Urethra, and Depth
- What Separates the Providers Who Thrive

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Transcript

I've identified, with the help of our amazing group, some traps that I think can help you stay out of trouble and get better results with your O-Shot® procedure, and I'll run through them at the end. Of course, open mic anytime anybody wants to speak.

All right. Let's jump in with the research, and then we'll move over to the O-Shot® traps.

So let's start with the research. I put links to all of this in your chat box. I think the only one that was open source was the one regarding cellular therapies for erectile dysfunction, but I put links to all of them in the chat box.

How We Prepare PRP: Filtration and the Variability Question

The main idea behind this first one, of course, is that they're pushing their centrifuge. I found this from several years ago, I think 4 years ago. It uses a filter rather than a centrifuge to prepare platelet-rich plasma.[1]

Someone brought one of these to me over 10 years ago, right after I came out with the Vampire Facelift®, probably 2011 or 2012. He was using prepared platelet-rich plasma at the bedside in nursing homes and made a fortune with it. Simple to do, bedside, to help stasis ulcers and pressure ulcers.[2] I didn't think it was up to par at the time, but I wanted to remind everybody — when we look at the review article regarding the treatment of male dysfunction, one of the criticisms, understandably, is always the variation in how PRP is prepared.

That will continue to happen, and I think you'll see maybe even a reintroduction of some of these filtration-based systems. That's all I'll say about that, but I'm hoping I can round up another option for you pretty soon that may be simpler and may be cheaper.

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[1] Gociman et al., "Caption™."

[2] Deng et al., "Efficacy and Safety of Autologous Platelet-Rich Plasma for Diabetic Foot Ulcer Healing"; Cervelli et al., "Use of Platelet Rich Plasma and Hyaluronic Acid on Exposed Tendons of the Foot and Ankle."

PRP for Anal Fistula: Preserving Sphincter Function

This first paper focuses on preserving sphincter function in patients with an anal fistula and demonstrates how platelet-rich plasma helped.[3] Of course, many of us don't really treat anal fistulas, but it showed excellent preservation of continence, and that helps support the idea of everything else we're doing. It's a relatively large study for the literature, so if you do treat fistulas, this will support adding PRP to your technique — and not necessarily from that manufacturer, which is part of the reason for it.

It's retrospective, with no control group, but they showed clinical healing and true closure with good follow-up of about 9 months. So it's a good demonstration, in the batch of PRP studies, showing regeneration of delicate tissue in an intimate region, which is what we do with our P-Shot® and our O-Shot®. If you're a surgeon, this is directly helpful to you. If you're one of our P-Shot®, O-Shot® non-surgical providers, it helps support what you're doing.

PRP and Filler for the Lips in Scleroderma — and the Origin of the Vampire Facelift®

This study was my favorite of the week, I think — lips in people with scleroderma.[4] Most of you know that when it came to coming up with these ideas for the P-Shot® and the O-Shot®, I was mostly borrowing. There's really nothing new under the sun — there's a Walt Whitman poem about that. It's all linear. It was taking what the dentists and some of the plastic surgeons had done and extending it to the labia, because the genitalia function in many ways like the face. It's highly innervated and highly vascular, especially the lips.

What they showed here is that with scleroderma, if you treat the patient with a combination of filler and PRP, you get a beautiful result — which is exactly what we do with our Vampire Facelift®. Their upper lip thickness increased from 4.2 to 5.6 millimeters and remained elevated for up to 2 years. The lower lip went up well too, and ***PRP improved tissue quality, not just volume***. HA alone also helped. Of course, there are limitations, as always — these are small prospective cohorts, no randomized trials. But it helped for up to 2 years.

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I first bumped into this right after I started. I wasn't really that smart about it; I just got lucky. I started using PRP the way a drug rep told me to use it, which was, quote, "like Juvederm."

When I did it that way, the shape went away. I could see the neovascularization, so I thought, "Let me just add in the filler."

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[3] Muinelo-Lorenzo et al., "Autologous Platelet-Rich Fibrin Matrix (Obsidian RFT) as a Sphincter-Preserving Treatment for Anal Fistula."

[4] Mahmood et al., "Lips in Health and in Systemic Sclerosis."

Then everybody liked it, and it was amazing when I combined filler with the PRP. I needed a name for it, and I called it the Vampire Facelift®.

After I saw how amazingly well it worked, I looked in the literature and found that the idea of an HA filler as a single layer with PRP on top had been used in distal, hard-to-heal wounds and distal extremities — for people with diabetes trying to re-epithelialize exposed bone and tendon.[5] If you just used an HA, it didn't work as well as a layer cake: HA with PRP on top. The vocabulary that's used is scaffolding. You put the HA, then you put the PRP on top of it, and then there's a scaffolding for the pluripotent stem cells to migrate to, and the new tissue builds on top of it.[6]

Scleroderma is just a horrible disease. I first bumped into it with our procedures over a decade ago. A woman came in with severe dyspareunia.

I thought, "Well, I don't know if it'll help or not, but let's try it."

It just worked tremendously well, and 2 years later — longer than that — she said it was still working for her dyspareunia. Since then, many of you have treated similar patients. We haven't done the studies yet, but I think the beauty of this is that if you're doing facial treatments, here you go, it's directly related. And if you're also doing the O-Shot®, you have something independently supporting the idea of doing an O-Shot® in the face of scleroderma.

A Critical Review of Cellular Therapies for Erectile Dysfunction

This one is the more controversial one, I think. You've got a who's who of sexual medicine all putting their names on this paper — brilliant people — and they reviewed the field with***out*** a meta-analysis. They did a literature search, though, and talked about the use of cellular therapies, shockwave, and stem cells for erectile dysfunction.[7]

You can see they went from 3,262 down to 36. Mostly, they're looking for a placebo control, as you would expect, and of course, they're looking for bias.

But I would argue with that placebo-control part of it, because we have a growing list of studies showing that injected saline — the hydrodissection from saline in a soft-tissue study — is not a placebo.[8] It

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[5] Cervelli et al., "Use of Platelet Rich Plasma and Hyaluronic Acid on Exposed Tendons of the Foot and Ankle"; Spanò et al., "Platelet-Rich Plasma-Based Bioactive Membrane as a New Advanced Wound Care Tool"; Deng et al., "Efficacy and Safety of Autologous Platelet-Rich Plasma for Diabetic Foot Ulcer Healing."

[6] Cervelli et al., "Use of Platelet Rich Plasma and Hyaluronic Acid on Exposed Tendons of the Foot and Ankle."

[7] Kohn et al., "Systematic Review on the Safety and Effectiveness of Restorative Therapies for Erectile Dysfunction."

[8] "Clinical Benefit of Intra-Articular Saline as a Comparator in Clinical Trials of Knee Osteoarthritis Treatments_ A Systematic Review and Meta-Analysis of Randomized Trials | Elsevier Enhanced Reader"; Sharma et al., "Delineating Injectable Triamcinolone-Induced Cutaneous Atrophy and Therapeutic Options in 24 Patients—A

causes regeneration, triggers cellular activity, and it's used to treat scarring, leishmaniasis, even osteoarthritis of the knee. So I would argue that's not necessary. But whatever — it's still helpful to us. In the PRP part of this report, they were mostly beneficial.

They did not do a meta-analysis, and they acknowledge that's one of the holes in their commentary. ***But they reported that, overall, it seemed helpful***, while we need more research with a placebo before it can be officially recommended.

So I think what this means for us is, one, we do have a standardized protocol.

By the way, there are some shams that are sham shams. One of them, I think, is botulinum toxin in the face — because you can look at your face in a few days and know if you got the placebo or not, by whether your muscles are moving. The other is shockwave; you know whether you're getting it by sensation (do you feel it?). So in my opinion, the sham is a sham — at least if you're trying to blind it.

Back to this study, though: there was no meta-analysis, and their conclusion was that there wasn't enough data from a single protocol. The protocols are all over the place in how it's done.

The one that showed no benefit over placebo, which they quote here, used half the volume of our P-Shot® protocol. We covered it when it first came out.[9] But, both the placebo arm and the treatment arm did show statistically significant benefit: remember, their placebo was not a placebo, so they were really comparing two different treatments. This is a strong and undeniable criticism of their study, which they do not bring up. Furthermore, their bias is very evident in one of the last statements in the paper, where they mention those who are "advertising these therapies without any supporting data"— completely ignoring other studies, including some with a "placebo" arm that did show benefit.[10]

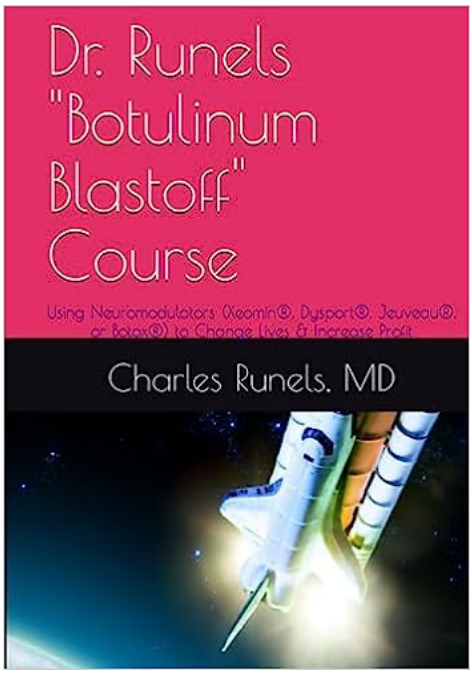
Retrospective Study"; Asghar et al., "Efficacy and Safety of Intralesional Normal Saline in Atrophic Acne Scars"; Popp, "Improvement in Endoscopic Hernioplasty"; Bagherani and R Smoller, "Introduction of a Novel Therapeutic Option for Atrophic Acne Scars"; Maiti et al., "Recalcitrant Dry Eye Disease in a 31-Year-Old Female"; El-Amawy and Sarsik, "Saline in Dermatology."

[9] Masterson et al., "Platelet-Rich Plasma for the Treatment of Erectile Dysfunction."

[10] Taş et al., "Early Clinical Results of the Tolerability, Safety, and Efficacy of Autologous Platelet-Rich Plasma Administration in Erectile Dysfunction"; Chung, "A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction"; Ruffo et al., "Effectiveness and Safety of Platelet Rich Plasma (PrP) Cavernosal Injections plus External Shock Wave Treatment for Penile Erectile Dysfunction"; Du et al., "Efficacy of Platelet-Rich Plasma in the Treatment of Erectile Dysfunction"; Anastasiadis et al., "Erectile Dysfunction"; Shaher et al., "Is Platelet Rich Plasma Safe And Effective In Treatment Of Erectile Dysfunction?"; Schirmann et al., "Pilot Study of Intra-Cavernous Injections of Platelet-Rich Plasma (P-Shot®) in the Treatment of Vascular Erectile Dysfunction"; Poulios et al., "Platelet-Rich Plasma (PRP) Improves Erectile Function: A Double-Blind, Randomized, Placebo-Controlled Clinical Trial"; Matz et al., "Platelet-Rich Plasma and Cellular Therapies for Sexual Medicine and Beyond"; Francomano et al., "Regenerative Treatment with Platelet-Rich Plasma in Patients with Refractory Erectile Dysfunction"; Hinojosa-

They didn't talk a lot about Peyronie's disease or penile rehabilitation post-prostate surgery, all of which we do.[11]

The bottom line, however, is that it's not officially recommended yet.



For that reason, when you do your consent form — and ours has it — you want something in there that says everybody knows it's not a standard procedure, that it's not a drug, that it's not FDA-approved because it's not a drug, and that you're using an FDA-approved device for making plasma, and that everybody knows we're going to do it anyway. Without that, somebody could get up in arms and say you misled them. So that's how you do it.

The fun thing, though, is that it's out there enough — you want to be talked about. If there weren't a lot of people out there doing it and bragging about it, there would be no need to comment about it. I don't know how much longer it will take. It usually takes 20 to 40 years for a new idea to be shown in research sufficiently that it stops being debated.

Remember, ***you never prove anything. You just keep running, and people try to disprove it***. That's not a political commentary; it's just how science works. I used to have this fantasy that, after enough research, something would be proven. There is no proving anything. It just stands until it's disproven. In every branch of science, that's the way it works. And so far, it hasn't been disproven. It's holding up—but there's not enough to recommend it as the standard procedure, and that's how we talk about it with our patients.

Gonzalez et al., "Regenerative Therapies for Erectile Dysfunction"; Chung et al., "Regenerative Therapies as a Potential Treatment of Erectile Dysfunction"; Finkle, "Sexual Impotency."

[11] Virag et al., "Evaluation of the Benefit of Using a Combination of Autologous Platelet Rich-Plasma and Hyaluronic Acid for the Treatment of Peyronie's Disease"; Kaltsas and Hatzichristou, "Erectile Dysfunction and Peyronie's Disease"; Dachille et al., "Platelet-Rich Plasma Intra-Plaque Injections Rapidly Reduce Penile Curvature and Improve Sexual Function in Peyronie's Disease Patients"; Culha et al., "The Effect of Platelet-Rich Plasma on Peyronie's Disease in Rat Model"; Minore et al., "Intralesional and Topical Treatments for Peyronie's Disease"; Lee et al., "A Novel Management for Postprostatectomy Urinary Incontinence: Platelet-Rich Plasma Urethral Sphincter Injection"; Chung, "A Review of Regenerative Therapies as Penile Rehabilitation in Men Following Primary Prostate Cancer Treatment"; Sopko and Burnett, "Erection Rehabilitation Following Prostatectomy [Mdash] Current Strategies and Future Directions"; Wu et al., "The Neuroprotective Effect of Platelet-Rich Plasma on Erectile Function in Bilateral Cavernous Nerve Injury Rat Model."

Oh, both meta-analyses conducted separately from this paper showed benefit, and we've covered them in past journal clubs.[12] I think we'll stop there. Those are the main things.

Oh, and again, I put a link to these papers in the chat box. I was able to download two of them. I had to buy one of them — holy smoke, it was $106 to download a freaking paper. I think that was the one about sphincter preservation. But I was able to download the one from the Journal of Sexual Medicine without paying; I think it may be open source. I put links to all of them in your chat box.

Let me jump over to the slides now. I actually made some slides about this because I thought there are enough people being tricked, so I should probably run through possible traps for the O-Shot®.

Traps with the O-Shot®: First, Relax — It's Safe

One of my heroes is Richard Feynman. He had lots of funny stories, and if you want a good laugh from a nerd standpoint, read his autobiographical book about his life.[13] He had theories on everything, and when he went back to high school to see his, quote, "permanent record," he only had an IQ of 120, which is just borderline — one toe into the genius range.

They said, "What do you think about that?"

He said, "It's wonderful. Look what I did with an IQ of only 120."

But he helped build the bomb, he figured out why the Challenger crashed, and he won a Nobel Prize in physics. He was a big believer in stepping back from the math and thinking logically — thinking like a child.

Does the math make sense, or is it leading into something stupid?

If you just think logically for a second, before we get to the science about PRP: you're making what the body makes when you scrape your knee or have surgery. You're isolating what the body normally does when it's injured. So saying you could hurt yourself with it is like saying you're going to suffocate from oxygen. I can't think of anything safer in medicine. Probably driving to my office is more dangerous — I've had 2 people crash their cars on the way to my office in the past 30 years, but no one's been hurt by PRP.

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So the first thing is to relax about it, because it's a pretty safe thing. I'm going to tell you some potentially scary things, but consider this: one of the manufacturers of PRP — just one of them — sells over a million PRP kits per year. And now, dozens of companies are making these kits. When you search

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[12] Du et al., "Efficacy of Platelet-Rich Plasma in the Treatment of Erectile Dysfunction"; Hinojosa-Gonzalez et al., "Regenerative Therapies for Erectile Dysfunction."

[13] Feynman and Leighton, *Surely You're Joking, Mr. Feynman*.

the literature for serious sequelae, there's one review article with something like 6 cases of something horrible happening to the face or vision. It's hard to tell exactly from the verbiage, but at least some of them were in hotel rooms with some unknown filler mixed in.

So it would be literally less than probably one in 10 million — if you had a serious sequela, you'd have a reportable case. But again, when you start mixing things in with it, the game changes. In cases of blindness or skin necrosis, HA was usually also present.

I had a near disaster with necrosis of the nose when I injected the nasolabial fold and thought I could get away with a mixture I used — one part filler, nine parts PRP — and I got away with it, thinking, "Oh, that can be treated like PRP."

But then one day I was teaching a course, and the woman's nose started to blanch. I had to get out the hyaluronidase and pray and massage, and 30 seconds later, it pinked up, and she had a great result. But any amount of HA mixed with your PRP, you have to treat it like the HA now.

Choosing the Right Candidate (the O-Shot® Is Not a Magic Shot)

The other trap is trying to treat someone who's not really a good candidate. The easiest rule of thumb that I — and I think our providers — have found, and I see some people on the call who've been with us a long time who I think would agree: sometimes, maybe it's a placebo effect, I don't know what it is, but sometimes you risk it on someone you don't expect to get better, and they do.

But a good rule of thumb is that if the etiology is local, then yes, there's a likelihood it may help — for example, episiotomy and the O-Shot®, lichen sclerosus, and urinary sphincter dysfunction. But if you're treating, let's say, anorgasmia in a woman who was abused as a child, you probably should think about something else. Or if you don't know it, but she has a microadenoma with hyperprolactinemia, you're probably not going to help her so much with an O-Shot®. So you have to think about the whole picture, as usual. You have to be a doctor — and that's the reason you deserve the fee you're paid. You're not just getting paid to do an injection.

When I first started teaching people the O-Shot®, sometimes they'd call me and say, "Oh, it didn't work."

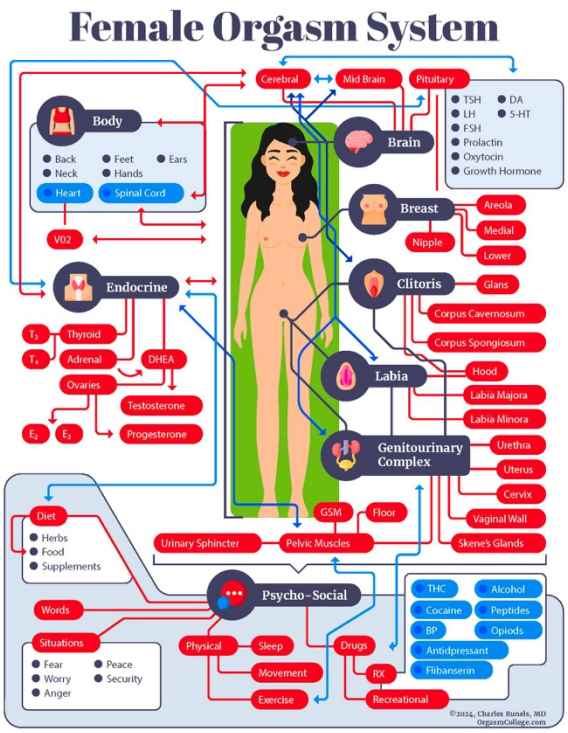
And then I'd walk them through all the causes for, say, dyspareunia or anorgasmia, and it would become plain that the physician somehow thought of it as a magic shot. So we have to keep reminding ourselves and our patients that it's not — which is why I spent a couple of years coming up with this poster. Eventually, if I can keep my brain long enough, there'll be a textbook to go with this poster.

The Female Orgasm System Poster

I sat down and tried to think, first order, what would make it so that a woman could not function sexually. Let's take the respiratory system as an example. You could talk about pulmonary function and pneumothorax and bronchospasm and cyanide poisoning and profound anemia — you'd be talking about all the ways to be short of breath, and you could map that out on a respiratory-system poster.

For a physician, you wouldn't have to get down to, say, the biochemistry of how oxygen binds the hemoglobin. It would be useful, it would be fun to know, but you don't need the details of that.

So in making this poster, I tried to think: what does a clinician need to think about, or at least know that someone else has thought about, to make sure a woman has good sexual function? I use the orgasm. Why orgasm as the marker of sexual function? Orgasm is the addictive part. Without the orgasm part, maybe there wouldn't be so many people walking around on the planet — from an overall world-evolution view, if you take away the orgasm, you wouldn't have as much drive for people to have sex. So you could call it sexual function; I just call it the orgasm system. And that is not the same as the reproductive system.



I don't need to keep harping on this, but one of the traps is to forget this picture — which is why I recommend you have it on your wall and in your brain, so you can talk with your patients about it and they don't think you have a magic shot.

All you have to do is point at it and say, "Okay, I'm going to do this O-Shot®. It's going to help you with blood flow and innervation in your clitoris and the anterior vaginal wall. It may help the muscle function of your genitourinary complex with the urinary sphincter — all three layers of muscle, two circumferential and one longitudinal. But you may still have decreased LH and FSH because you're on an opioid, or you may have an unknown thyroid disorder or something else, a hyperprolactinemia, or one of your herbs may be goofing you up. Or it may be that I need to know about the fact that your spouse is beating you up, and get you to a counselor."

In other words, if you want optimal function, we should think about — or have someone think about — everything on that poster. The other extreme is, "Oh, it hurts to have sex; let me try this O-Shot® thing."

That is the trap I'm trying to remind you to avoid.

And the other trap is this: even if you have that whole poster and more in your brain, if you don't point out to your patient that it may take more than that shot — maybe you need to do some blood work — then they have higher expectations and get angry because the shot didn't work, but they don't want to have their blood work done.

Consent and Protection

The next trap is consent. It should go without saying, but the consent form is very scary. I literally took the consent form that was used with the G-Shot, which has now been condemned by ACOG — but the man who came up with it is brilliant, Dr. Matlock, and he practices in California.

So I took his consent form and added to it. I made it so that if I could think of anything that could go wrong with sexual function in the female genitalia, I put it on there.

Because the truth is, we don't know. There could be a one-off. And some of the things women can have, there's no physical sign of.

A patient could start saying she has pain with sex, and it could be real. It may be that she's just wanting a payday. But either way, I have no way to comment on that, so I need a consent form that warns that anything's possible, even the bad stuff. And then I get a lawyer to approve it, because it's different in every state.

If you have a certificate from our group, we can get you malpractice coverage. So far it's been ubiquitous — it depends on your background, but so far, as far as I know, we've gotten malpractice coverage. If your carrier won't cover it, we can get you malpractice coverage if you have a certificate from our group — either from us, or from one of our teachers, or from our online training followed by a test. And of course, our staff checks people out as well. So: consent and protection.

Use the Patient's PRP — Not Exosomes or Birth Products

This next one is another one that shocks me, and it happens probably once every two to three weeks. I'll get a phone call, and someone is not doing PRP. They've swapped and they're doing all exosomes, because the drug rep said that's all you need, or some sort of birth product.

They had some weird thing happen, or no results, and they say, "I don't know why it isn't working."

I talk with them, and they're not even using PRP!

So if you do something other than PRP, that's great — you can just say you're adding it to the O-Shot®. But if you do an injection in the genitalia and you don't use the person's PRP, then that's not an O-Shot®.

It's something — maybe better, I don't know. But I've seen so many different materials called exosomes and so many different birth products out there. If you think PRP is non-standardized, once you start going there, it becomes even more unpredictable.

Now, out of 16 years — and that's why we get malpractice coverage — *I'm sure we've done over a million O-Shots®, and we've had no permanent serious sequelae*. The worst I've seen is some temporary loss of sensation and orgasms getting worse, and in every case I know about, it came back to baseline or better. Nothing permanently bad, out of literally over a million cases. ***So that's much better than anything advertised on TV — the drugs where they say if your liver falls out or you get a rash, all these***

horrible things can happen to you for the prescription drugs. Or with flibanserin, you could get profound hypotension and die. We don't have to think about that stuff with our O-Shot®.

Let me start over on this part. We have not had anything serious happen, but we've had a few people challenged. I think we're up to nine, out of our thousands of providers over the years, who were challenged by the medical board. In none of those cases was it because of a bad outcome. In every case but one, it was a colleague complaining who didn't even understand what they were doing, and in every case the board ruled in favor of our provider. There was one case where a patient complained because she did not get the wanted benefit for incontinence, and the doctor did not give her money back.

I'm telling you, ***the cheapest money you'll ever spend is a refund.***

I tell them, "Give it 8 weeks, and in 8 weeks I'll either refund it or repeat it. After two procedures, if you're still not happy, you're going to get a refund, and I'll find someone else or something else to do with you. But I'm not going to keep your money, even if you want me to."

Safest, best money you'll ever spend.

=>Benefits of the Cellular Medicine Association<=

So if you ever had something happen, or you went in front of the medical board because a colleague complained about how much money you're making and how you're making their patients well — that happened to me. I got a patient well who had seen another doctor who did not get him well; I got him off his diabetes and hypertension medicines, and his internist reported me to the medical board. The patient loved me. So when that happens, if it happens, we can take up for you. We've had to do that — write a letter — so far, I think eight or nine times.

But if you're shooting up something other than PRP and you change the protocol, it may be better. I can't support you, and the group can't either, because I don't really know what you're doing. So if you do something different, just call it something else, or say you did an O-Shot® plus the something else.

Drug Reps, Cheap Centrifuges, and the Paperwork You'd Show the FDA

Along those lines, you'll have drug reps come in, and one of our people will be talking to some good-looking person who hasn't done the procedures but is pretty, and who's been selling this centrifuge or these exosome products for three months.

For some reason, the doctor will just say, "Oh, makes sense to me."

Then I'll find out six months later that's what they're using instead of PRP.

Can we all agree that salespeople don't always tell the truth — and sometimes they don't tell the truth just by not saying everything they know, and sometimes they may be perfectly honest but just don't know as much as we do after 16 years and over 3,000 doctors doing O-Shots® in 50-plus countries? Maybe we should stick with our protocol. Now, the protocol needs to evolve, and I want and need the people in the group for that. It has already evolved — not from what I've thought, but from what I've

curated from what you all have taught me. That needs to keep happening. But at this point, an O-Shot® is PRP, and it involves activation with either calcium gluconate, calcium chloride, or thrombin. And right now, the numbing cream we're using, which works better than even the clitoral block, is a 30 percent lidocaine ointment.

I already talked about PRF. I love PRF in the right condition. I see Bill Song on the call — he's a wizard with PRF in the face. A wizard. You should do his course. But in the O-Shot®, injecting that into the clitoris, I would be worried.

We actually did have one of our providers have a case of blanching and necrosis using PRF in the lip. So ***if you have a place where you'd be worried about HA, you probably should worry about using PRF there.*** For dentistry, in the right hands, in the face — yes; but please, not in the O-Shot® or the P-Shot®. And the same with exosomes. If you do that, call it something else. Those are some of the traps for that.

Also, this happens almost every day: someone will call or text me and ask for a cheaper centrifuge, or we'll find out they're using their lab kits. Part of the reason we protect our price point — and we all do stuff for free — but part of the reason we avoid advertising a price less than suggested, even though we might all do free things on the side, is that we want a price that allows us to buy quality equipment, and it's not cheap. But it does allow you to buy quality equipment and still make a profit. So trying to save money by using an uncleared centrifuge is just not a good idea.

We did have one case of serum sickness where someone injected using a LabCorp kit, a yellow top. And the salesman — if he says it's cleared, ask him for the paperwork.

One of my favorite questions to ask a salesperson is, "Give me the piece of paper I would show the FDA if they walked in my door."

If they can't give you that — and I've gotten all sorts of runarounds, but never the piece of paper when it's not the real deal. I'm also pretty picky: if I have to hide it and not put it on my website, that worries me. Maybe you have a higher tolerance for that sort of thing, but my feeling is that if I can't talk about it on my website, I'm probably not going to do it.

Injection Technique: Seeing the Field, Targeting Beneath the Urethra, and Depth

For this next one — I see it a lot when I'm teaching, and I suspect it happens quite a bit in offices without me knowing. This isn't a dangerous thing, but it will decrease your efficacy. When I watch people injecting in their workshops, there's a tendency to try to do it without seeing what they're doing. You really can't do a good job unless you can see the needle as it goes into the anterior vaginal wall.

That involves several things. You might need to tilt the pelvis. And almost always — not always, but almost always — the level of your eyes should be low: below the anterior vaginal wall, or at least level with it. Otherwise, you're looking down on a tunnel, trying to see the roof of the tunnel, but your eyes are above it and you can't see around the corner. So one of the easiest things to do is just get low. If you have a bed that won't go up, you might have to get on your knees.

I like a headlight. If you like a gooseneck, or you have something really cool hanging from the ceiling, go for it. I like headlights because I can put one on, turn it on, and not have to touch it again until I'm through the procedure, and it's always aiming where I want to look. But when I see people in the workshop, they'll often be trying to do the procedure with their headlight aimed at the person's knee or something. You can't see in the dark — most of us can't — so make sure your headlight is there and aimed right.

The other thing is the labia, the whole female anatomy — it varies so tremendously, as you all know. Sometimes it's hard to find the clitoris or to see where you are in the anterior vaginal wall. So I like finding the urethra first; that orients me. If you're having trouble finding the clitoris because it's small, follow the labia minora up, and the labia minora will end at the clitoris, so that helps you find it.

I learned the labia majora trick from Dr. Dallar down in Miami, one of the urologists in our group. If you take the labia majora — have your patient, or preferably your helper, pull the upper third of the labia majora toward you and angle it 45 degrees, so the vector is 45 degrees off the floor toward the ceiling — it will pull the anterior vaginal wall around and up. It's not a bone, it's soft tissue, so you can actually rotate it out where you can see it better.

The other thing I see, in the research and with some of our providers, is that they'll go to other places. It's fine if you want to do that — use the extra PRP for that if you want — but if you look at sexual function: this was Dr. Grafenberg's idea way back in the '50s. That's where "Dr. G" came up with the thing. He wasn't initially talking about a spot; his idea was that the whole urethra was the most erotic, most arousing part of the female body. He actually documented female ejaculation back in the 1950s.[14] So the urethra is there, the paraurethral glands are there, and the surface is so insensitive that you literally don't even need numbing cream to do your O-Shot® there.

The urethra and the paraurethral glands have a lot to do with sexual function. If you're doing injections at three o'clock, or even to each side of the urethra, which I see in some of the studies, I'm not sure what you're doing. It may be good for the tissue, to make it healthier. As far as sexual function goes — next time you're masturbating, if you're a woman, or having sex with your lover, if you're a man or a woman — if you just put pressure there, there's some stretch that could be pleasant. But really, if you want to bring someone to orgasm, it's not the three o'clock position.

So if you want the best results, four cc goes into the anterior vaginal wall directly beneath the urethra. Anything on either side should be extra PRP, for whatever reason — sometimes a point just for spring. But putting that wall volume somewhere else is something less effective, is what I'm saying.

On the depth: that's a misprint on the slide; it should say a one-and-a-quarter-inch needle, which is what we use. I see people frequently, when we're teaching workshops, advance the needle and go too deep as they push the plunger. You have to keep it shallow enough that, hopefully, you'll see or feel a bulge where you do the injection. It should be only at the second or third rugae, just inside the introitus. So

[14] GRÄFENBERG, Ernest, "The Role of Urethra in Female Orgasm."

it's smooth around the vaginal introitus, and then, within Hart's line, when you see the horizontal rugae, you know you're inside the vagina. Sometimes it's hard to tell. The second or third one — that's where your needle goes.

Almost done. If she says "ouch," you've touched the urethra. As an ER doctor, we were trained how to do — I never had to do it, but I was trained on how to do — a bladder tap on a baby with a needle. You could stick a needle in a carotid artery if you wanted to. So if you touch the urethra — I've asked urologists and gynecologists, many of whom pass through our workshops, and no one has ever told me about any permanent harm from that. But if your needle's in the urethra, you're just doing a bladder irrigation, and it hurts, and it tells you you're too deep.

Part of the reason we talk about saline not being a placebo is that there's an effect from the hydrodissection. If there's an effect from the hydrodissection, then saline is a placebo when it's pushed IV and compared to a drug IV — but when you're hydrodissecting tissue, that's not nothing. And if it's not nothing, then it matters which tissue plane you're in when you do the hydrodissection. So if you're too deep, you're not putting the PRP where it goes. There's some field effect, but you're losing the dissection of that tissue and not getting as much effect.

If you do touch the urethra, you don't have to abort the procedure — it happens to everybody occasionally. Just take a breath, pull back the needle a millimeter or two, look at your needle, and make sure you're not so deep. If you come out all the way, that's fine; just go back in. And your angle? The angle to the anterior vaginal wall should be about what it would be if you're starting an IV — not perpendicular, but about a 30-degree angle. Slip into that subdermal space and inject.

What Separates the Providers Who Thrive

The other thing — I'm preaching to the choir right now, because we see people who come into our group and literally, without exaggeration, make millions. Some open multiple clinics or franchises, or develop their own intellectual property, or hire extra staff, surgeons, or physician extenders to help them. They just go crazy, and they call with the sole satisfaction of changing lives and families.

Then others hook up with us and, after a couple of weeks or a month or two, they drop out. Of course, I want to know the difference between those two groups, and I've checked this pretty frequently. Without exception — and there may be something I don't know about — the people who drop out are not logging in and keeping up with what we're doing. They think they know, but they don't know what they don't know.

The people who do well show up to the journal club, or at least watch the video and log into the website. The people who really kill it are usually logging into that website — even if they learned from another one of our teachers — literally 30 to 60 times in the first couple or three weeks. Those people do well, and they're calling us with questions. We have five full-time staff, not to help me with patients, but to support our group. So they're calling, talking with our staff, showing up to journal club, and keeping track of the new stuff. They're sending out the emails when I give them a suggested email that connects to the recent research or press. Those are the ones.

If you have questions, if you're not getting good results, if you're not having patients show up, then this is the time. We'll have open mic in a second — ask the questions. And you have not just me, thankfully. I'm looking at our list, and I have amazing people on the call right now; many of them have been with us over a decade. So you have not just me, but their opinion too, and you can call our group. We have three employees who have been with me over 8 years, and they've seen the people who get richer and the ones who drop out. Literally during COVID, we had people who doubled their business and others who just went out of business, depending on how they were doing things. So ask questions.

I think that's it. I hope that was helpful to you. I don't see any questions, so thank you very much for being on the call.

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