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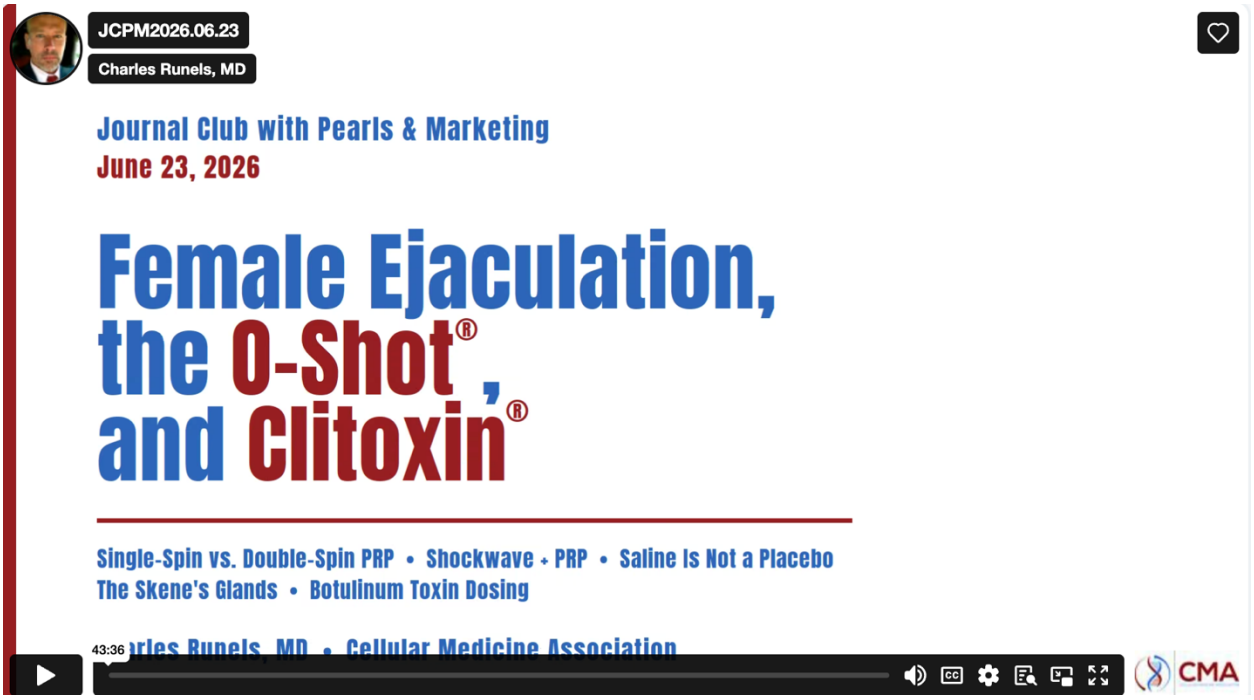
The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of June 23, 2026, with Charles Runels, MD.

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



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- Shockwave Combined with PRP for ED and Interstitial Cystitis
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Transcript

Introduction

Today I'll answer a question I get periodically. I don't think I've covered it on a Journal Club in years, if at all — regarding ***female ejaculation and how it might relate to our O-Shot® procedure***. Before I get to that, which will involve a number of diagrams and papers, let me cover two or three articles that came out in the past week that I think you might find helpful.

PRP in Dermatology: Single-Spin, Double-Spin, and How to Deliver It

The first one is about platelet-rich plasma and devices for platelet-rich plasma in dermatology.[1]

They're not covering our sexual indications or urology, just dermatology, which would include alopecia. They start with a nice overview of what PRP is, which is useful for those of you who may be new. And then they give something that I think will surprise some of you.

I've seen two studies showing that, with alopecia, a single spin is actually superior to a double spin. That's surprising to many of you. I've always said I think this research is very strong in orthopedics — that you really need a double spin to achieve around 5 times the concentration of whole blood for optimal results.

But with our procedures, the answer to that is no one really knows. The research is starting to accumulate some. I've added a link to your resources for all the references I'm about to talk with you about. I had to purchase some of them, so I try to be respectful of that, but I'll show you the main things I think were helpful. More and more, research is backing up the idea that it might really be better to use a single spin when treating alopecia.[2]

And then, after you have the PRP prepared, how do you deliver it to the skin?

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[1] Williams and Tosti, "Platelet-Rich Plasma Devices in Dermatology."

[2] Legiawati et al., "Comparing Single-Spin Versus Double-Spin Platelet-Rich Plasma (PRP) Centrifugation Methods on Thrombocyte Count and Clinical Improvement of Androgenetic Alopecia"; Ghanem et al., "Comparison of Single-Spin to Double-Spin Platelet-Rich Plasma Centrifugation Methods in the Treatment of Androgenic Alopecia."

They talk about derma rollers.[3]

Sixteen years ago, when I first started working with PRP, these were common. I found them more painful, but they're still in some studies and still work. If you just physically consider it, it's difficult to do the same number of puncture wounds. If you have a device that does — if you do the math on it, the RPMs and the number of needles — you can have thousands of microneedle puncture wounds per minute, where with a rolling device, not so much. And if you think about the mechanics of a rolling device, it can be more of a tearing versus a very quick in-and-out.

So I think most of us have decided that the roller device might be okay, but the pens work better. And then the lesson that was learned several years ago is that you definitely want a pen that's FDA-cleared for this purpose, or else you can cross-contaminate and transfer pathogens from one patient to the next.[4]

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So it's imperative. Anything else you're doing is truly criminal, and two people are in prison for breaking that rule and transmitting HIV.

Done the right way, we handle blood all the time, but we have to keep reminding ourselves that it can't just be, quote, "a provider" who turns out to be someone who's great at makeup and nails but really doesn't have the qualifications to do what we do.

I saw a recent article the AMA put out recommending that we say what we are — whether we're doctors, physician extenders, nurse practitioners, RNs, or whatever we are — instead of using a "provider" word that can be confusing. I was talking with one of my sons about his visit to, quote, "the doctor" in New York City. He's still not sure what the qualifications of the person who took care of him are. As you know, there can be some blurring in how people introduce themselves.

So, back to this. For those with proper training, this is as safe as anything we do, and safer than almost everything we do. Any skin type — we handle blood all the time. We break the rules, and horrible things can happen. So if you're using one of these rollers, it works not as well, I don't think — and I think just the math of it shows that — as doing the pens.

And then there's just injecting subdermal, intradermal. Even though the research shows that for alopecia, the single spin with microneedling works best, sometimes you have an area that's thin, but there's still enough hair there that it's difficult to make the rim surface of your pen flush with the skin, so your delivery of the puncture wounds is inconsistent and unreliable. So in those areas especially, I like to inject intradermally about a centimeter apart, about 0.1 cc of PRP per injection.

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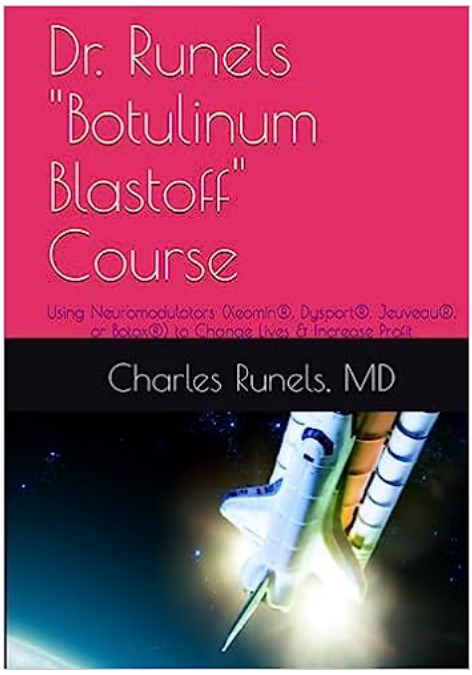
[3] Williams and Tosti, "Platelet-Rich Plasma Devices in Dermatology."

[4] "Vampire Facials Linked to Two Confirmed Cases of HIV In New Mexico."

But it's not like dosing some dangerous drug. You have to kind of get a feel for it, or it takes too long. If you're watching the plunger and doing each injection trying to accurately measure that much, you'll torment the patient, because it takes too long.

They also talk about ***mesotherapy guns***. I see this more in people from other countries, though some in this country have them. I think they're more commonly used in Europe. We had a physician from Canada in our recent hands-on workshop, and she uses this a lot. They're fast, so you can do intradermal injections very quickly at an exact depth. Instead of microneedling and then having it absorbed through the insult to the surface, you actually have an injection with each one of those rapid insertions of the needle.

And I know there are some who are using other devices where it's absorbed by a jet of air. I know these are catching on in some places. My worry is that, somehow, the trauma of passing through the skin might denature some of those small peptides. Just like if you've reconstituted growth hormone — Saizen or Genotropin — ever, you can't agitate the vial. You put the saline or the water in, and you gently swirl it. If you shake it, you tear apart the amino acid chain; it's denatured, you lose the code, and it's no longer of use.



Many of the peptides that are in platelets have that same nature, so I worry about blasting it through.

Some even try to argue that just passing it through a small needle — or pulling platelets from the venipuncture through a small needle — activates them. They insist that you should use a 17- or 18-gauge needle to do your phlebotomy, or else you're activating the platelets. No one's really sure of the answer. But I think that, considering the size of a platelet, a 30-gauge, or a 21-gauge butterfly, is still pretty small. Blasting it sonically through the skin, though, would be obvious disruption. So that was just my take, until the research is done. I can see we're trying to get away from needles, but I worry about the needleless delivery systems. Someone should do the study and compare them.

The ***vibrating devices*** — these are more for pain, and they actually work well. You can buy those from Amazon — just a little vibrating thing that you put against the skin while you're doing the injection. If you learn how to do it the way I teach it on our membership site, you really don't need much in the way of pain relief, because you'll be done in less than a minute, literally, without rushing. When I treat the scalp, it's usually 30 to 45 seconds, depending on how much scalp I'm treating, without rushing. So if it's taking a long time, obviously, there's more prolonged pain, which leads to less tolerance. Anyway, the vibrating device is great.

And if you're doing a hair transplant, of course, it's a different game. But just injecting or microneedling it shouldn't be a long thing. I do use this a lot — the cooling — just an ice pack, just regular ice put in a Ziploc bag. And I precede the treatment usually with 30% lidocaine ointment. BLT, if you have it, is okay,

but I use the ointment when I do the O-Shots®. I've started using it on the scalp. It's too strong to use if you had, say, the back, or a large surface — legs — where you're trying to do hair removal. But for our procedures, where the surface area is small, 30% lidocaine ointment works great.

Nerve blocks — I think that's more for... I used to do it. I teach how to do it. There are videos on our website about how to do it, including one by a hair transplant surgeon. Of course, as an ER doctor, I did it routinely. But by the time you're through with your nerve block — actually, before you're through with it — I will be finished treating the person's scalp. So I quit doing that so much.

Let's see, what else do I want to say about this? It's a nice article that reviews some basic ideas, and those were the main points I wanted to take away from it. I'll come back to that when we talk about female ejaculation.

Shockwave Combined with PRP for ED and Interstitial Cystitis

This next one was interesting. We're starting to see more and more about shockwave combined with our PRP procedures. Some of you are in the GAINSWave group, which is an excellent protocol. Others of you are using other protocols, with great results. And now we have multiple studies showing that if you're using shockwave for ED, you'll get much better results when you combine it with our P-Shot® procedure.[5]

There are also multiple studies now showing that for interstitial cystitis, using PRP can help with the pain.[6] The studies I've seen have involved injecting directly into the bladder. Of course, many of us are seeing great results just injecting with our basic O-Shot® procedure. But in this study, they used shockwave with PRP and showed some synergistic effects.[7]

Great article, especially for those of you who have Shockwave in your office.

We have amazing results just with our basic O-Shot®, but if you have the shockwave, and it's been shown to improve results, why not? This is so ripe for some of you to study, because I've been hearing about it from our providers for over a decade now. I think it needs a good study from a urologist who

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[5] Chung, "A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction"; Geyik, "Comparison of the Efficacy of Low-Intensity Shock Wave Therapy and Its Combination with Platelet-Rich Plasma in Patients with Erectile Dysfunction"; Dogan and Cil, "Erectile Function Recovery Using Shockwave and Platelet-Rich Plasma."

[6] Willison et al., "Application of Platelet-Rich Plasma in Gynaecologic Disorders"; Zheng et al., "A Standardized Protocol for Modified Platelet-Rich Plasma Collection for the Treatment of Interstitial Cystitis/Bladder Pain Syndrome."

[7] Long et al., "Effect of Combining Low Intensity-Extracorporeal Shockwave Therapy with Platelet-Rich Plasma among Female Patients with Interstitial Cystitis."

maybe can do both methods and compare the two with a crossover. I think you'll find our O-Shot® is as effective with a lot less drama, since you don't have to inject into the bladder.

Answering a Critical Review: Why Saline Is Not a Placebo

This next one, I think, is worth looking at.[8] I found it to be very biased, but that doesn't mean we don't look at it. We want to see our most critical, our smartest critics — we need them to keep us smart. You should welcome an enemy, of course, metaphorically. We're at war. It's an intellectual war, and we should seek disagreement to help our thinking. So I want to show you where someone disagrees with what we're doing, and give you my reasons why I think they're seeing part of the picture, so that you have an awareness of every side of what's happening in the debate, or the conversation.

I like to think there's been a scientific conversation going on since somebody figured out how to make a fire or make a wheel. When we jump in and do something, if we're not aware of the conversation that came before, and in the other rooms — as in other countries or other specialties — we can come across looking ill-informed at best, and at worst, we can almost be like a child who just jumped into a grown-up's conversation.

And part of the basic idea — I know you know it, but I'm saying it so it can be front of mind as we talk about what it takes to prove something, or not prove it, or support it, or not support it. The basic premise of science is not that we prove things, but that we present a hypothesis, and then we try to disprove it, and it stands until someone disproves it.

So, with that in mind, let's look at the main criticism of this paper when they get to discussing adult dysfunction. They quote the paper they use, which says, "Randomized evidence is mixed. In the prospective double-blind placebo-controlled trial by Masterson..."

And this is the one — it's the only one they really have to wave around showing negative results.

You can say that a later randomized placebo-controlled trial reported benefit. It wasn't just later — it was prior to that as well. We have at least four double-blind placebo-controlled studies showing benefit.[9] So both before and after that, they showed benefit. And what they don't mention about this

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[8] Huang et al., "Platelet-Rich Plasma in Selected Urological Conditions."

[9] Chung, "A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction"; Narasimman et al., "A Primer on the Restorative Therapies for Erectile Dysfunction"; Taş et al., "Early Clinical Results of the Tolerability, Safety, and Efficacy of Autologous Platelet-Rich Plasma Administration in 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?"; Chung, *Medical Sciences A Review of Current and Emerging Therapeutic Options for 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

Masterson study is that they used half the volume that we use. They did not activate the PRP with anything — calcium chloride or anything like that. Some of you use thrombin or calcium gluconate.

It was unclear to me what they did. They asked the people not to stop their PDE5 inhibitors, but I can't see where they documented what actually happened with that. And of course, they don't bring up the fact — and it is a fact — that saline in a soft-tissue study is not a placebo. We have multiple review articles in dermatology about various uses of saline. When you diffuse it into soft tissue, you're having a mechanical effect that has been widely and repeatedly shown to help with scarring, leishmaniasis, even some osteoarthritis of the knee. So you're not doing nothing.

And in this Masterson study, both the placebo arm and the PRP arm showed benefit, even though it was half the dose without activation.[10] Both of them were statistically significant in their improvement of erectile function. And PRP beat the placebo arm, but not in a statistically significant way, when it was done at half dose without activation.

So ***what they really did was compare two treatments*** [even though they called one are a placebo arm].

I don't see this talked about in the urology literature. It is talked about in the dermatology literature. So this is one of those examples where conversations are happening, but those standing in one room are unaware of what's being said in another room.

The most dramatic example of this happened while I was in medical school. You had gynecologists routinely doing endoscopic surgery — partially, and probably mostly, introduced initially by one of the gynecologists in our group, Dr. Michael Goodman. So he introduced it, it's being done, but it took another gynecologist to see that, oh, this might work for cholecystectomy. So you had a number of years — not weeks or months, years — where gynecologists were routinely doing endoscopic surgery and the general surgeons were not. There were two different conversations happening.

And much of what I was lucky enough to come up with really was that. It was just listening in the other rooms and bringing it over here. I listened to what the dentists and orthopedic surgeons were doing and brought it into urogynecology and urology and dermatology.

Plasma and Cellular Therapies for Sexual Medicine and Beyond"; Chung et al., "Regenerative Therapies as a Potential Treatment of Erectile Dysfunction"; Francomano et al., "Regenerative Treatment with Platelet-Rich Plasma in Patients with Refractory Erectile Dysfunction"; Yogiswara et al., "The Potential Role of Intracavernosal Injection of Platelet-Rich Plasma for Treating Patients with Mild to Moderate Erectile Dysfunction"; Towe et al., "The Use of Combination Regenerative Therapies for Erectile Dysfunction"; Siroky and Azadzoi, "Vasculogenic Erectile Dysfunction."

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

So, back to this criticism. If this is the best they've got, then we're actually in pretty good standing, because they also mentioned meta-analyses, and two showed benefit. Short-term is debatable, but really, if you have to repeat something every year or every year and a half, that's not so bad.

And the other thing that's not mentioned is that all of the other alternatives are not addressing the pathophysiology. In other words, ***you can take PDE5 inhibitors every day, but you're not slowing down, or even possibly reversing, the neurovascular problems that might be causing the problem. Yet we have hundreds — actually thousands — of papers showing that platelet-rich plasma can trigger neovascularization and neurogenesis,*** which does not happen with the other alternatives.[11],[12]

So the idea that we shouldn't be offering it... I'm not saying it's proven — again, you don't prove anything — but when you have literally thousands of papers that show benefit, and you have this one double-blind placebo-controlled study that I think was poorly designed and didn't recognize that its placebo was not a placebo, I'm going to disagree. They're saying it's not far enough along to do it. But I think if it's my penis, or the penis of others who are informed, that's the deal.

You have to have an informed consent that says, "This is not standard. Your insurance isn't paying for it. There are people who say it needs more research, but I think it might help, and if it doesn't, I'm not keeping your money."

We have a very strong consent form — so get your attorney to look at it — but I think informed consent is the foundation.

And now we have a decade and a half of real-world data, which is not nothing. If this were just ripping people off, it'd be all over the internet. The world's too small. The internet is too informative if we were stealing from people. I know that's not a study, but it's not nothing — and actually, the FDA is starting to pay more attention to that, to help things move along.

As far as when they review these articles about Peyronie's disease — the same thing. They don't really even mention the main man, the legend who came up with the idea. I guess I shouldn't say that, it sounds

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[11] Wu et al., "Dual Effect of Chitosan Activated Platelet Rich Plasma (cPRP) Improved Erectile Function after Cavernous Nerve Injury"; Toloui et al., "Effectiveness of Platelet-Rich Plasma in Treating Spinal Cord Injuries"; Yasak et al., "Electromyographic and Clinical Investigation of the Effect of Platelet-Rich Plasma on Peripheral Nerve Regeneration in Patients with Diabetes after Surgery for Carpal Tunnel Syndrome"; Foy et al., "Functional Recovery Following Repair of Long Nerve Gaps in Senior Patient 2.6 Years Posttrauma"; Sánchez et al., "Platelet-Rich Plasma, a Source of Autologous Growth Factors and Biomimetic Scaffold for Peripheral Nerve Regeneration."

[12] Bindal et al., "Angiogenic Effect of Platelet-Rich Concentrates on Dental Pulp Stem Cells in Inflamed Microenvironment"; Norooznezhad, "Decreased Pain in Patients Undergoing Pilonidal Sinus Surgery Treated with Platelet-Rich Plasma Therapy"; Li et al., "Delayed Two Steps PRP Injection Strategy for the Improvement of Fat Graft Survival with Superior Angiogenesis"; Zhang et al., "Effects of Platelet-Rich Plasma on Angiogenesis and Osteogenesis-Associated Factors in Rabbits with Avascular Necrosis of the Femoral Head"; Sclafani and McCormick, "Induction of Dermal Collagenesis, Angiogenesis, and Adipogenesis in Human Skin by Injection of Platelet-Rich Fibrin Matrix."

disrespectful, but I love the guy — the guy who came up with the idea of injecting a vasoactive substance into the penis, from which we now have Caverject and Trimix and all that. He did a study in 2017 — so, 9 years ago — showing that Xiaflex was inferior to PRP for Peyronie's disease.[13] It's usually not even mentioned, even though this guy is a legend in the field: Ronald Virag.

So I think, looking at our critics — it's worth knowing and thinking about, and you use it to motivate you to do more critical thinking. And you don't argue; you just keep putting out the good stuff. You do another study. You keep pointing out the inconsistencies, which I just did. And the reasoning — another inconsistency — Xiaflex has been pulled from Canada, Europe, Japan; it's not even on the formulary. You can't get it. It's still in the US. And we went through some pretty remarkable numbers a couple of weeks ago about what happens with fracture and, for example, surgery, and the incidence of erectile dysfunction.

So why would you go to that first, when it's a series of injections that, if you pay for it, costs $21,000 — before you try something which is admitted in this article to be pretty much without side effects? Think about your PDE5 inhibitors. Okay, it's rare, but you can go blind, you can have a heart attack, profound hypotension — and all those things do happen. Or you can have a PRP injection where you might have a little pain and a bruise. And okay, maybe something comes up down the road that we don't know about — but again, 15 years.

So that's my thinking. I could be proven wrong, but right now there's no proof either way. We have something that's still standing. And the beautiful thing about this report is that it doesn't say we're wrong — it's just asking for more studies. The only, biggest complaint I have about the arrows that come at us is: let's please listen in through the wall to the other room, to hear what the dermatologists are saying about saline injected into soft tissue not being a placebo. It's a treatment.

A Question About the O-Shot®, Clitoxin®, and Female Ejaculation

Okay, so here's the question. Let me pull this up, and I'll just give it to you the way it was sent to me. Again, these references are in your handout; the links to them are there.

Here's the question, from one of our people who's been with us over a decade — a beautiful, smart plastic surgeon out in the western part of our United States.

He said, "I have a female patient ask me if the O-Shot® with botulinum toxin can help her squirt."

In other words, doing her O-Shot® and then combining it with our Clitoxin®.

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[13] 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"; Virag, "INTRACAVERNOUS INJECTION OF PAPAVERINE FOR ERECTILE FAILURE"; *Wikipedia*, "Ronald Virag."

He said she was able to do so years ago, but it's less now. "I remember you telling me that you wrote a protocol of some type on squirting. Would you please share that protocol with me?"

Okay, this is what I'm going to do with that protocol. It's out there. The quick version of what happened with me: over 20 years ago — close to 30, maybe 30 years ago — I saw a woman have an ejaculatory orgasm, and there was a different emotional response, a more open emotional response, that felt like it made it easier for us to be close, versus what normally happened after a wonderful orgasm.

So I became interested in it, read about it, was experimental with other lovers, and came up with some ideas that I think would help make that phenomenon available. So I wrote about it, and others have bought that course, which lives out there online, and I've gotten good reports. It doesn't mean it's a study; it just means it's been helpful.

I want to be very, very clear. I don't think this needs to be the goal. There should be no real goals other than just pleasure and emotional and spiritual closeness when sex happens. It's the glue of love, it's the scaffolding of love, and it can even be a form of prayer. It can be inspiration. Many prophets and poets — and just regular people like me — have talked about that, and it happens no matter what happens in the bedroom when it's going on. I don't say that to inform you; I'm just saying it so you know I don't think teaching you about orgasm... I didn't want you to think that means I'm trying to make that the goal, or that anything less than that is some kind of failure.

On the other hand, it is a phenomenon that happens, and I was lucky enough, one, to have what I just told you about — to have a lover who demonstrated to me that it was possible. But I also had a medical school that was somewhat progressive, because they offered a two-month sexuality course in my first or second year in Birmingham.

And the professor, on one of the first days in class, showed a video of a woman ejaculating, and he said, "I don't want anyone to ever leave this medical school and think that female ejaculation is not something that happens. It makes you look uninformed."

So I didn't think much about it until I witnessed it, saw that emotional response, and started thinking about it.

I don't want this course to be in the hands of... I'll get back to the course, actually. But let me show you the anatomy and how I think it integrates with our ideas about the O-Shot® and Clitoxin®. That's the main question here. I'll get back to the course that I wrote 20 years or so ago, way before there was an O-Shot®.

What Female Ejaculation Is: The Role of the Skene's Glands

Before there was an O-Shot®, and after I had written that book about female ejaculation, the G-Shot came around. Not being a urologist or a gynecologist, I never did that. I thought it was a brilliant idea, but I never offered that procedure, because it was known to sometimes cause a granuloma.

It's done with an HA filler, so it's been banned by ACOG. Even though the idea was brilliant, it can have problems. In one study, of 82 people who had something like that done, two of them had a granuloma significant enough to block the urethra and cause urinary obstruction requiring surgery.[14]

So, if I break it and I can't fix it, I'd rather not do it. So I never did it, but I was watching the idea.

Then, after using PRP in the face and in the penis for a while, I thought, "All right, let's try it." My thinking was not anything about incontinence — that hadn't even occurred to me yet. A second patient, whom I treated for dyspareunia, told me it helped her incontinence, and then I figured, well, that's something I should have thought of.

But the reason I chose the place where we do the injection was in regard to female ejaculation. If you look in the male, most of the volume that comes from the ejaculate comes not from the epididymis; it comes from the prostate gland. And in the female — it's not showing it in these diagrams, but there are the ducts of the Skene's glands [see video]; they show you that much, at least. So the periurethral glands, or the Skene's glands, are equivalent to the prostate gland in a male. And in studies that have documented female ejaculation, it is true that some of the women are urinating, and that can be pleasurable — but some of them are actually excreting fluid from the periurethral glands, or the Skene's glands, and that fluid is biologically and biochemically exactly like the fluid that comes from the prostate gland. It even tests positive for PSA.

So when I did the procedure, my idea the very first time was, "Let me put it beneath the urethra, midline, so that it might improve the health of the periurethral glands," thereby improving the strength of the orgasm and facilitating ejaculatory orgasm.

And indeed it has, in many of our patients.

To give you an example: one of our gynecologists called me once and said, "I'm worried. I did an O-Shot® on a woman, and now she says she's incontinent."

I said, "Oh, I'm not sure how that would happen. Have her come to the office, and tell me what you figure out."

So the lady came to the office, and what was happening was that whenever she had an orgasm, she was squirting — having crazy, fun orgasms that were leaving her spent and happy and emotionally close — and the fluid was coming along with that. She had never had an ejaculatory orgasm and didn't know that was a thing, I guess.

And since then, I've lost count of how many people have told me they've had one. I know I've personally seen probably a dozen, but I've heard it so many times, where they have someone past 65, past 70, who not only starts to have orgasm for the first time but starts to have ejaculatory orgasms. I don't put that

[14] Park et al., "Hyaluronic Acid Pulmonary Embolism."

out as a reason for the procedure, and you've probably never heard me talk about it, because I don't want people thinking it's a failure if that doesn't happen.

If you do study the material I put out about that, I make it very plain that this is not some mechanical thing. Women are mysterious. The body itself, of course, is mysterious — I hesitated because that's so cliché, but as you know, there's so much that goes on with sex. I think we're still probably kindergartners in understanding it. So imagine you're with your lover, and your lover's a woman, and sex is going great, and then the fire alarm goes off, or her cell phone rings, and it's her child, or 16 other things — somebody's at work having a problem. Just the mood and the movement and the sex and the orgasm possibility itself can be interrupted and even arrested.

It has to be in line emotionally and physically. Sex itself is the cherry on top of good health. But that ejaculatory orgasm takes patience and time and connection. Yeah, you can create something that's physical more quickly if you understand your lover's body, but for that true, emotional, spent sort of ejaculatory orgasm — that in some ways is like when a man ejaculates — I think things are going on with the pituitary gland and prolactin and oxytocin that maybe we don't even understand completely.

So, back to how this relates to our procedures. I think the O-Shot® most definitely improves that possibility. I think it's helping make the glands healthier.

That's the idea about what female ejaculation is. It's the female version — we all have the same parts — of the paraurethral glands, or the Skene's glands, emptying out simultaneously with orgasm. And yes, you can have a similar sensation with either urination or some form of urination, or a combination. But we do have studies showing that the fluid is not urine. We have ultrasound studies showing that in some women, it's coming from the paraurethral gland.

Why the O-Shot® Injection Site Matters

So, back to how our procedures — both the O-Shot® and Clitoxin® — can somehow contribute to that. The O-Shot®, I think, is making the paraurethral glands healthier and more voluminous, in the same way it's helping with lubrication. Not just the paraurethral glands — it's helping with lubrication.

Two studies now have shown women with dyspareunia after treatment for breast cancer, who can't be on estrogens or don't want to be — that dryness that causes dyspareunia — we have two good studies, and we have over a decade of experience, that that's low-hanging fruit for us. The O-Shot® helps those women like crazy; it lasts 9 months to 18 months.[15]

[15] 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"; Chen et al., "Platelet-Rich Plasma for Genitourinary Syndrome of Menopause in Breast Cancer Survivors"; Saleh and Abdelghani, "Clinical Evaluation of Autologous Platelet Rich Plasma Injection in Postmenopausal Vulvovaginal Atrophy."

So it's not just the paraurethral glands, but I think that's what's happening. Some of you need to do the studies, but I think that's what you'll find. One easy study would be to just do the straight-up O-Shot® — that one injection — but it can't be proximal to the bladder.

I think I got lucky, and part of the reason it's helping sex is that I was thinking paraurethral glands, and injecting very distal to the bladder — second or third rugae, in the space between the urethra and the vagina. That's why I was shooting for that space: I was thinking of ejaculation in females, and orgasm, as Dr. Grafenberg taught it.[16] I wasn't thinking urinary incontinence. But I think I got lucky, because by putting it there, hydrodissection most likely happens all the way back to the sphincter — whereas if I had been smarter and put the injection near the junction of the urethra and the bladder, it probably would not have been as good for sex, because water doesn't run uphill, and fluid doesn't hydrodissect toward an area of more tissue density.

So I think I got lucky, but I know we're seeing it happen — that many women are having ejaculation for the first time, and even orgasm for the first time, when you do the procedure the way we teach it.

Do you need to put extra injections over there? Before you answer that question, go take 4 cc of PRP, which is what we're using, and just inject it into someone's face. You won't get it all in. One cc is enough, subdermally, to cover the whole cheek. So I think some of the studies coming out are from people who haven't really watched the behavior of the PRP. I'm grateful that we were able to see it. I've used it for a number of months in the face, watching how it travels in the tear troughs and in the cheek. I promise you, when you put 4 cc in that midline, you're covering the whole area — probably the whole urethra, and into either side. It's a lot of fluid.

I think that's what's happening, and why it's facilitating ejaculatory orgasm. I think it's improving the health, the neovascularization, and of course the nerves and the blood flow — but also the actual glandular tissue, I think, is probably getting healthier. There's a study for somebody: use ultrasound, measure it, check it out.

How Clitoxin® Fits with Female Ejaculation

The Clitoxin®, I don't think, is directly helping with the ejaculatory orgasm, but I do think it's helping with the orgasm, by several mechanisms. We know that in the penis, and in treating migraine, there's some strong evidence that we're attenuating sympathetic activity and therefore accentuating parasympathetic activity, which leads to harder erections and fewer migraines when we inject either the corpus cavernosum or the procerus.

And so, if that's happening — the only study so far injecting botulinum toxin into the clitoris was the one my brilliant wife, Alexandra, and I did.[17] But it could have never happened without this group. I want

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

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

to make sure you guys know: I will always, always feel blessed and grateful for the financial and moral support from this group. I try to say that at least once every time I speak from the stage — that I'm just the point man for a lot of very smart, brave, intellectually brave people.

So directly, I don't think it's helping — except that we do have studies showing botulinum toxin also triggers neurogenesis and neovascularization.[18] We have studies treating scar tissue in the plastic surgery and wound care literature. So there could be some of that happening. But we're not putting botulinum toxin in the anterior vaginal wall, for fear we may relax the urinary sphincter. So we're just putting it in the clitoris, and therefore it's not affecting the local tissue where the fluid comes from, where it originates when the woman has ejaculatory orgasm. So I don't think it decreases the chances of ejaculatory orgasm; but if a woman is wanting to experience that, I think she needs the O-Shot® done in the way we do it.

And remember, also, when we combine botulinum toxin with our PRP in the clitoris — not the anterior vaginal wall — that it increased FSFI more than twice what was seen with flibanserin or bremelanotide. So that orgasm would be better, but secondarily it may help the propensity to have the pleasure of an ejaculatory orgasm.

The Emotional and Spiritual Dimension of Orgasm

And just as a sideline: there are those who — even in a woman who's had an ejaculatory orgasm — there can be this worry about the embarrassment of the fluid. What's the lover going to think? And even if she knows her lover is not going to be bothered, and they actually take pleasure in the event, both during and afterward, there can still be a reluctance that is difficult to get past sometimes, even in a woman who's had ejaculation before.

In the Chinese Tao, it's talked about — nine levels of orgasm — and the ninth, highest level is described as a little death.[19] The woman will also often feel like she's about to have a seizure or die right before ejaculatory orgasm and feel the need to pull back a little bit or stop. It can border on pain, and there's a mixture of fear. So I think it's one of those things where it's like we just got two kittens from the pound: you can't chase them, you have to wait for them to come to you. And it's exactly that way with ejaculatory orgasm.

You can't chase it.

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[18] Disphanurat et al., "Efficacy of Botulinum Toxin A for Scar Prevention After Breast Augmentation"; Lewandowski et al., "Off-Label Use of Botulinum Toxin in Dermatology—Current State of the Art"; Fasano et al., "The Regenerative Effects of Botulinum Toxin A"; Franz et al., "Botulinum Toxin Conditioning Enhances Motor Axon Regeneration in Mouse and Human Preclinical Models"; Aru et al., "Microcirculatory Effects of Botulinum Toxin A in the Rat"; Duchen and Strich, "THE EFFECTS OF BOTULINUM TOXIN ON THE PATTERN OF INNERVATION OF SKELETAL MUSCLE IN THE MOUSE."

[19] Decu, "(Taoism) Chang, Stephen - The Tao of Sexology."

You just fill the room with love, and sometimes it happens. But you can facilitate it.

There's one other question I haven't answered, but while it's on my mind: if you want the course on female ejaculation, you can send me an email. I don't want to put the link here, because I want it to go to people who I think will appreciate it — and sometimes we have our metaphorical brain enemies who would like to cut down everything we do. So I'll put it in your hands if you'll shoot me an email. I'll put my best email in the chat box, and then I'll answer this last question about the amount of toxin. If you send me your email and name to that email address, I'll send you a link to my course on ejaculation.

Botulinum Toxin Dosing with Clitoxin®: 50 Versus 100 Units

Okay, last question. Wow, this one went way over — you can tell that subject is dear to my curiosity. The short answer: we covered the idea of how much you should use of Clitoxin®, which is botulinum toxin.

When we first did the study, we knew that the Xeomin people had done a study showing that with men, if you inject 50 units, the men who had failed — who could no longer have an erection with PDE5 inhibitors — a significant number were able to achieve an erection, and it was mostly gone by 6 months. But when you injected 100 units, it would last up to 9 months to over a year.[20] So that's what we do with Priapus Toxin®: some go up to 200 units or 300 units if the 100 doesn't work.

With females, we weren't sure what was going to happen. Would it be nothing, or would it be persistent genital arousal disorder? So we started, and we did the paper, with 50 units. But if the mechanism is actually using the tissue as a port to get to the ganglion along the lateral vaginal wall, then the relative difference between the tissue — the volume of the clitoris versus the volume of the penis — would not matter. What matters is what you're telling the ganglion to tell the vagus nerve to tell the midbrain, because that's the path.

So the 50 units was a first, conservative try, but we're mostly using 100 units now when we do Clitoxin®, and it seems to be working better.

Also, this is an observation from my wife that I'll pass on. We like Daxxify in the face, but she notes it doesn't seem to work as well for the Clitoxin® or Priapus Toxin® procedures, and there's some biology that suggests it has less of an effect on the autonomic nervous system than Botox, Xeomin, or Dysport. So we're mostly using Xeomin for our Priapus Toxin® or Clitoxin® procedure, and that's why. And we're mostly going 100 units for Clitoxin® instead of 50 — and that's why: ***because it's not relative, we think, to the volume of the tissue of the clitoris or the penis. It's more of a port, with axonal transport to the ganglion, and that wouldn't really matter much, we don't think, between males and females***.

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[20] El-Shaer et al., "Intra-Cavernous Injection of BOTOX® (50 and 100 Units) for Treatment of Vasculogenic Erectile Dysfunction"; Giuliano et al., "Effectiveness and Safety of Intracavernosal IncobotulinumtoxinA (Xeomin®) 100 U as an Add-on Therapy to Standard Pharmacological Treatment for Difficult-to-Treat Erectile Dysfunction."

Financing Research Through Membership

So, in this journal club, I've given you at least 50 different research ideas. I'm looking at the names, and there are people on this call who can do that. So please help us out and realize that, by being in our group, you're financing at least one or two studies a year.

We don't have the millions, but we think there are ways we might reach the million-dollar research budget. I've got a couple of nonprofits and some other ideas. So hang in there.

Thank you for being on the call.

Shoot me an email to that address if you want the little course I did about female ejaculation. Have a great week. See you next time.

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Tags

O-Shot, Clitoxin, P-Shot, Priapus Toxin, female ejaculation, Skene's glands, paraurethral glands, PRP, platelet-rich plasma, botulinum toxin, Clitoxin dosing, botulinum toxin dosing, Xeomin, Daxxify, Priapus Shot, female orgasm, ejaculatory orgasm, female sexual dysfunction, dyspareunia, vaginal dryness, breast cancer survivors, urinary incontinence, PRP dermatology, alopecia, single spin PRP, double spin PRP, microneedling, PRP delivery methods, mesotherapy, shockwave therapy, GAINSWave, erectile dysfunction, interstitial cystitis, PDE5 inhibitors, saline placebo, Masterson study, Peyronie's disease, Xiaflex, Ronald Virag, informed consent, off-label, PRP research, neovascularization, neurogenesis, FSFI, flibanserin, bremelanotide, regenerative medicine, sexual medicine, Cellular Medicine Association, Journal Club with Pearls and Marketing

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) <=

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