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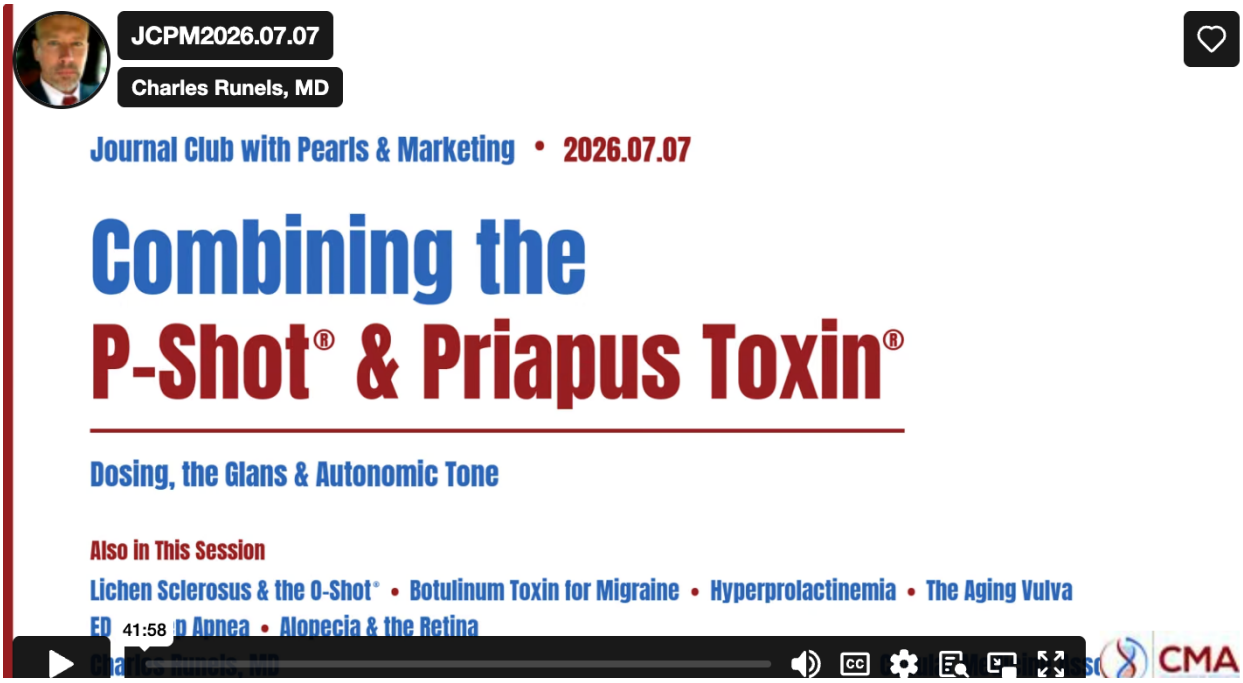
The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of July 7, 2026, with Charles Runels, MD.

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



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- A Marketing Pearl: Teach the Disease

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Transcript

Opening and How to Submit Questions

Welcome to our Journal Club. We had several questions come in on the website. Just a reminder: anytime you have a question that's not urgent, you can post it to the membership websites, and I usually will get to it the very next Journal Club. If I don't, just text my cell phone, and I will apologize and answer whatever question you have.

We'll get to a couple of those, but papers first. This one is mostly a reminder, and most of us are doing some type of sexual medicine.

COVID-19 and Sexual Dysfunction

I put this here just to remind us — I think most of us know it — that sexual dysfunction is a side effect of COVID-19, and some of those who have long COVID are still suffering with decreased sexual function: decreased arousal, and general desire, and orgasm.[1] The paper's ideas of intervention — weight management, stop smoking, and get educated — I think we can all do better than that. But of course, that's always included. This paper is a reminder: when people come in with fatigue that they date the onset to COVID-19, they're probably struggling in the bedroom as well. And there are, of course, the general things that make people healthy that can help.

But we have some evidence that our procedures can also help. For example, there was a study showing that it helps with the alopecia that can be associated with COVID-19.[2] And my general way of thinking about sex in general is that you can't fake it. It's always the extra thing that happens when you have your best health.

I think we were designed such that we won't reproduce if we're not well, and when things are right, we do. When we're not well, things won't function. So it's the cherry on top of good health. And so, of

[1] Tran et al., "Associations of Age, Health Literacy, BMI, Tobacco Use, and COVID-19 Infection History with Sexual Dysfunction among COVID-19 Survivors."

[2] Gentile, "Preliminary Investigation on Micro-Needling with Low-Level LED Therapy and Growth Factors in Hair Loss Related to COVID-19."

course, we think about hormones, but we can also think about making the tissue healthier with our procedures, along with the education.[3]

But the more direct treatments of our procedures can definitely be part of the plan. And just so you know, many in our group are having success integrating our procedures into that plan.

Multiple Sclerosis and Sexual Function

This one is dear to my heart because I have a special hate for multiple sclerosis. I think it's okay for us as physicians to pick a few diseases that we just decide to make war on and have a great disdain for. We don't have enough energy and mind space to hate every disease. But I think having a war to wage helps you get up in the morning.

A lot of people wake up early and have a party to get ready for a football game, which is a kind of war that gets televised and makes lots of money for people. And really, metaphorically, perhaps it matters — but does it really matter what men or women do on a court with a ball? I'm not knocking sports. If you want to watch them, go for it. But the same idea applies to medicine, I think. It's perhaps not good that people get more enthused about watching others fight a war over a football than about waking up in the morning and figuring out how to fight the war against sexual dysfunction, or any particular disease.

Which is what you're doing, metaphorically, when you read the research and you talk in depth with your patients, and you stay up late and you get up early, and you miss sleep, and you don't get paid for what you do. It's because you've been thrown into an arena by your passion for fighting a certain war. And I think as physicians, it's our duty to have that sort of mentality. I don't think you have the energy and time to have that much emotion about every disease.

But MS just picks on people. It bothers me. It feels like it picks on people. They have no obvious reason for suffering, and it just gets them — male and female, and at ages too young to be worried about this sort of thing. And I think it's forgotten often that men and women do suffer with sexual problems. So this study, which I'll give you the link to, has some non-pharmacological ideas about what might help. I don't even want to get into all of it here. I'll shoot it your way, and before I hang up the call, I'll give you these references.

I only bring it up here to simply remind everybody that if you're seeing someone with MS, our stuff works. Obviously, it's not acting centrally, but let's say... I'm trying to think of a good analogy. If you have a bicycle that won't go fast, and the wheel is not absolutely perfectly tuned up — I used to do triathlons. You want your wheel perfectly lined up; you get your spoke wrench and get your wheels perfectly aligned. But you also have, say, a chain that needs to be oiled. Well, even if you don't oil the chain, if you make the wheel more aligned, you might go faster.

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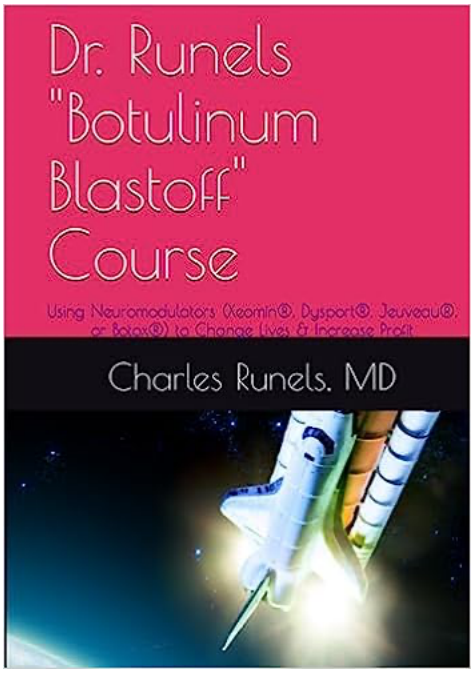
[3] runels, "Female Orgasm System."

The same thing applies to pulmonary rehab. We do pulmonary rehabilitation. You don't make the lungs better, but by increasing VO2 max, the person is able to function better because they need to burn less oxygen to do the same activity. And so tuning up the genitalia — even though you can't directly affect the central nervous system or perhaps the etiology of MS — has merit, and many of our people have helped people suffering with multiple sclerosis tremendously by offering our procedures.



Always, always remember that testosterone seems to play a role. Although it's debated, if you read the research, I think you'll agree that it must be thought about, both in men and women.

Botulinum Toxin for Migraine: What Happens to the Muscle Over Time

This one I thought was interesting because most of us treat migraine. It's talking about the neuromuscular changes that happen when you treat migraine with the full dose over a period of time.[4] I get this question a lot, even in the facial arena: if you're really treating it and the muscle never has a chance to move, what happens with the muscle? They showed here that, with time, there does become some weakness, especially in the trapezius muscle.

To me, the take-home message for my practice with this paper is this. If you've read my book or my course about botulinum toxin, you've seen it: most of my patients who come to me for botulinum toxin to treat their migraine do not get the full protocol. I tell them that if they want that treatment, they should see their neurologist and charge it to their insurance. But if they want me to treat it, I don't necessarily have to do the full protocol — and I'm not billing their insurance for it.

Many of them get tremendous relief just treating the corrugators and procerus. Just those muscle groups are enough to very prominently help with migraine. If you add in the frontalis, you can get better results — though with some, you can't fully treat the frontalis without drooping their brow. If they go to the neurologist, they're probably going to get a droopy brow if the frontalis is maximally treated. So some of my women patients will get by with eight to twelve units in the frontalis. Then I'll maximally treat the procerus and the corrugators, as I describe in my book or in the online course, and that's enough for their migraines to be put at bay for two to three months — therefore avoiding some of what happens: that floppy-neck feeling and possible atrophy.

[4] Plensäll et al., "Long-Term Neuromuscular Alterations during Botulinum Toxin Treatment for Chronic Migraine."

Now, some want it. There are women who want both their masseters and their necks to have a more lean, swan-like appearance. If that's the goal, then so be it. But if it bothers them, this paper is just pointing out that it is a real possibility, and if it bothers you, I don't think it's necessary that you have the full treatment.

Hyperprolactinemia in the Sexual Dysfunction Workup

I put this one here to remind you — I think things are swinging the other way, but if you look for it, you will likely find it. If you have even a moderately busy clinic and you get a prolactin level on people complaining of either erectile dysfunction in men, or decreased arousal, hypoactive sexual desire disorder, or anorgasmia in women, you will often find a hyperprolactinemia. Well, I shouldn't say often — you will regularly find it. If you're looking for it, you will find it one or two per year, in my experience.

And the beauty of it is that when you find it, it's easily treated. You put them on Dostinex twice a week and — assuming they don't have a mass, and usually it's a microadenoma — they go on that and they're life-changers. But for the longest time, this was not part of the routine workup of people with sexual dysfunction. I've made it part of my workup for the past twenty-six years, and I recommend you do the same.

This paper is just pointing out that, if you read the discussion, people who have hyperprolactinemia are going to have this psychological feeling where, at best, it'll decrease their arousal, and at some level they start to have fatigue.[5] Okay, let's see. We're getting almost through these. We'll get to the questions momentarily, and I'll try to be under thirty minutes.

Fat Grafting, PRP, and the Aging Vulva

This was a response to another paper about using fat grafting mixed with PRP for the aging process.[6] The main reason I put it here was that it was a bright response to another paper. And I put it here because of this. The bottom line is: their sex gets better.

It's not just about appearance. Even though they might be coming to your office saying they want, say, to re-establish color and texture and volume to the labia majora, in the end they usually wind up having better sexual function as well — and that's in here. So here we go: "We observed potential improvements in sexual well-being and quality of life."

So it was not just about appearance.

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[5] Sedef et al., "Prolactin Levels and Female Sexual Distress."

[6] Ghezeljeh and Sarmadian, *Response by Jabbaripour Sarmadian to "Autologous Fat Grafting Combined With Platelet-Rich Plasma in the Treatment of Female Genitourinary Aging: A Retrospective Study" by Ren et Al.*

The first really landmark study showing that, when it comes to the aesthetics of the female genitalia, was of course Michael Goodman[7] and others, who showed that it's not just about appearance. When you address a woman's concern about the appearance of the labia, there's a very good chance her sexual function will improve.

When we do our Vampire Wing Lift® — "wings," of course, referring to the labia as suggested in Rod Stewart's song, "Tonight's the Night." Go back and re-listen to that; he talks about spreading the wings, and it's in a couple of jazz songs too. So, to make it G-rated, we talk about a wing lift. Others are using different names.

And it's something that's coming up a lot now and being called "Ozempic vulva."

Before Ozempic was around — twenty years ago, when I was running a weight-loss clinic twenty-five years ago — people would complain of their face collapsing. Then, after we came up with the Vampire Facelift®, we just took the same idea and applied it to the labia majora, using an HA filler for structure and PRP to recruit stem cells, neovascularization, and neurogenesis. Remember, you get neurogenesis with PRP too, with the HA serving as a scaffolding for the stem cells, and we get great results.

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But if they want fat, that's good too. Some women, as you know, don't have a lot of fat to go harvesting, and it's a lot simpler to use a quality hyaluronic acid filler. All of that is explained, of course, as part of our O-Shot® training on our website.

Alopecia Areata and the Retina

This one was something I didn't know — there are a lot of things I don't know, but this one's within our area of expertise. Many of you are treating hair loss. I was not aware that there can be retinal abnormalities associated with it. A good friend of mine lost her vision and had a detached retina recently in one of her eyes. Of course, that happens spontaneously in people with severe nearsightedness, just as part of the side effects of having a football-shaped eyeball. But I did not know it was a known associated problem — not a side effect, but an associated problem — with alopecia areata.[8]

So I think it's just worth knowing, so that you always come across with a good feeling when you go to bed at night, a good soul satisfaction. The reason you went into medicine — you could have made a lot more money doing something else, but you went into medicine to help people, to heal them. And it's always nice when you catch something early.

[7] Goodman et al., "A Large Multicenter Outcome Study of Female Genital Plastic Surgery."

[8] Ameri et al., "Retinal Abnormalities in Alopecia Areata."

So when you see someone with alopecia areata, remember this paper, and remember to make sure they're getting their yearly eye exam to watch for things that can go on with the retina.

Erectile Dysfunction and Sleep Apnea

And the last one, then we'll do our questions and I'll take questions from you all. Again, just a reminder that if you're treating ED, ask about sleep apnea.[9] They have apps now that'll record it for you. I think there are half a dozen out there now. I like mine, though. What is it? Hold on a minute...

So I looked at a bunch of them, and this is my favorite: Sleep Cycle. It has a nice way of keeping track of apnea that is useful, and I'd recommend people at least do that if they have ED. It's tough — getting used to those machines is tough — but it's worth doing.

Okay, let's see what else we've got. I think that was all the papers I had this week. Let's do the questions, and then see what questions or comments you might have. I want you to correct me when you see something that I've missed. And I want to show you something, too, that will be helpful. I keep forgetting there are a lot of things that come with your membership that most people don't know about, so I want to show you one of those.

Protecting the Trademarks: The TRAP Page

This is what I wanted to show you that most people don't know about. If you go to CellularMedicineAssociation.org/trap. I use that word intentionally, with disrespect, because this is the place to go if you see someone advertising our procedures.

A big part of what we spend our members' money on is legal. Without it, I promise you — and we know, because we know how hard we have to work at this — there would be people advertising all sorts of inferior procedures using our names and charging prices so low that there's no way you could even buy the materials. If they're advertising, for example, that they're doing a Vampire Facial® for sixty dollars, you can't buy the equipment for that. So what they're doing is using some lab that was not intended for it, or using an inferior device. And two people who did that sort of thing are now in prison because they inadvertently transmitted HIV. This is not the place where people need to be skimping or doing it if they don't know what they're doing.

So we have full-time staff that checks credentials before people go into our directory. And as one of our members, if you see someone advertising our procedures and you don't see them on our directory, they're not one of us. Oftentimes you'll see them advertising at a discounted rate. When you see that happening, you can call in, but a quicker, easier way is just to go to our website, CellularMedicineAssociation.org/trap — because you're trapping a crook.

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[9] Pang et al., "The Association between Obstructive Sleep Apnoea and Erectile Dysfunction."

By now everybody knows that this is something that's trademarked for quality control. And of course, we also use the funds that come from our members to pay our staff and finance research. It takes a staff of about five people, not counting my time, to take care of our members — getting them oriented, checking credentials, helping them when they can't get logged in, that sort of thing. But the biggest expense is legal. We have a local attorney, we have an IP — intellectual property — attorney in Chicago, and they have a company called BrandShield.com out in Israel that polices worldwide.

If we catch somebody, they get one email, and then if they don't take it down, the next step is BrandShield contacts the internet service provider, and they lose their website or their social media account. Sometimes they'll just lose that page off the social media account; most of the time they'll lose the whole website.

So if you see someone doing that, you just go here. This is free to you as one of our members, because without it, I promise you, this will go downhill.

The truth is, I love my life, because I get to talk to people who are amazing, and I get to think about things that I like to think about. But if I didn't have to do it to buy groceries — and I've sometimes thought, "Well, I'll just quit. There's no CMA. Just let it go away." And what would happen is, in about six months, you'd see O-Shots® being advertised for about a hundred bucks by Joe Blow, by anybody advertising it, because there's nothing illegal about using a name. So I feel obligated, and I've put some things in place so that if something happens to me, the organization will keep going as long as people want to be in it.

We're glad when you do this, because people need to be taken care of. Occasionally we'll get an email from someone who says, "I got the O-Shot®. It hurt like crazy. It didn't help. I bled." And we'll ask them who did it. Every time but one, it was someone not in our group. There was one time where one of our providers put a lot more PRP than what was suggested, and the person had the pain, and we figured out that wasn't the thing to do. So if it's one of us — if that ever happens again — we'll call you. We'll talk about what happened. But except for that one time, it's always been someone not in our group, and then we just turn them over. In other words, you're doing the patients a favor by identifying those who may not know what they're doing.

So you just fill this out, and then my staff looks at it to make sure. If you want to be notified, you can put your info here; if you don't, you don't have to. Then, usually — it depends. If it's a social media account, Twitter or X, and Facebook, it usually goes away pretty quickly, in a week or so. If it's a website hosted in a civilized place, it'll usually be taken down quickly. If it's in some odd place that makes a living out of stealing from people, then it might take longer. Sometimes we have to get the Chicago attorney involved, and it might take a month or so. But we go after them, and if you don't see it go away in a month or so, let us know, so we know to do something different. That's something that's part of your benefits, and I wanted you to know about it. Most people, for some reason, don't.

Okay, let me talk about these questions that came in, very quickly, and then we'll call it a day.

Question: Treating Nipple Inversion and Breast Asymmetry on Social Media

The first one is: how do I treat nipple inversion and breast asymmetry on social media without violating the terms?

The short answer is, I don't think you do.

You can try it. You might get away with it for a while, but everybody I've known who's relied on social media for any length of time eventually loses their account. One of my favorite people lost his account recently. It's unfortunate. You can talk about hate and do lots of bad things, but if you talk about trying to heal people, there are just too many attorneys in the world. If the social media account lets it stand and then there's a bad outcome, they're at risk, so they can't let you do it.

So the answer is that — and I'm going to show you in a second — you use the only place where you can speak without censorship, which is your own webpage and your own emails. When you're posting on social media, you're building your house on someone else's property. They get to come around and demolish it if they want, make it go away, because it's not your land. But when you own the website and you own the email address, no one's censoring that in the US so far. Except MailChimp was censoring for a while in regard to COVID, and one of our people got censored about PRP, so I'd come off of MailChimp.

Ironically, there was a Wall Street Journal article — probably three or four years ago now; actually it was more than that, because it was right before COVID — talking about how big companies were rediscovering email, because it's uncensored and it's long-form.[10] You wouldn't write a letter to your mother with a tweet, but you might do it with an email. Same thing when you're communicating with your patients: you can do more long-form, deep communication with email. And they used MailChimp as an example — and then MailChimp wound up censoring some people during COVID, right after that. So I would pull off of MailChimp, but every other one is not censoring yet, so far, in the US. With social media, you're taking a risk.

So if I were going to talk about this, I would use my social media to build my email list, and then communicate by email. I talk about that in more depth in my course; if you don't have access to it yet, send us an email or call the office and have them give you access. I call it Five Notes, in reference to the five components of an uncensored, freely communicating education and marketing funnel — or channel — for your patients, and it's not social media. There are people who get rich with social media, but they have things they can talk about, and medicine is not one of them. So I'm not saying kill your account, but that's not the answer.

As far as what products can be used for the inverted nipple: I've used all of those products you've listed there. But for the nipple, I prefer straight-up Juvederm Ultra Plus, for two reasons. I like the syringe, and second, I've now had twenty-plus years of using it without ever seeing a granuloma. I would definitely not use Radiesse there, because — there are places Radiesse is a great product, places to use it — but

[10] Mims, "The Hot New Channel for Reaching Real People."

you're more likely to have some nodule formation, and you don't want to scare people with nodules in the breast. Even using the HA in the breast, you want to make sure they've had a recent mammogram or an exam. And if they have a mammogram right after you inject the HA, the radiologist is not going to know what the heck it is. So the person should tell the X-ray tech, so they don't freak out when they see the HA that you've injected.

Question: A Protocol for Lichen Sclerosus

The second question: share a protocol for lichen sclerosus. I get this one a lot. It's a great question. I'm going to show you something that you may not know about, and then I'll answer it. Copy this question — watch what I'm going to do. Let me pull up something here for you. It's another benefit of your membership that's very valuable and that a lot of people don't know about yet, so shame on me for not making it more well-known.

So if you log in — here's the O-Shot® membership site — then down at the bottom it says, "Hey there. Ask me anything." I think that's a little bit overstating it, because I don't really want it to ask anything, but anything about this procedure.

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So if I take that same question and paste it here — which I haven't done yet, so who knows, it may tell us something stupid.

There it is. So what this is, is AI. ***It's using ChatGPT, but it has read only our websites, nothing else. It's over 900 videos and literally millions of words***. It's read everything, and then it gives you an answer. So it doesn't go all over the internet and give you crazy stuff; it gives you an answer based on what we've curated. And this isn't all me talking, because oftentimes we've had other people on here telling their tips. And there's your answer.

Let's just read it and make sure I approve of it, because it's read what we've put here — but maybe it misread it, or went crazy. We had another AI on here that was giving stupid answers, so I made it go away. My middle son has been helping revamp these. He's way smarter than me — finance degree, numbers guy — and he's been helping me revamp the websites after working ten years in film and in finance. He felt sorry for the old man, and he's helping me out. So he redid the AI. Let's see what it says and make sure I agree.

I just copy-pasted that same question. It says the official materials — which would be this website, the O-Shot® website. In other words, you cannot get to this chat AI outside of our membership site, and out on the open internet you're going to get a lot of conflicting information that you've got to go through. But here, this is reading our website: "Do the usual O-Shot® and then inject it directly into the active lichen sclerosus plaques, including the labia and the hood. You can combine it with PRP." My wife was actually the first to tell me about this, where she'll microneedle the very areas.

And it gives you a summary. We'll click on that — sure enough, there it is, in our website, with a summary, giving pictures, the whole thing, right? Let's go back to the answer. "Do you inject into the

labia majora and minora? Yes. The protocol includes injecting into the labia, the clitoral hood, any sclerotic tissue — not just the standard O-Shot®." And again, it takes you right back to this detailed description, with videos and all sorts of stuff.

But it's not through. "For phimosis, mild scarring may occur. In true phimosis, where the clitoris is completely or significantly buried, surgery is usually required." I love this answer, because it's what I would have said — it actually read it, and it's giving it back to you. The recommended approach is: you do inject first. I'll show you one of the pictures where this happened. This one right here. This lady came to me. I'm not a surgeon. I injected this first to get things rolling and make the tissue healthier, then sent her to Kathleen Posey, a brilliant gynecologist over near New Orleans, who did the phimosis surgery.

This woman hadn't had sex with her husband for seven years. This little opening here, through which she was urinating — her clitoris is buried. You cannot pull the hood back. And yes, she was using clobetasol religiously, under the direction of a very smart dermatologist, for years, just kept slapping clobetasol on this. I could put the first digit of my thumb into that hole — that was all it would fit. I injected it to make the tissue healthier, Dr. Posey freed up the clitoris and reinjected, and this was six or seven weeks later. Last time I checked, it had been several years; she got retreated about a year out and was still doing well. This looks miraculous, but it's just basic science once you understand what it is we do. And to me, it's tragic that there are still people walking around like this who don't know.

So when you see that, yes, they need surgery — but you can still treat them, and if you're not the surgeon, look for a surgeon in our group so they understand what you did. Go to the O-Shot® directory. After surgery, they may still want to follow up with you, because doing nothing — without the PRP — if you did the surgery, this would come back very quickly.

Okay, so back to this answer: just what I said — inject it, send them for surgery, re-inject it — and it gives you the discussion. I love that answer. It actually read it. So there's a detailed answer with sources within our website, see that? For everything we just talked about. And after this webinar gets posted, it's probably going to be one of the resources too. So that's AI, and it's in every website. If you're on the P-Shot® site, it's going to read the P-Shot® material. And look how far it goes back — eleven years of us doing this.

And I say "us" very deliberately, because you're on the call now. Some of you may speak up, some may not, but you're on this call, you're contributing. I would have no motivation to do this if I didn't have smart people showing up. I can't talk to myself. So you show up, you motivate me, you support the group with your money — which pays for the attorneys — and then sometimes you correct me, even if it's via email another day, and the world keeps getting better. So that's the answer, without me having to answer it — because it's a better answer than I could give you in the next thirty minutes if you go to those pages and watch those videos.

Let me go to the next question that was posted and see if this will do just as well with it.

Question: Patients on Antiplatelet Medication

The next one was: are the recommendations the same for people on antiplatelets? The answer is yes. There are those medications that interfere with the proteins of coagulation, and then those that actually just interfere with platelet function — and aspirin's the most common one of those. The going recommendation is to stop it for a week before and a week after the treatment. Sometimes they can't stop it, because they might be in danger of a heart problem. In that case, just do it. There's still evidence that you might get a great result. It may be attenuated, but it doesn't completely negate the results, so just do it.

Question: Combining the P-Shot® and Priapus Toxin®

The next one is a harder question — at least it's more involved. So let's see how it does with this one. This one's about the P-Shot®. Let's see if our AI can answer it. It's actually a very smart question.

Here, this is the P-Shot® website. That's the back side, but when you log in, this is what you're looking at — actually, you'll probably be on the dashboard when you log in. There are lots of helpful videos, and it's shocking to me how many people just don't go in here and soak this up, because there are your consent forms and all sorts of marketing, places to get good deals on your supplies, and of course details on the procedures. But here's the chat. Let's see how it does.

Here's a question that was posted to the website. It's about the combination of the Priapus Shot® and Priapus Toxin®: basically, do you still put the toxin in the head of the penis, or does it just go in the corpus cavernosum? And a question about the number of units. So let's get this to go away... there we go, now I can click it.

It says it shows me putting 25 units in each syringe, mixed with the PRP. It is confusing — this is a very good question, by the way, which is why I'm curious how it handles a very smart question. As you know, when we do this procedure... when I first started doing it, I tried an injection just on each side, in each corpus cavernosum, and it wasn't enough material to spread. You could see where it was — it wouldn't spread completely. But I found that if I did two injections on each side, it would cover, unless the person has a micropenis; in that case, you just need one on each side. And of course, the glans is contiguous with the spongiosum, so it's a different compartment, and that gets a separate injection.

So if you're doing the procedure, you know we usually put two and a half on each side. You could put more, but if you have two aliquots of five, you put two and a half on each side near the base, then one and a half on each side, and two near the distal part, and then two in the glans. So the question becomes: where do you put the Botox? Does it go in all of them or not? Let's see what it says, and whether I agree.

"It can be mixed directly with the PRP as I inject it, following the usual injection." Now, there is one study about how you might be decreasing the effect of the toxin by combining it with PRP. It said, but not completely negating it — and actually, I think my wife understands this better than I do. It has to do with light chains and heavy chains: even though you might be negating some of the effectiveness on the muscle, it could be that you're even enhancing the autonomic change, which is part of what we're

looking for. So the bottom line is, some people are separating it out, but most of us are just putting it all in one syringe and doing it, and it's working.

“Here's what the official guidance supports: the PRP can be mixed with the Botox, and after mixing, the P-Shot® is then done in the usual way.” The usual P-Shot® includes what we just talked about: two and a half on each side, then one and a half on each side, and two in the glans. It does not lend any exception or avoidance of the glans. Very good. That's right.

And the reason why — even though the glans... this is my thinking, and the research may eventually prove this wrong. I'm sure something I said today will be proven wrong one day. But my best understanding right now is that if part of the improvement in erectile function is due not just to relaxation of smooth muscle, with a resultant increase in arterial blood flow, but also possibly to changing the autonomic tone, with a relative increase in parasympathetic tone — which is what governs erection — then it wouldn't really matter whether it was in the glans or the corpus cavernosum, because they're both connected by autonomic nerves of the ganglion that affect the autonomic tone. So that's why, even though you don't depend on the glans for firmness of erection, you could still be signaling to the autonomic nervous system to improve erection, even in the glans.

So if you want to separate it out, you could — and just put the toxin in the glans and not in each of the corpus cavernosum, or in each of the corpus cavernosum but not in the glans. But I don't see a need for that. I think it's okay to put it everywhere. Very good. So there's a very good answer, and then it takes you to the sources.

Often people who ask these questions are asking smart questions that clear up something I didn't make plain enough. So thank you for that very smart question, and there's the answer. So hopefully that was helpful. Let's see who has questions.

Question: alloClae for the Vampire Wing Lift®

Give me a moment to slide some of these references over, and we'll see if there are any questions in the group.

Here's one: “Any experience in the group with alloClae for the wing lift, or alloClae mixed with PRP?” Theresa, I'm going to unmute you. Okay, you should be able to talk now if you want.

“Can you hear me now?”

Yes, perfectly.

“AlloClae is approved for the body. It's cadaver fat.”

“And I didn't know if anyone had used that yet for the wing lift, or if anyone has tried mixing it with PRP in any application.”

Let me see — has anyone on the call done that? If so, could you raise your hand, and I'll unmute you. I tell you what I'll do, Theresa — it's a great question. I'll put that to the group in my next email and see if I get any responses. I have not done it. Have you tried it?

"Yeah. And I've historically mixed HA filler with PRP for many applications and it works extremely well. So I'm curious about this — denatured, if you will; they basically say they've taken the DNA out of it. How they do that, I don't know. But it's not whole fat cells; it's supposed to be like a matrix, the way the HA would be for the PRP. They don't promote it with PRP, but I just know from experience it's probably going to work the same. So I was curious if someone else had experimented yet."

Oh, it's a great tip. And when you used it, did it look... You used it in the labia majora — did it work well?

"I have not put alloClae in the labia majora. I've been afraid, because it goes in with a large-bore cannula."

I see. I see.

Where have you used it with the PRP?

"In the buttocks."

Oh, yeah, that makes sense. Absolutely.

"They promote it for the buttocks. They're mostly training plastic surgeons for breast augmentation with it."

"But I'm curious to see if the PRP grows natural fat with this as kind of an immediate bulking agent."

Mm-hmm. It makes sense.

Yeah. We know that fat — if you look, there was research 15 or 20 years ago showing that when you mix fat with PRP, there's a higher survival rate. As you know, a lot of people are doing that already, so it makes sense that this product would work as well.

"It's interesting — a plastic surgeon locally did a fat graft to the breast and sent the patient here for PRP, immediately, within three days after. And when she went back, the surgeon told her that it worked, that she had almost 80% survival."

Beautiful. Interesting. I see that a lot. My experience has been that if people just go around knocking on doors, trying to get their local specialist to start sending patients, it doesn't work. But when — I don't know how you got that relationship, but what can often happen is this: if someone shows up at your office and they've just had a procedure — let's say they come to my office with ED, and they had prostate surgery a year ago; or they have sexual dysfunction and they went to see somebody for their genital mutilation — and you wind up helping them, and you do an old-school phone call to the person they saw, even if they weren't referred, that's how I've seen people start to get that relationship.

As an example, one of the nurse practitioners in our group built a huge practice for women with female genital mutilation. She was up in Ohio, where they have a lot of women who immigrate from Somalia.

Do you know that somewhere around 80% of the women in Egypt have suffered female genital mutilation? It's a huge, much greater percentage than most people know about. And just by picking up the phone and calling the person's gynecologist whenever they showed up, and saying, "Hey, Ms. Jones is here, and I'm going to treat her and send her back," she developed a relationship. Then, rather than learn to do the procedure themselves, they just kept sending patients to her, and she did a tremendous business.

Anyway — how did you get that relationship? How did it happen that a plastic surgeon sent her over to you?

"I don't know, because I've never met this surgeon. He's a younger surgeon, and I guess he probably knew about it and didn't want to bother with it himself."

Yeah.

"And he was just looking for a reputable place, I guess. He's pretty local."

Mm-hmm.

"So I intend to reach out and nurture that a little bit, because based on his findings that it was more beneficial with the PRP and the patient was elated. She was already a patient of mine, so maybe she just mentioned it to him."

Hmm, that could have been. Yeah.

"That she goes here too, because she visits his spa too."

"But I don't know. It was just cool."

Yeah, very cool. Well, thank you for speaking up. That's good stuff.

I don't see anything else, so let me slide these references over for everybody.

A Marketing Pearl: Teach the Disease

I'm always honored when you all show up. I hope that was helpful, and thanks, Theresa, for jumping on the call. Give me a second, and I'll put these links over in the chat so everybody has a chance to copy them if you want them.

As far as the marketing goes, my philosophy — if I said it in one sentence — would be what David Ogilvy said: if you teach the person about their disease, they trust you to treat it. So even if it doesn't directly relate to your procedure, if you take any article we talked about that interests you and shoot it out as an email to your patients — like, as an example, the one about COVID — you send that out with a link to it and say, "Here's some research that says, if you're struggling in the bedroom and you had COVID, there may be a reason for it, and here's the research."

And I just talk to them like they're doctors. Most of your patients can read this. Of course, if they can't read it these days, they can just feed it to the chat, and the chat will read it for them. I just try to never talk down to people. So that's a good one.

The prolactin one is a good one that you could send out to people. The sleep apnea one, too — if you're a male and you're struggling, here's something to remember, because if we forget about it, of course they do too.

Okay, I'll give it another five or ten seconds, and we'll call it a day. All right. Thanks again. Have a great week, and thank you for being on the call. T

hank you, Theresa. Bye-bye.

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Tags

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