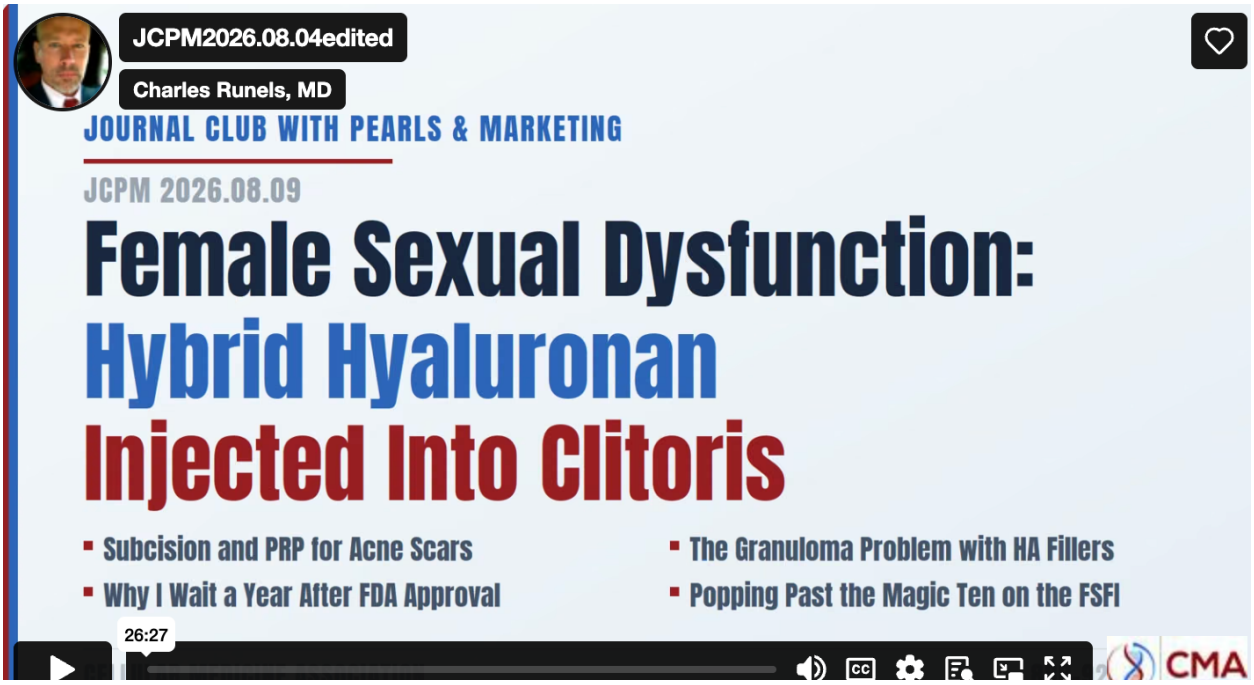
JCPM2026.08.04

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of August 4, 2026, with Charles Runels, MD.

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



Topics Covered

- A New Idea for Female Sexual Dysfunction and Good News for Acne
- The Life-Changing Benefit of Treating Acne
- Subcision and PRP for Acne Scars
- The Consult: Hand Them the Mirror, Then Study the Photos
- Injection Technique: Filler, PRP, and Microneedling
- Marketing Pearl: Using Open-Source Papers and Their Pictures
- Hybrid Hyaluronan for Clitoral Injection: A Man-Made Way of Doing What PRP Does
- The Granuloma Problem: Why I'm Not Ready to Put HA in the Clitoris
- Why I Wait a Year After FDA Approval
- From Corvelli's Foot-and-Ankle Study to the Vampire Facelift®
- Weinberg's Meta-Analysis: Putting the FSFI Numbers in Perspective
- Their Results: Popping Past the Magic Ten
- Where the Research Is Heading: Scaffolding, Signaling, and Neuromodulation
- Take-Home: Teach Your Patients What You Can Do

- Closing Thoughts: Not Ready for the Clitoris Yet

Charles Runels, MD
Author, researcher, and inventor of the Vampire Facelift®, Orchid Shot® (O-Shot®), Priapus Shot® (P-Shot®), Priapus Toxin®, Vampire Breast Lift®, and Vampire Wing Lift®, & Clitoxin® procedures.

Transcript

A New Idea for Female Sexual Dysfunction and Good News for Acne

Welcome to the Journal Club, with Pearls & Marketing. We have a very interesting new idea regarding the treatment of female sexual dysfunction. Don't think it's ready for primetime, but it gives some nods in our direction that are complementary and could be a clue to where things might be heading. And then there's also a terrific article on treating acne that reconfirms what we do, which is always nice.

And both are open source, so you could share them with your patients to educate and identify those who need what we have.

The Life-Changing Benefit of Treating Acne

I don't ever want to fail to emphasize the dramatic, life-changing benefit you can have for people, for people, when you treat their acne. It's just, it's tremendous. I think we can acknowledge it intellectually, but having suffered with horrible cystic acne as a teenager, and having felt what it's like to want to hide my face, it's probably more life-changing than most people recognize when you make acne better.

Somehow, I dodged the scars, but I was treated back then in the '70s: the dermatologist would still treat you with multiple repeated radiation treatments for acne. I don't even think it helped that much, but I'm paying the price today. I visited the surgeon today to figure out which piece of my face I'm going to cut off next, from the basal cells that will come because of that.

But having the feeling that you don't want people to look at you and having people look away when they see your face because you can't even tell the shape of your nose from the pus that's collected, is one way to feel unattractive. The other way is to go through that and then suffer the horrible scars.

And to make those go away in such a way that people feel like they're now just not repulsive. I don't mean attractive, just not repulsive, which can be the goal for some people. And you can take them there and do something life-changing. I haven't heard of anyone yet making a living just treating acne scars, but I swear I think it could be done.

Subcision and PRP for Acne Scars

All right, so here's another paper that uses subcision and PRP.[1] It gives me a chance to go back through the protocol about what it is we do

The Consult: Hand Them the Mirror, Then Study the Photos

First, I just hand the mirror to the patient. If you're doing any sort of consult related to facial aesthetics, just hand them the mirror and ask them to tell you what they want to "make better."

And after they do that, then I take pictures (I use my iPhone and upload the photos to the business version of Dropbox, which is HIPAA compliant), and then I look at the pictures, not just their face.

I just use my phone. You could use a big iPad if you want to see it better. If you have something fancier, that's fine too. But if you just stop and take a few moments to look at the photographs, you will see things you might otherwise miss. It also avoids the awkwardness of staring at someone, so both of you will be more comfortable. The patient's watching you examine the photographs, and that gives them comfort, just that you are taking the time to do that.

And then I like to hand them something to point with and say, "Show me the scars," or whatever it is.

In this case, it would be scars. "Show me which ones bother you the most," because some will be deeper or broader. And then, for the deep pitting scars, these are not as deep as I would want to see, but this one would be right in that area (see the video). You can see that one is oval-shaped and extensive. There's another right in that area.

Injection Technique: Filler, PRP, and Microneedling

For the extensive scarring, the deeper scars, I might put in a 0.1 or 0.05 filler injection. I like Juvederm Ultra Plus, then subcise it with PRP or a mixture of PRP with a filler, and inject that, subcising and injecting it at the same time.

If it's not so deep, then just PRP subcision, and I usually put the PRP in a one cc syringe with a Luer lock.

And if I'm normally doing cosmetic work, I'll have a thirty-gauge needle, but for subsizing scars, I'll use a twenty-five and go back and forth, undermine it while I'm injecting, and then inject intradermally.

And they don't cover it here, but because it's another variable; but then I'll microneedle on top of that and apply the PRP topically.

Then bring them back four to six weeks later and do it again. And you will have not only dramatic results that look absolutely great, as you're seeing in this article. Those are not out-of-the-ordinary

---

[1] Nguyen and Lam, *Treatment Outcomes Using Subcision Combined with Platelet-Rich Plasma for Atrophic Acne Scars: A Study in Vietnamese Patients.*

results (see video), where you have not only smoothed skin but ***also normalization of pigment,*** so there's less of either dark or red discoloration.

Marketing Pearl: Using Open-Source Papers and Their Pictures

You have the article about acne in the handout section. And because it's open source, you can actually use the pictures as long as you attribute them to the paper.[2]

Open source means you could use the pictures too, and tell people that you know how to do this, and that you actually add to it if you do that, the microneedling as well. Okay, so let's go to the one I really want to talk about today, and I promise I'll be done in thirty minutes, which would be two thirty central time.

Hybrid Hyaluronan for Clitoral Injection: A Man-Made Way of Doing What PRP Does

This one that just came out is about hybrid high and low molecular weight chains of hyaluronan for a clitoral injection. This mix-mixture is not something that I'm familiar with: Profhilo®, it's a hydrated extracellular scaffolding.

Profhilo® is NOT yet FDA approved.

It's a low-molecular-weight HA that provides a stimulant, combined with the scaffolding.

It's a man-made way of trying to do what PRP does. You remember, PRP contains growth factors. When it gets activated, it turns to platelet-rich fibrin matrix, or PRF.

To this day, the only PRP FDA-cleared device I know of that includes calcium chloride is Selphyl.

Some of us have a Selphyl kit; others buy the calcium chloride separately and add it right before injecting when we do the O-Shot® and the P-Shot®. That kit was sold for use on the face. The calcium chloride makes it hurt more, so I quit using it when I treat the face.

The Granuloma Problem: Why I'm Not Ready to Put HA in the Clitoris

The thing about this, the downside to this is that there are cases, if you go back 15 years ago, there was a study as an example where they looked at the number of cases of granuloma formation when injecting around the urethra, which is where we go with our O-Shot®, with

[2] Nguyen and Lam, *Treatment Outcomes Using Subcision Combined with Platelet-Rich Plasma for Atrophic Acne Scars: A Study in Vietnamese Patients.*

HA. And there are other studies on calcium hydroxyapatite, or Coaptite, which is FDA-approved for incontinence. So it's a bulking agent with almost exactly like Radiesse, only you're injecting it into your vaginal wall.

And why do you not inject Radiesse in the lip?

Because you get granulomas.

And in one study, two of eighty-one people, women, who had that injected for urinary incontinence, two of them developed granulomas sufficient to cause urinary obstruction requiring surgical correction

The beauty of this study, though, is that they had none of those. There were sixty people. But we don't know long-term. The thing that worries me about putting HA in the clitoris is that.

Because there are residuals from the manufacturing process, and it's supposed to be one in ten thousand with Juvederm, who develops a granuloma. I've never seen it, but supposedly one in ten thousand people who get Juvederm Ultra Plus, which is what I use, will have a granuloma.

I have seen them with other HAs. You've heard me talk about it if you've been in the journal clubs. Two of them, one of them was Hydrel, the other was eXpressions. And I know Hydrel was pulled by the FDA. I don't know if eXpressions was, but both of those HAs called —I saw multiple granulomas the first month I used them, so I had to go in and use hyaluronidase and cortisone to dissolve them, and I eventually had wonderful outcomes.

No one was scarred, but I'm imagining having to do that in the clitoris. Even if it were one in ten thousand, that's much more frequent than granulomas with PRP, which are one in millions. Literally, I can only find a half a dozen or so cases, and in all cases, there was a question of it being mixed with an HA.

You don't really get a granuloma with PRP.

But I love the progression here because I think about the progression of thought that's demonstrated.

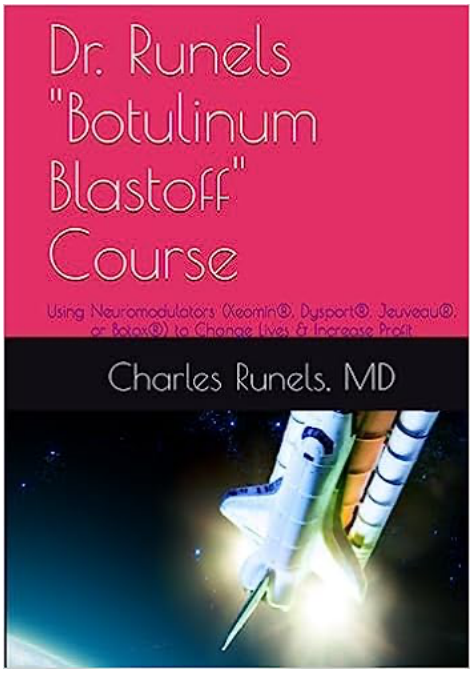
By the way, they reference our paper, two of them. The first one we put out in two thousand and fourteen using PRP to improve sexual function, and the other one I did with Andrew Goldstein using it for lichen sclerosus.

And I'll give you both of those papers,[3] and I want to look at the numbers in a moment. But what they did was use the HA. One was low-molecular-weight; the other, high-molecular-weight. The advantage, of course, is that it worked, and because it's a pharmaceutical, you can now actually-- It's patented and

[3] Goldstein et al., "Intradermal Injection of Autologous Platelet-Rich Plasma for the Treatment of Vulvar Lichen Sclerosus"; Runels et al., "A Pilot Study of the Effect of Localized Injections of Autologous Platelet Rich Plasma (PRP) for the Treatment of Female Sexual Dysfunction."

registered, and you can pay very good-looking people to go into doctors' offices and tell them to squirt it, and you don't have to do a phlebotomy. You just pull out a syringe.

So if we can get it—if it actually works better or as well as PRP—and you can skip the phlebotomy and the granuloma, maybe it's the way to go. I don't think it is yet, though, because of that possibility. I want to see this be out and approved for this indication for a year.



Why I Wait a Year After FDA Approval

As an intern doing my residency, I had an old school internist tell me, "Charles, when a new drug hits the market, don't start using it just because the FDA approved it. If you've got another option, do that for at least a year, because other things will pop up after the approval, and it's a lot, and you don't want to be the person who has to call the patient for an unexpected experience that was revealed after it makes it to market."

So before I use this for this indication, I want to see it approved by the FDA and have it out for a year, and then see how many granulomas and goofed-up clitorises show up. So far, we're a decade and a half into the O-Shot® procedure, and we don't have one granuloma occurrence with injecting the clitoris. But I love their idea, and it's similar to what we talked about in other studies.

From Corvelli's Foot-and-Ankle Study to the Vampire Facelift

Corvelli back in two thousand and ten, I've quoted this paper a lot. In this paper, if you consider the progression, they use PRP with HA for exposed bone and tendon in the foot and ankle.[4] And it's similar to what they're doing here, except instead of using an HA combined with PRP, they're using an HA combined with a different HA; one of the two HAs is doing the work of the PRP and recruiting similar growth factors

With the VEG and all the cytokines, chemotactic factors, and collagenesis that PRP promotes, we know there's a certain effect.[5] For twenty years, we have known that, for example, Restylane did the first study showing that it doesn't all get absorbed—the HA triggers collagenesis.

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

[5] Okumo et al., "Multifactorial Comparative Analysis of Platelet-Rich Plasma and Serum Prepared Using a Commercially Available Centrifugation Kit"; Pavlovic et al., "Platelet Rich Plasma"; Sánchez et al., "Platelet-Rich

Corbelli showed that you can use an HA as scaffolding, with the PRP promoting growth on the scaffolding. In this study, they use an HA as scaffolding and a different HA for growth.[6] So that's a, that's also a conceptual link to our Vampire Facelift® procedure.

We are placing them (HA + PRP) in the same location because we're taking HA and injecting it into the cheek to reshape and lift it away from the bone. So it's a true facelift in that regard. And then we're adding PRP for more collagenesis, neurogenesis, and we don't know, but if it works as it did in the foot and ankle, this is the way I used to talk about it 16 years ago.

If this works as it does in the foot and ankle, there should be a scaffolding effect of the HA, allowing the PRP to last longer. Yeah, the effects of the HA last longer because pluripotent stem cells migrate to the area and build new tissue.

But remember, the PRP is autologous. It's biodegradable, with no granuloma reports in this case that we're up to; it would probably be literally one in a hundred million in those weird cases in the face. Where the fillers were implanted, these are technically an implant in the clitoris. That makes me squirm a little bit.

And the study was not designed to find long-term problems. It did exactly what they intended it to do to show short-term effects on sexual function.

Weinberg's Meta-Analysis: Putting the FSFI Numbers in Perspective

Before I show the results, let me give you some structure to put these numbers in perspective.

Weinberg really did us a big one. Back in 2018, he looked at the various meta-analyses of the various materials used for treating female sexual dysfunction.[7]

And he looked at the effect of the treatment compared with the placebo. You understand, obviously, the placebo in one study will behave differently from the placebo in the other study measuring the female sexual function index.

And to put all of this in perspective, if you look at women who complain about sex versus women who love their sex, there's usually a difference of about ten in the female sexual function index score, the total score.

Plasma, a Source of Autologous Growth Factors and Biomimetic Scaffold for Peripheral Nerve Regeneration"; Alves and Grimalt, "A Review of Platelet-Rich Plasma."

[6] Atef et al., "Hybrid High and Low Molecular Weight Chains of Hyaluronan for Clitoral Injection Is an Effective Modality Treatment for Increasing Female Sexual Satisfaction."

[7] Weinberger et al., "Female Sexual Dysfunction and the Placebo Effect."

The three FDA-approved materials for sexual dysfunction are bremelanotide, flibanserin, and DHEA cream. And you can see in this study that the placebo actually worked better, and the scale only goes up to 9.

None of them are bumping over 10, which is on average what you would need to make most women be to the level, the improvement that they would need to be on par with their sisters who are having a good time. Hence, there is a need for a usually multifaceted, multi-tooled approach.

If you're having pain, I'll give you enough morphine eventually that you'll quit hurting (or quit breathing).

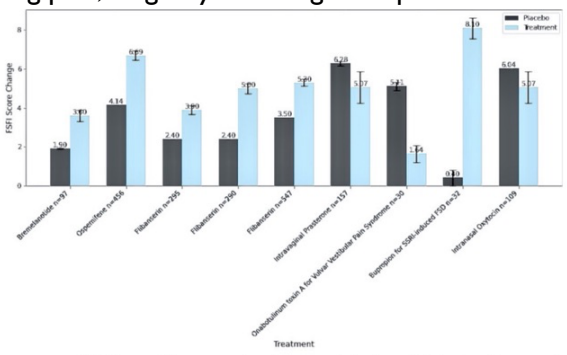


Figure 6: Overall improvement in FSFI for seven different commonly used treatments for female sexual dysfunction with corresponding placebo effects. (Weinberg, 2018).

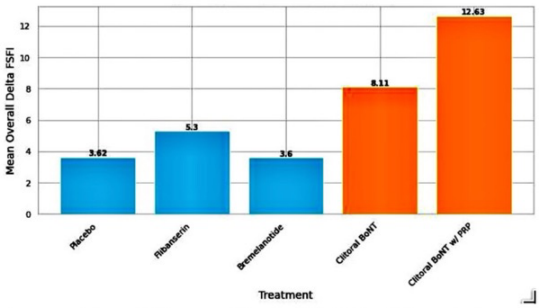


Figure 7: The average improvement in the overall FSFI scores revealed by a metanalysis (Weinberg, 2018) comparing the average placebo response with the average improvement with either flibanserin or bremelanotide (the only two non-hormonal, FDA-approved treatments for female sexual dysfunction) indicated that both the clitoral injection of BoNT and the injection of BoNT combined with PRP could show more benefit compared with placebo than the two FDA-approved drugs, even if the two FDA-approved drugs were used as the placebo.

We don't have a magic bullet for sexual dysfunction. Another thing worth noting, I think, is that if you look at bremelanotide, it only pushed it 3.8, which is for some of the other studies would have been really not enough to get it approved. They happened to have a very low placebo score. For some reason, their (bremelanotide) placebo score was not as high as in many other studies. So keep that in mind. Ten is what you really need to make things work for coming close to a magic bullet.

Now, if you take those and put them together, which is what we created this chart based on this chart from Weinberg's meta-analysis, and so we just pulled these numbers.

The average placebo there was that, three point six. Flibanserin, five point three. If you look at, across the studies, it bumps it by about five point three. On average, one extra sexual encounter per... Not per day, not per week, but per month. Get to have ***sex one extra day per month*** for taking a medicine every day, and it's still off label if you're over sixty-five years old, which would be me if I were a woman.

bremelanotide, three point six, which you can see would be on par with the average placebo response to everybody else. Our Clitoxin® procedure was eight. Eight, which blew away everything on this list except for stopping an SSRI and starting Wellbutrin.

That's not even one change. You stopped your serotonin drug, and you started Wellbutrin, and that, by the way, that's a strong move to make, and I highly recommend it. It has to be done the right way to keep people from crashing: Wellbutrin can sometimes trigger anxiety when you first put people on it.

But it's definitely the drug of choice if testosterone does not work for depression in women. And again, intranasal oxytocin. I think it gives you a nice glow, but the way I put it, if you want the benefit of feeling that glow after you've had sex without the time and work of having sex, do some intranasal oxytocin.

And it's literally biochemically what you get, right?

After a massage or something. So if you want that fun glow, and you're just working at your desk, do some intranasal oxytocin, and you won't have to spend the money on a massage. But when we combined them together, we popped over that magic ten when we combined an O-Shot® with Clitoxin®.

Their Results: Popping Past the Magic Ten

Look at this. In this study, it's open source. In this study, before injection, the average was nineteen. After the injection, they did two injections, thirty days apart.

When they give the second one, now they're up to sixteen.[8] That's a crazy result.

In our study, they just had one injection.

So in our study, who knows? Maybe if we'd done something similar (two injections), we would have gotten similar results. And it's along the progression. They're expanding the regenerative framework.

Where the Research Is Heading: Scaffolding, Signaling, and Neuromodulation

If you want to think about these three ideas, you have scaffolding biology with the hyaluronic acid or the HA, you have regenerative signaling with the PRP, and then you have neurosignaling and neuromodulation, as well as regenerative signaling from botulinum toxin.

There could be some synergies going on that we need to explore, like PRP versus HA versus hybrid HA, PRP plus HA versus PRP plus hybrid HA.

Where does botulinum toxin fit into all that, as a standalone or as an addition to those combinations?

And so there's this progression that's happening over the past twenty years or so to-- and I think future studies are going to try to figure out how all this is interacting, so that hopefully we can get people to pop up to that sixteen mark and know who's going to respond and who won't, and who's going to have complications and who won't.

---

[8] Atef et al., "Hybrid High and Low Molecular Weight Chains of Hyaluronan for Clitoral Injection Is an Effective Modality Treatment for Increasing Female Sexual Satisfaction."

But this is very encouraging. Again, I don't think it's ready for prime time. I'm sure that with the budget of something you can actually patent and sell, it could be marketed and accepted much faster than our O-Shot has been. But as of now, the O-Shot alone is beating any FDA-approved drug on the market. And, O-Shot combined with Clitoxin, we could probably use these FDA-approved drugs as the placebo arm and still show benefit.

The other thing they did was use saline as a placebo, which, again, to me, is a possible treatment arm.[9]

But if you look at their placebo arm, it was four, which is right at that three-point-six mark in the other meta-analysis I showed you here. So most of these are around the four mark. On average, it was 3.6 by Weinberg.

Take-Home: Teach Your Patients What You Can Do

Remember, it's not your patient's responsibility to know what you can do. It's our responsibility to teach them.

I'm giving you the studies we just talked about in the handout section. This one is open-access, but it's from the Journal of Sexual Medicine, a high-impact, reputable journal. This is the one my wife, Alex, and I published about Clitoxin®.[10] Oh, I was really honored that they referenced our original article, this one about PRP from two thousand and fourteen. And I haven't mentioned Dr.

Posey in a while. Dr. Posey was just really amazingly supportive in the beginning of our group, and she-- I was just a mascot. She published this study about treating lichen sclerosis that I just think was amazing, and just amazing, courageous gynecologist over in the New Orleans area. but this was the one they referenced that was done in concert with Andrew Goldstein.

So there's everything from our discussion, and I hope that was helpful to you. And we're right at thirty-one minutes, so let me see if there are questions. If not, we'll shut it down for the day.

Closing Thoughts: Not Ready for the Clitoris Yet

If you teach your people about their disease, they will trust you to treat their disease. That can be an email that says, "Hey, here are studies for something that's not really ready yet, but it talks about what we do, which is the O-Shot® using PRP."

---

[9] Asghar et al., "Efficacy and Safety of Intralesional Normal Saline in Atrophic Acne Scars"; Searle et al., "Saline in Dermatologic Surgery"; El-Amawy and Sarsik, "Saline in Dermatology"; Popp, "Improvement in Endoscopic Hernioplasty"; Bagherani and R Smoller, "Introduction of a Novel Therapeutic Option for Atrophic Acne Scars."

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

And we do combine HA with PRP when we do the Vampire Wing Lift®. That is something we're doing and can safely be done. The guy who invented Juvederm invented an HA for the posterior vaginal wall to help with dryness, but it is off-label for the anterior vaginal wall because of the granuloma fear.

So I would not be putting HAs in the clitoris. We covered a brilliant study, but we do not know long-term complications as we do with PRP. So, HA in the clitoris is ***NOT*** the thing to do yet.

Okay. Hope you had time to grab those papers, and I'll see you next week. Always honored when you make it to the call. Bye-bye.

=>Benefits of the Cellular Medicine Association<=

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

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

References

Alves, Rubina, and Ramon Grimalt. "A Review of Platelet-Rich Plasma: History, Biology, Mechanism of Action, and Classification." *Skin Appendage Disorders* 4, no. 1 (2018): 18–24. https://doi.org/10.1159/000477353.

Asghar, Aneela, Zahid Tahir, Aisha Ghias, Usma Iftikhar, and Tahir Jameel Ahmad. "Efficacy and Safety of Intralesional Normal Saline in Atrophic Acne Scars." *Annals of King Edward Medical University* 25, no. 2 (2019): 2. https://doi.org/10.21649/akemu.v25i2.2867.

Atef, Lina Mohammed, Ghada Farouk Mohammed, Mohammed Saleh Al-Dhubaibi, Mahmoud Soliman, Saleh Salem Bahaj, and Yasser S. N. Saleh. "Hybrid High and Low Molecular Weight Chains of Hyaluronan for Clitoral Injection Is an Effective Modality Treatment for Increasing Female Sexual Satisfaction: An Interventional, Randomized-Controlled Parallel Study." *Sexual Medicine* 12, no. 5 (2024): qfae067. https://doi.org/10.1093/sexmed/qfae067.

Bagherani, Nooshin, and Bruce R Smoller. "Introduction of a Novel Therapeutic Option for Atrophic Acne Scars: Saline Injection Therapy." *Global Dermatology* 2, no. 6 (2016). https://doi.org/10.15761/GOD.1000159.

Cervelli, V., L. Lucarini, D. Spallone, L. Brinci, and B. De Angelis. "Use of Platelet Rich Plasma and Hyaluronic Acid on Exposed Tendons of the Foot and Ankle." *Journal of Wound Care* 19, no. 5 (2010): 186–90. https://doi.org/10.12968/jowc.2010.19.5.48045.

El-Amawy, Heba Saed, and Sameh Magdy Sarsik. "Saline in Dermatology: A Literature Review." *Journal of Cosmetic Dermatology* 20, no. 7 (2021): 2040–51. https://doi.org/10.1111/jocd.13813.

Goldstein, Andrew T., Michelle King, Charles Runels, Meghan Gloth, and Richard Pfau. "Intradermal Injection of Autologous Platelet-Rich Plasma for the Treatment of Vulvar Lichen Sclerosus."

Journal of the American Academy of Dermatology 76, no. 1 (2017): 158–60. https://doi.org/10.1016/j.jaad.2016.07.037.

Nguyen, Lam Van, and Tan Tan Lam. *Treatment Outcomes Using Subcision Combined with Platelet-Rich Plasma for Atrophic Acne Scars: A Study in Vietnamese Patients*. n.d.

Okumo, Takayuki, Atsushi Sato, Kanako Izukashi, et al. "Multifactorial Comparative Analysis of Platelet-Rich Plasma and Serum Prepared Using a Commercially Available Centrifugation Kit." *Cureus* 15, no. 11 (2023). https://doi.org/10.7759/cureus.48918.

Pavlovic, Voja, Milan Ciric, Vladimir Jovanovic, and Predrag Stojanovic. "Platelet Rich Plasma: A Short Overview of Certain Bioactive Components." *Open Medicine* 11, no. 1 (2016): 242–47. https://doi.org/10.1515/med-2016-0048.

Popp, Lothar W. "Improvement in Endoscopic Hernioplasty: Transcutaneous Aquadissection of the Musculofascial Defect and Preperitoneal Endoscopic Patch Repair." *Journal of Laparoendoscopic Surgery* 1, no. 2 (1991): 83–90. https://doi.org/10.1089/lps.1991.1.83.

Runels, Charles, Hugh Melnick, Ernst Debourbon, and Lisbeth Roy. "A Pilot Study of the Effect of Localized Injections of Autologous Platelet Rich Plasma (PRP) for the Treatment of Female Sexual Dysfunction." *Journal of Women's Health Care* 03, no. 04 (2014). https://doi.org/10.4172/2167-0420.1000169.

Runels, Charles, and Alexandra Runnels. "The Clitoral Injection of IncobotulinumtoxinA for the Improvement of Arousal, Orgasm & Sexual Satisfaction- A Specific Method and the Effects on Women." *Journal of Women's Health Care* 13, no. 3 No. 715 (2024). https://doi.org/10.35248/2167-0420.24.13.715.

Sánchez, Mikel, Eduardo Anitua, Diego Delgado, et al. "Platelet-Rich Plasma, a Source of Autologous Growth Factors and Biomimetic Scaffold for Peripheral Nerve Regeneration." *Expert Opinion on Biological Therapy* 17, no. 2 (2017): 197–212. https://doi.org/10.1080/14712598.2017.1259409.

Searle, Tamara, Firas Al-Niaimi, and Faisal R. Ali. "Saline in Dermatologic Surgery." *Journal of Cosmetic Dermatology* 20, no. 4 (2021): 1346–47. https://doi.org/10.1111/jocd.13996.

Weinberger, James M., Justin Houman, Ashley T. Caron, et al. "Female Sexual Dysfunction and the Placebo Effect: A Meta-Analysis." *Obstetrics & Gynecology* 132, no. 2 (2018): 453–58. https://doi.org/10.1097/AOG.0000000000002733.

Tags

female sexual dysfunction, hybrid hyaluronic acid, high and low molecular weight hyaluronan, clitoral injection, O-Shot®, platelet-rich plasma, PRP, platelet-rich fibrin matrix, PRFM, growth factors, granuloma, hyaluronidase, Juvederm Ultra Plus, calcium hydroxylapatite, Coaptite, Radiesse, urinary

incontinence, Female Sexual Function Index, FSFI, meta-analysis, bremelanotide, flibanserin, Wellbutrin, intranasal oxytocin, Clitoxin®, botulinum toxin, Vampire Facelift®, Vampire Wing Lift®, lichen sclerosus, acne scars, cystic acne, subcision, microneedling, dermal filler, scaffolding, collagenesis, neovascularization, FDA approval, patient education, medical marketing, regenerative medicine, sexual medicine, cosmetic medicine

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