JCPM2023.11.21

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of November 11, 2023,[1] with Charles Runels, MD. The video of the live journal club can be seen here←

Figure 1. Charles Runels, MD

New Time and Preview

Welcome to the Journal Club. Thank you for showing up at the new time. I guess I got old. I'm more awake and smarter at 2:00, my time, than I am at 8:00 pm.

This time also makes it where it's possible for our members in Europe and Asia to participate, where at 8:00 PM Chicago time makes it inconvenient if you live in Europe or India or Australia.

The *first topic today is what can you do with these procedures and what can you not do*?

We have a lot of new people. COVID's over, our workshops are going crazy. But even those who've been in the group for a while perhaps could use a review of possibilities with our procedures (and what's not possible, or less likely to be helped).

[1] "JCPM2023.11.21 PRP-What to Treat and What Is Less Likely to Improve | Traps | A 5-Min Email Tick."

So I plan to give you ***easy*** and ***hard***, ***most likely to improve*** to where the patient loves it, and ***what won't work***—for all our main procedures, facelift, facial, O-Shot®, P-Shot®, and breast lift, and then some ***pearls and traps*** that might save you some heartache and some wasted time, and the uncomfortable situation of having an unsatisfied patient and having to give money back, which you should do, but we don't like to do it a lot. So, we need at least 80% success rate, I think, to make it where this is fun to do.

When I say easy and hard, I mean for each procedure, where are you more likely to get an 80% success rate versus not? What are some pearls to making sure that happens, or more likely to happen? What's some traps that are likely to lead you astray from less likely happy patient?

Then I have ***a quick little email method***. As some of you know, I cycle out profit models one per week. This week's profit model in my 52-week cycle is a little trick that I haven't taught. It's really simple. A lot of you do it, but if you do it consciously, it will make you money and it will help people who need your services find you. I can teach it to you in five minutes.

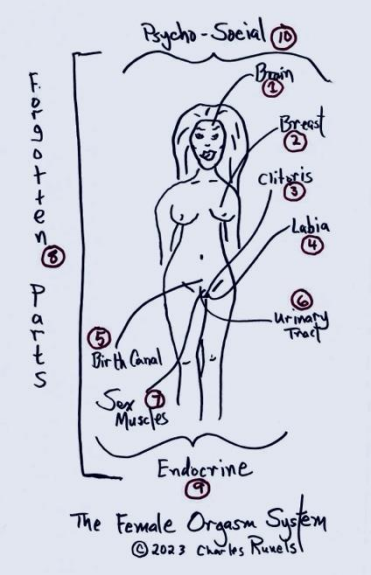

Figure 2. Systems analysis helps determine if the O-Shot® will be of benefit.

Systems Analysis Needed to Assure Best Results with PRP Procedures

Okay. So, first, let me show you a picture, and then let's talk about how this relates to hard and easy for all the different procedures. Just some principles that can be illustrated with this picture.

When someone says to me, either patient or provider, "I tried that O-Shot®. It did not work," to me that's like saying, "I use bronchodilators, but they did not work," without telling me something other than you had dyspnea.

If you say, "I had dyspnea and I used bronchodilators and it didn't work," I would want to know, "Was your dyspnea because you inhaled half of a hot dog into your throat, or do you have profound anemia? Do you have a shunt in your heart? Do you have cyanide poisoning, or do you have bronchospasm?"

Only in the case of bronchospasm does the idea of using a bronchodilator apply. When someone might use a bronchodilator to treat dyspnea for profound anemia, it's not going to work.

Making a diagnosis to determine best therapy cannot be done without a systems analysis. But it seems using therapies for sexual dysfunction is often done without a complete systems analysis IS often done.[2]

I don't see that mistake (using the wrong therapy because a systems analysis was not done) being made in other branches of medicine. But for some reason, in sexual medicine, I see it a lot where people get frustrated telling me something, whether it's a laser or radio frequency, hormones, whatever it is, telling me something "did not work," and when I ask them for more info (trying to figure out why “it didn't work”), I realize they were trying to do use the proverbial hammer to take care of something that needed a saw or a screwdriver).

I'm not sure why that applies to sexual medicine more than other parts of medicine, but my guess is, or my hope is, that as we start to talk more about systems regarding sexual medicine, then it will be less likely to happen. So this is the principle, ***systems analysis***, we are applying as we go through what's likely to get better and what's likely to not get better by all of our different procedures.

For example, let's think about the O-Shot®. If you told me that O-Shot® didn't work and the woman had anorgasmia, and then you tell me, "But I haven't checked her hormone levels," well, she might have the healthy vagina of a 29-year-old female who's never had a child, but because she's been on birth control pills since she had dysmenorrhea or metromenorrhagia from the time she was 15, and because of that, she's had low testosterone her whole menstrual cycling life, she's lived with a chronically low testosterone level.

I mean, that's how birth control pills work. They suppress LH and FSH, so you don't cycle your period, and you don't get pregnant, but you also don't make much testosterone.

That's a fact. It's not a postulate from down here in South Alabama. It's not something I learned at the herb store. That's a fact. It may not be a happy fact, but it's a fact.

And so, then if you tell me that you treated her vagina, it's never had trauma, she's never had a bicycle crash, delivered a baby, and everything's working down there as far as tissue health, except that there's been very little testosterone, which the vagina needs as much as the penis, and you do an O-Shot®, it might help, but what she really needed was testosterone.

So that's what I mean. Maybe she's got a spinal cord injury or maybe she's got hyperprolactinemia from a microadenoma of her anterior pituitary gland, and that was not identified. So she's not going to have the sex drive until you do a prolactin level and find out she needs Arimidex.

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[22]For more about the Female Orgasm System, go to https://orgasmcollege.com/femaleorgasmsystem/

So that's the sort of thing that happens when you think in terms of systems analysis, and that's the principle I'm going to apply. No, everything I'm about to tell you does not have a research project. You can't patent a person's blood. So we don't have many millions of dollars for our research. Our research budget for the CMA is about a half a million a year, give or take, that's it, and we spend more than that on attorneys just protecting our intellectual properties from the scammers who would use our good reputation to rip patients off.

So, anyway, that's the idea as we go through the hard and easy for each procedure.

If you already know this, then maybe you should still stay because, to me, that's some of the most dangerous for any physician, including myself. The biggest danger for me is thinking I know it all because I've been teaching it for 13 years, because I'm sure that I'll tell you something in the next hour that is wrong, but I'm going to tell you the best I've been able to determine from reading ... Best I can tell almost every research paper that's come out, or at least knowing the subject matter of all 16,000 papers that have come out in the past decade, and talking to around 3,000 doctors over 13 years.

So this is ... In the process of telling you hard and easy, likely to get well, not likely to get well, I'll also be giving you low-hanging fruit for possible research projects to figure out if what I'm telling you is actually true or if it's just skewed with anecdotal reports that are somehow not right. So let me swap over to this list, and let's go through it together.

I just wanted you to see that, as we go through the list, we'll be talking in terms of systems analysis, which makes it all make sense. Okay, so let's start with the facelift and talk about what's easy and hard.

The Great News about Cash Procedures that Will Make You Smile (and it is NOT the Money)

Now, the fun thing about everything we're about to go through here is that we ... By definition, if you're charging cash for something and someone's paying you and then they're happy about it, then even our easy list is other people's hard lists. Put another way, if you do something for someone and they give you money, and you haven't done something that the doctor taking insurance cannot do, then you just stole from the patient.

For example, I won't treat migraines with botulinum toxin without first telling the person, "If you go to your neurologist, your insurance will probably pay for this. Now if you wanted to look pretty, I'll do it and make your migraines better. But if you want it to be the price of a copay, go there."

Then if they choose to stay, they will pay me cash and I will do something better than the neurologist can do, because I'll make the migraines better and make their face look younger. So that's what I mean.

So even our easy to treat things or more likely to get well indications are other people's less likely to get well not because we're necessarily smarter, just because we've learned about this tool, platelet-rich plasma, when to use it, when not to use it, and others have not.

Vampire Facelift® Procedure: Hard and Easy

Let's talk about the hard first. So, this would be not likely to improve.

So for the facelift, if you think in terms of what we're doing, we're lifting those tissue away from the skull. So the opposite will be a surgical facelift where you're pulling the tissue tighter, closer to the skull, and there's a collapsing of tissue. Still looks younger in that case because you're changing the texture to a smoother texture and perhaps removing redundant tissue, but you're not lifting it back to that round, plump, rubor face of the 16-year-old blushing bride.

> ***It is difficult to show improvement with a filler-type procedure if treating an already full face.***

This would be someone who's already had something done recently. Maybe they're obese, maybe just genetically, they have pretty, round cheeks. Another way to put it, it's difficult to show improvement with fillers in a face that's already full.

The pearl here is that you can do it, but ... Usually in the female, enhancing the cheeks so that you are de-emphasizing whatever beginnings of a jowl might be forming.

The other would be redundant tissue. So if they ***have bags under their eyes, if they have a double chin, that's surgery***. They need a blepharoplasty or a facelift, lower facelift.

It's difficult to make that better. (TRAP) As a matter of fact, if you try to fill in around the bags that are under their eyes with an HA, you'll just usually make them look worse. So, I refer a lot of people for blepharoplasty.

So easy would be volume loss, especially under the eyes and in the cheeks. Now you realize this is what you would do with fillers. And so, what we're doing with the PRP on top of the fillers is that ***the PRP polishes off the sculpture and adds increased tone, texture because of the neovascularization.***

> ***You're sculpting with your HA filler, and then by adding PRP on top of it and around it, you improve the appearance of it and can make good filler work look amazing.***

The other thing that would be difficult is the glabella region because you can't add HA fillers there for risk of causing blindness. (TRAP) Even the PRP, I think, is better to avoid that area, the only half a dozen

cases I can find where something horrible happened with platelet-rich plasma involved mostly the glabellar region.

It was absolutely suspicious because the blindness occurred in cases where we're not sure what else was mixed with the PRP—sometimes in hotel rooms with unknown licensing of the provider, possibly no license at all. We're not even sure what the thing was that was mixed with the PRP.[3] [4]

But, still, the only tragedies I can find in the literature is about a half a dozen cases of something horrible that happened when the glabella region was injected with PRP mixed with something else. So just avoid that. That's where you use your botulinum toxin.

The same thing with the frontalis or the forehead because you can use your botulinum toxin there, and you can do the Vampire Facial® with microneedling. But if you go up there with fillers, you're risking a horrible outcome.

Vampire Facial® Procedure: Hard & Easy

So, with the facial, hard-to-see-results indications would be if you tried to change shape, because the Vampire Facial® procedure was not made for shape; it's made for color and texture. So this would be under the eyes for that crepe papering that happens, for discolor, for the dark color under the eyes. Actually that also applies to the facelift …adding PRP under the eyes, subdermal, can help with the color, for the dark color. Then, topically, with microneedling, you can help with color and texture, so that crepe papery look in the suborbital region, you can help with that.

And scarring, right? Easy: color, texture & scars: acne scars, surgical scars. Those are easy wins with the Vampire Facial.

There is also one study out showing that microneedling with PRP for hair growth worked better than injecting PRP.[5] The problem with just using microneedling on the scalp, is that when you treat the scalp, there are some areas where the hair is so thick, the microneedling is not practical because you can't get your device to touch the scalp (even thought the hair is thinning, there's enough to block the needles).

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[3] Kalyam et al., "Irreversible Blindness Following Periocular Autologous Platelet-Rich Plasma Skin Rejuvenation Treatment."

[4] Iovino et al., "Iatrogenic Ophthalmic Artery Occlusion after Platelet-Rich Plasma Dermal Filler Documented with Ultra-Widefield Imaging."

[5] Ozcan et al., "PRP Application by Dermapen Microneedling and Intradermal Point-by-Point Injection Methods, and Their Comparison with Clinical Findings and Trichoscan in Patients with Androgenetic Alopecia."

hair is blocking). You have the setting on the device of a half a millimeter to two and a half millimeters. So if there's any layer of hair there at all, your needle's not reaching the scalp.

To have an effective microneedling session, you need to be able to get the circular rim of your microneedling device to be adjacent to the scalp…touching the scalp completely around the circle.

If it's not, you're microneedling the air in the room and not the person's scalp.

> ***If the rim of the microneedling device is not touching throughout the circumference of the tip, you're microneedling the room, not the patient.***

That's why I never do microneedling alone for hair growth; I combine microneedling with injections or do injections only. If you're part of our Vampire Facial® group, Facelift® group[6], you have access to videos regarding hair. If you don't know how to access them, move around on the membership website, and if you still don't see it, call our office at 888-920-5311.

O-Shot® Procedure: Hard & Easy

Now the O-Shot®, easy and hard to treat indications.

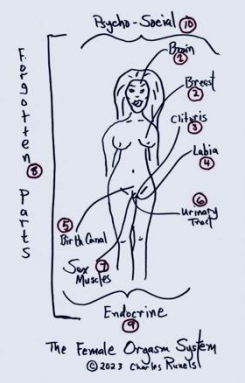

Figure 3. Simplified diagram of the female orgasm system.

Remember our picture?

For this one, hard-to-treat-effectively would be etiologies occurring somewhere other than where you're putting the needle. Said another way, we can rejuvenate tissue with platelet-rich plasma, but if you put the needle in the anterior vaginal wall, you are not doing anything to correct testosterone levels in the brain, so the O-Shot® procedure may indirectly improve arousal and libido and orgasm by improving the sensation and the response of pressure against the anterior vaginal wall. But if there is no testosterone in the woman's body, you're still going to have a less likely positive result.

So one of the hard-to-treat problems (problems more likely to be caused by something other than less-than-optimal genital tissue) would be complete anorgasmia. I have found (after three decades of taking care ***of women that with a complete, never-had-an-orgasm-in-their-life situations), anorgasmia***, the best treatment for

[6] Here's where to apply for our Vampire Facial® provider group (https://vampirefacial.com/members)←

that is the adequate replacement of testosterone.[7] When you get testosterone adequately replaced, the sex drive becomes very strong; it can become the opposite problem—like asking a 17-year-old boy not to have a sex drive. It's hard to not have one.

But most people don't adequately replace testosterone in women, and that's a whole different topic. You don't have to do the replacement; you can refer that out. You can still use your O-Shot® to enhance the response, but if you're trying to treat complete anorgasmia with just an O-Shot®, that success rate's probably somewhere between 10% and 30%.

If you treat these women, you should make sure they know you're going to give all their money back if they're not happy with what happens and be prepared to do that. The best would be to replace their testosterone level (if you want, do the O-Shot® in conjunction with it), and then recheck their blood levels in six weeks and see how they are doing to make adjustments.

I prefer injections to start, rather than creams or pellets, because you can't change the dose of the pellet for three months, and the creams are absorbed inconsistently and require compliance by the patient. Just inject depo-testosterone (50 mg IM) and then do that every 21 days, watching how they respond, and then add in your pellets after 2 or 3 months (and dropping the injections) based on how they're responding, adjusting the dose of your pellets—that's what I think works best.

As I said, hormones are a whole different science beyond what we're talking about here. But to me, testosterone is the best treatment for complete anorgasmia.

The other problem for which it is difficult to see a positive result with the O-Shot® procedure is the ***woman who wants to have an orgasm with penis-in-vagina sex*** and with no hands and no devices. She wants to experience an orgasm, or she's feeling pressure from her lover, who wants to see her have an orgasm from just his penis.

If you think about the system of producing an orgasm that now involves two bodies joined together, there are so many variables that are not related to where you're putting that needle. He may have a penis that isn't fitted to her vagina, either too big or too small, for her to have pleasant sensations. It could be that he's beating her up and she resents even being in the room with him. Maybe he's got premature ejaculation.

By my definition, premature ejaculation is if you ejaculate before everybody's satisfied with the encounter. Sometimes that means having sexual intercourse for 30 seconds and sometimes it may mean

[7] If the woman is not sure if she has ever had an orgasm, she says something like, "I think I might have had one once," then she has never had one.

hours. So that is a different skillset and, again, beyond the scope of what we're talking about here, but it's absolutely possible. I've taught men to do it now since 2004, when my first book came out.[8]

> ***Premature ejaculation is if you ejaculate before everybody's satisfied with the encounter.***

And so, I know it's teachable. If you're interested in that, I have a book. You can find it online. Just download it for free. It's *called Anytime... for as Long as You Want*. If you Google that with my name, there's a section at the end of that book that talks about how to have sexual intercourse for as long as you want.

I've bought every book on Amazon, and I'm not exaggerating. I've bought every book on Amazon about premature ejaculation. In my opinion, they're all ... What's a nice way to say this? Not helpful for most people. But, mine will work if the man implements all of the suggestions.[9]

Okay. So if the woman wants an orgasm with penis and vagina sex, all we have is survey data. We don't have double-blind, placebo-controlled studies looking at these answers. But, we do have thousands of data, about 3,000 data points, from our survey that's administered inconsistently. But we do have data points from multiple patients, around 3,000, from various providers, and I have a decade-plus, and I'm hearing from our people. My bet is that this is probably around 30% to 50% success rate, wanting to have an orgasm with penis-in-vagina sex (even without control of the male/partner side of the equation).

We do have those who do have success. So I'm not saying don't treat the hard cases. Just don't make that the first five people you treat, or you'll get discouraged and think, "The O-Shot® doesn't work."

Now ***our easy cases again are other people's hard cases***.

Easy cases would be stress urinary incontinence and everything's intact. Her bladder's not outside the vagina. Her cervix is not hanging outside the vagina. She doesn’t need to have to be 18-year-old pelvis,

[8] Runels, *Anytime...for as Long As You Want: Strength, Genius, Libido, & Erection by Integrative Sex Transmutation*.

[9] Runels.

but she has fairly intact pelvic musculature and ligaments, and so that everything's sitting pretty much where it needs to be. For that, our O-Shot® works tremendously well.[10] [11] [12] [13] [14]

Then I have multiple doctors that tell me they get ... See, I have trouble saying it because it's unbelievable. But I have doctors tell me they get 100% success rate for stress urinary incontinence. It's close.

(TRAP) Now the nuances with this are that, over and over again, people tend to go too proximal to the bladder and they go too deep. When you do this procedure right, after you've ... Especially for incontinence. Let me come down and we'll type this out, the pearls and traps.

With the O-Shot®, it's stay shallow on the anterior vaginal wall and stay distal, only about a centimeter from the hymenal remnant. When you look in the vagina, you see the horizontal rugae, it's about the third. It's that distal. You're almost outside. You're not in the smooth tissue within Hart's line, because it will hurt more. You are inside the vagina.

> ***Stay shallow on the anterior vaginal wall and stay distal, only about a centimeter from the hymenal remnant.***

(TRAP) The other trap is that people go too deep. And so, when you're finished, you should feel a protrusion, like a hematoma. Basically that is what you're doing, right? ***You're making a hematoma without the trauma on the anterior vaginal wall.*** If you can't feel that, it will still sometimes work, but that's how I know I got it right. You've essentially made a liquid sling with your PRP.

(BIG TRAP) I know some teachers that teach for us are altering the technique—this worries me. It's okay if you want to go other places with the PRP, but there must be at least 3 cc directly beneath the urethra.

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[10] Long et al., "A Pilot Study."

[11] Samy Tahoon, El-Din Hussein Salem, and Anwar Abdo Mousa, "The Role of Platelet Rich Plasma Injections in Cases of Stress Incontinence."

[12] Athanasiou et al., "The Use of Platelet-Rich Plasma as a Novel Nonsurgical Treatment of the Female Stress Urinary Incontinence."

[13] Kirchin et al., "Urethral Injection Therapy for Urinary Incontinence in Women."

[14] Runels, "A Pilot Study of the Effect of Localized Injections of Autologous Platelet Rich Plasma (PRP) for the Treatment of Female Sexual Dysfunction."

Sometimes, I have people in our group tell me what they're doing, and it's not our procedure. They'll swear one of our teachers taught them something crazy. I don't know because I wasn't in the class. But it's embarrassing because it's the opposite of what we're teaching.

Let me back up a second.

The Opposite of What We Are and What We Do

The high school coach that teaches his football athletes sex ed in the 10th grade is going to show how to put a condom on a banana, and the vagina's going to be conceptualized as pretty much a tube to put a penis in that leads to a cervix where a baby can grow.

We know it's much more complicated and elegant than that.

We just got through going over in the last journal club about the superficial and deep transverse perineal muscles, the bulbospongiosus and ischiocavernosus and the hiatus of the iliococcygeus and the levator ani and all its different components, and the pubococcygeus and its three components with ... We can go on and on.

The vagina is not a freaking tube!

It's so elegant and so complicated, really, that I don't think ... Even the experts are still doing research to try to understand it; people have whole careers just trying to understand the female pelvis.

Now back to our procedure, the original idea is that Dr. Grafenberg, 50 years ago, figured out the anterior vaginal wall, over the urethra is the most sensitive part of the vagina. He documented female ejaculation.[15]

And so, my original idea with the O-Shot®, I didn't think about it helping incontinence, we just got lucky. But I was thinking about female ejaculation. Because I had already written a book on teaching a woman to ejaculate, that had been marketed online for five, six years before that, I was thinking about enhancing sexual response by injecting around the urethra and the periurethral glands to enhance the ejaculatory response by making that tissue healthier.

(TRAP) That stuff doesn't live laterally and posteriorly in the vagina. It's not there. And so, you can squirt the lateral, or posterior vagina with all the PRP you want and it's not going to help incontinence. So if you learn from a teacher or you've modified the procedure where you're not specifically injecting

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

anterior vaginal wall directly beneath the urethra and you're trying to help incontinence, you might as well squirt it in the patient's left ear because you're not going to help it. So that's super important. I'm not sure why the procedure is being altered to not include the tissue directly beneath the urethra.

Now on the other hand, if you have someone who has dyspareunia ... Let's go back up here to our easy and hard stuff. The easy stuff also includes dyspareunia. I mean, this is game-changing. We actually have studies showing that it helps women with dyspareunia secondary to dryness after they've been treated for breast cancer and can't be on hormones.[16]

Dyspareunia of unknown cause (after all appropriate testing has been done) responds well to our O-Shot® procedure.

I have no idea why.

But if you have a person who's been to three doctors and they've had ultrasounds and MRIs and psychosexual therapy and family therapy, and they've used lidocaine creams, and they've done everything they know, and it still hurts to have sex, I don't know why, but the majority of the time if you just do our regular O-Shot®, it will get well (always return all of their money if they are not better at 8-12 weeks, or repeat it if there is improvement but not completely well).

And this unknown category is under talked about. It's embarrassing for us to say we don't know something. It's probably been five, six years ago. There was an editorial in The Green Journal where the editor said that we might as well face it, a lot of people we treat for dyspareunia, we don't really know why.

The full algorithm for diagnosing dyspareunia is like back pain. It can be simple, it can be complicated, it can be serious, and it can be not serious. So back pain, you can have anything from a dissecting aortic aneurysm to a gallbladder, to a heart attack, to a muscle strain. Same with dyspareunia. There are so many causes. It's not a simple diagnosis.

Usually before anyone offers to pay you for an O-Shot®, they've already seen a couple of doctors, and the idea of having a big mass or something surgical has usually been ruled out. If not, then that should be thought about. But the "unknown" etiology for dyspareunia, for some reason, gets better most of the time.

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[16] 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."

The ***other most-likely-to-improve after an O-Shot® procedure would be lichen sclerosus***. And, yes, it's spelled with a U at the end, not an I.

We have a growing number of studies showing that our procedure helps.[17] We like combining it with UV therapy.[18] If you want to know all about that, there are people in our group, including my wife, that have had ... and Kathleen Posey's the one who's done the most of this, I think, and published a study.[19] We have a growing body of strong evidence that we can help lichen sclerosus.[20] [21] [22] [23] [24] [25] [26] [27] [28]

[17] Goldstein et al., "Intradermal Injection of Autologous Platelet-Rich Plasma for the Treatment of Vulvar Lichen Sclerosus."

[18] Garrido-Colmenero et al., "Successful Response of Vulvar Lichen Sclerosus with NB-UVB."

[19] Posey and Runels, "In-Office Surgery and Use of Platelet Rich Plasma for Treatment of Vulvar Lichen Sclerosus to Alleviate Painful Sexual Intercourse."

[20] Msc et al., "Autologous Platelet Rich Plasma (PRP) Intradermal Injections for the Treatment of Vulvar Lichen Sclerosus."

[21] Casabona et al., "Autologous Platelet-Rich Plasma (PRP) in Chronic Penile Lichen Sclerosus: The Impact on Tissue Repair and Patient Quality of Life."

[22] Goodchild, "How Kim Kardashian's Vampire Facial Could Provide Relief to 1m Women."

[23] Goldstein et al., "Intradermal Injection of Autologous Platelet-Rich Plasma for the Treatment of Vulvar Lichen Sclerosus."

[24] Lee, Bradford, and Fischer, "Long-Term Management of Adult Vulvar Lichen Sclerosus."

[25] Parygina et al., "Platelet-rich plasma in the treatment of scleroatrophic lichen of the genitals."

[26] Marnach and Torgerson, "Therapeutic Interventions for Challenging Cases of Vulvar Lichen Sclerosus and Lichen Planus."

[27] Behnia-Willison et al., "Use of Platelet-Rich Plasma for Vulvovaginal Autoimmune Conditions Like Lichen Sclerosus."

[28] Krapf et al., "Vulvar Lichen Sclerosus."

There was one study that used saline as a placebo that seemed to show that PRP did no better than placebo[29], but this study failed to consider that hyrodissection with saline in a soft-tissue study is not a placebo.[30] [31] [32] [33] [34] [35] [36] [37]

And corticosteroids (which do not work for everyone with lichen) are not without problems.[38]

(TRAP) The trap for this one would be that, ***when treating lichen, you must make sure they had a biopsy before treating. You need to know what you're treating*** because somewhere around 10% of them convert over to squamous cell carcinoma.

Another easy win with the O-Shot® procedure is for muscle tenderness or point tenderness: a woman will say, "It hurts to have sex, and it hurts, right here;" they can put their finger on the spot, and when you press there, it reproduces their pain.

You're putting pressure on one of the pelvic floor muscles.

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[29] Goldstein et al., "A Randomized Double-Blind Placebo Controlled Trial of Autologous Platelet Rich Plasma Intradermal Injections for the Treatment of Vulvar Lichen Sclerosus."

[30] "Clinical Benefit of Intra-Articular Saline as a Comparator in Clinical Trials of Knee Osteoarthritis Treatments_ A Systematic Review and Meta-Analysis of Randomized Trials | Elsevier Enhanced Reader."

[31] Sharma, Gupta, and Rani, "Delineating Injectable Triamcinolone-Induced Cutaneous Atrophy and Therapeutic Options in 24 Patients—A Retrospective Study."

[32] Asghar et al., "Efficacy and Safety of Intralesional Normal Saline in Atrophic Acne Scars."

[33] Bokey, Keating, and Zelas, "HYDRODISSECTION."

[34] Popp, "Improvement in Endoscopic Hernioplasty."

[35] Searle, Al-Niaimi, and Ali, "Saline in Dermatologic Surgery."

[36] El-Amawy and Sarsik, "Saline in Dermatology."

[37] Cass, "Ultrasound-Guided Nerve Hydrodissection: What Is It? A Review of the Literature."

[38] von Krogh, Dahlman-Ghozlan, and Syrjänen, "Potential Human Papillomavirus Reactivation Following Topical Corticosteroid Therapy of Genital Lichen Sclerosus and Erosive Lichen Planus."

Then, instead of injecting with triamcinolone, you do what the NFL sports trainers do,[39] [40]and you inject the trigger point with PRP. Now we know that PRP helps remodel torn tissue and helps it heal with less fibrosis, better strength, and better circulation.[41] So that's another one of our "easy" ones.

Usually, they'll get worse for a week, and then it starts to go away, and it's gone in three to six weeks. For one woman with dyspareunia (that was reproduced by palpating the pelvic floor), I had to repeat the injection five times, and every time, it got better. I'd see her every eight weeks.

I would give it at least eight weeks (after injecting the pelvic floor) or the sex muscles[42] before you decide if it worked or not. Then, I would repeat it. It took five treatments, and then it was gone, and it stayed gone for 3 years, then I had to repeat it once.

Interstitial cystitis, I guess it could be a standalone category, but I'll put it under dyspareunia. Interstitial cystitis, we have growing numbers of studies. So far, the studies have mostly involved injecting into the bladder itself.

But here's a low-hanging fruit for someone who wants to do this study. Our procedure has extremely good success rates just doing the regular O-Shot® ***for interstitial cystitis.***[43] [44] [45]

Let's see. Then you have the ***episiotomy scars***. That is you just didn't do the regular O-Shot®, but instead of putting 3 cc in the anterior vaginal wall ... I mean instead of putting 4, put 3 in the anterior vaginal

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[39] Middleton et al., "Evaluation of the Effects of Platelet-Rich Plasma (PRP) Therapy Involved in the Healing of Sports-Related Soft Tissue Injuries."

[40] Bubnov, Yevseenko, and Semeniv, "Ultrasound Guided Injections of Platelets Rich Plasma for Muscle Injury in Professional Athletes. Comparative Study."

[41] Aguilar-García et al., "Histological and Biochemical Evaluation of Plasma Rich in Growth Factors Treatment for Grade II Muscle Injuries in Sheep."

[42] Runels, "Female Sex Muscles Part 2."

[43] Jhang, Yu, and Kuo, "Comparison of the Clinical Efficacy and Adverse Events between Intravesical Injections of Platelet-Rich Plasma and Botulinum Toxin A for the Treatment of Interstitial Cystitis Refractory to Conventional Treatment."

[44] Chen et al., "Platelet-Rich Plasma Ameliorates Cyclophosphamide-Induced Acute Interstitial Cystitis/Painful Bladder Syndrome in a Rat Model."

[45] Jhang, Lin, and Kuo, "Intravesical Injections of Platelet-Rich Plasma Is Effective and Safe in Treatment of Interstitial Cystitis Refractory to Conventional Treatment-A Prospective Clinical Trial."

wall and add the leftover cc, infiltrate the area there in the posterior part of the introitus, maybe even a little bit into the perineal body, and they will quit tearing and hurting.

Again, you may have to repeat it two or three times, eight weeks apart. So you got that.

I don't know why, but we have ... I can postulate, but we have great success too with urge incontinence. Had several reports of people who were scheduled for surgery for horrible urge incontinence. I know it's often mixed, but then they had their O-Shot® and everything's great.

We know PRP causes neurogenesis,[46] [47] [48] [49] [50] [51] [52] so perhaps that's involved, I don't know. But we have great results with that.

[46] 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."

[47] Foy, Micheo, and Kuffler, "Functional Recovery Following Repair of Long Nerve Gaps in Senior Patient 2.6 Years Posttrauma."

[48] Kuffler, "Platelet-Rich Plasma and the Elimination of Neuropathic Pain."

[49] Chung, "Regenerative Technology to Restore and Preserve Erectile Function in Men Following Prostate Cancer Treatment."

[50] Sánchez et al., "Platelet-Rich Plasma, a Source of Autologous Growth Factors and Biomimetic Scaffold for Peripheral Nerve Regeneration."

[51] Pandunugrahadi, Irianto, and Sindrawati, "The Optimal Timing of Platelet-Rich Plasma (PRP) Injection for Nerve Lesion Recovery."

[52] Abo El Naga, El Zaiat, and Hamdan, "The Potential Therapeutic Effect of Platelet-Rich Plasma in the Treatment of Post-COVID-19 Parosmia."

Decreased orgasm. Not anorgasmia, never had one in their life, but decreased orgasm. The woman used to have orgasms and now they're just blah. Our O-Shot® procedure often helps.[53] [54] [55] [56] [57]

Again, you must think about the whole system,[58] but it often helps. I think that pretty much covers it.

(TRAP) A trap is that not activating the PRP. I'll tell you what I'm postulating when I'm giving you the facts. Here's the fact. PRP activated is not the same as PRP not activated, and saying that it's completely activated by pushing it through a needle versus adding calcium chloride, calcium gluconate, or thrombin, or an HA to activate it is just not accurate. Yeah, it gets activated if you just shake the platelets. Sure, pushing through the needle causes some activation.

That's the only thing I can think of. Some of the studies, they're pushing it through a needle very slowly, as if they're trying to keep it from activating. So I understand that reasoning. I think I'm seeing some research projects being done in the sexual arena by people who haven't played around with PRP and other arenas where you can see what it's doing.

Okay. So let's talk about the P-shot® now, hard and easy.

P-Shot® Procedure: Hard & Easy to Treat Problems

One of the hard-to-treat patients is the man ***suffering longstanding vascular disease.*** This would be the person that Viagra does nothing. Now that we have Priapus Toxin™ or the P-Shot 100™, where we're adding one hundred units of neuromodulators to our PRP, those studies indicate even people with

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[53] Runels, "A Pilot Study of the Effect of Localized Injections of Autologous Platelet Rich Plasma (PRP) for the Treatment of Female Sexual Dysfunction."

[54] Sukgen et al., "Platelet-Rich Plasma Administration to the Lower Anterior Vaginal Wall to Improve Female Sexuality Satisfaction."

[55] Sharp et al., "Measuring Quality of Life in Female Genital Cosmetic Procedure Patients."

[56] Jb, "O-Shot: Platelets Rich Plasma in Intimate Female Treatment."

[57] Sanoulis, Nikolettos, and Vlahos, "The Use of Platelet-Rich Plasma in the Gynaecological Clinical Setting. A Review."

[58] Runels, "Female Orgasm System."

spinal cord injuries, 40% of them can resume sexual activity by combining the botulinum toxin with their PDE5 inhibitors.[59] [60] [61]

So, doing a P-Shot® with platelet-rich plasma and using botulinum toxin together, maybe. But if I have someone who has had so much vascular disease for so long that they never have tumescence, they can take a bottle of Viagra; nothing happens, and they're likely to have the iliac vascular disease as well, then changing the health of the circulation through only the penis with a P-Shot® procedure is less likely to give a benefit.

I say this knowing that some physicians in our group have results with these people. I know one of our urologists told me that before he does a penile implant, he always does a P-Shot®--on everybody, and sometimes these people resume function and don't need the implant. If they do need the implant they recover faster; they have healthier tissue and do better post-op. Surprisingly, he has people who improve and do not need the implant.

So it's not a hard and fast rule, pun intended, but I do think that if you made a habit, if the next five patients you treated people in this category were in this category, you would probably become discouraged.

The other one I avoid treating with only a P-Shot® procedure is the ***man who's main goal in life is to grow his peni***s more than 10% of what it is now. Now we just did another study where we showed that you can see growth with the P-Shot® combined with physical therapy, and it can be noticeable, but, unfortunately, it's most noticeable in those who are least bothered (10% growth on a 6-inch penis is more than 10% growth on a 4 inch penis).[62] [63]

To put it in absolute numbers, if a man has a three-inch erection, it's difficult to get him to a six-inch erection. But you can get five or a five and a half to six and you can get seven to eight in length. The first to change is usually girth. Length can change as well, but when you have someone with a micropenis whose social life might be most affected by a penis size, not psychologically but practically because of

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[59] Giuliano, Denys, and Joussain, "Effectiveness and Safety of Intracavernosal IncobotulinumtoxinA (Xeomin®) 100 U as an Add-on Therapy to Standard Pharmacological Treatment for Difficult-to-Treat Erectile Dysfunction."

[60] El-Shaer et al., "Intra-Cavernous Injection of BOTOX® (50 and 100 Units) for Treatment of Vasculogenic Erectile Dysfunction."

[61] "Research – Priapus Toxin™"

[62] Brandeis et al., "(130) Increasing Penile Length and Girth in Healthy Men Using a Novel Protocol."

[63] Kumar, "265 Combined Treatment of Injecting Platelet Rich Plasma With Vacuum Pump for Penile Enlargement."

micropenis, I've treated some of those guys for free and it's difficult to see enough growth that their lover can tell the difference.

On the other hand, ***if you put just an inch on the circumference on a six-inch penis, you have doubled the volume***. So percentage-wise, there are noticeable changes. But if their main goal in life is to grow a porn king penis, just psychologically, I've found those people to be difficult to please.

Now our most-most-likely-to-improve complaints after a P-Shot® (easy), again, are other people's hard to treat problems.

Peyronie's disease is one of our high success problems and our P-Shot® works better than Xiaflex.[64] [65] [66]

Another easy win is ***decreased erection***, but they don't want to be on the PDE5 inhibitors, and there's nothing else that slows the pathophysiology progression down. PDE5 inhibitors, implants, TriMix injections, none of that slows down the progressive neurovascular changes of aging and the hypotrophy of the man's penis. By the time he's 65, on average, a man loses half of the endothelium of his penis.

> ***So, you could make the case, and I do make the case every chance I get, that why would you wait until Viagra quit working to try our P-Shot®? Why would you not use the P-Shot® in concert with your Viagra, or even before you needed the Viagra to help maintain the health of your penis?***

[64] 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."

[65] "Peyronie's Disease."

[66] Culha et al., "The Effect of Platelet-Rich Plasma on Peyronie's Disease in Rat Model."

So hopefully this will become more commonly done. Our research is growing, supporting the idea, but these are easy. They'll usually see a bump in seven from our procedure,[67] [68] [69] [70] [71]which is about what you see with Viagra. It's also about what you see with just aerobic exercise.

Only one study showed lack of benefit from an injection of PRP into the corpus cavernosum; the study injected ½ of our usual dose and did not activate the PRP, and changed our procedure in other significant ways that would decrease the effectiveness.[72] [73] They also used saline as a placebo (and did not explain why their placebo had significant benefit—also failing to acknowledge that saline is NOT a placebo in soft tissue studies.[74]

I recommend you do everything you know to do to help the man save his sex life and then back off things. Your win is going to be they will cut their Viagra or Cialis to half their usual dose. If they're on a low dose, they'll be able to throw it away. But if they're on a high dose, they're not likely to be able to throw it away.

(TRAP) **One of the traps of the P-Shot® is they stop everything when you do the shot**. So you do a P-Shot®, and the day you do the P-Shot®, they throw all their medicines away.

Well, that's more than one variable.

What you want to do is have them stay on their medicines, and then after their erections are as optimal as you can make them make, see what you can decrease or stop.

(TRAP) The other trap is that they overuse the pump.

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[67] Chung, "A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction."

[68] Brandeis et al., "(130) Increasing Penile Length and Girth in Healthy Men Using a Novel Protocol."

[69] Poulios et al., "Platelet-Rich Plasma (PRP) Improves Erectile Function: A Double-Blind, Randomized, Placebo-Controlled Clinical Trial."

[70] Siroky and Azadzoi, "Vasculogenic Erectile Dysfunction."

[71] Chung, "Medical Sciences A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction."

[72] Ganijee et al., "Thoughts On."

[73] Shaher et al., "Is Platelet Rich Plasma Safe And Effective In Treatment Of Erectile Dysfunction?"

[74] See the references regarding this topic under the above discussion of the O-Shot® procedure.

(TRAP) The other trap is that the man has unrealistic expectations. Again, you're going to go up about seven on that five to 25-point erection scale, not 20. Seven.

Another easy win is BXO (lichen in a man's foreskin). There's a video on our membership site that shows you how to treat that, and we have a high success rate. Studies are showing that it works.[75]

Another easy win is Peyronie's disease. To see this whole protocol, go to priapusshot.com/peyronies. You can see the whole protocol for treating Peyronie's disease.

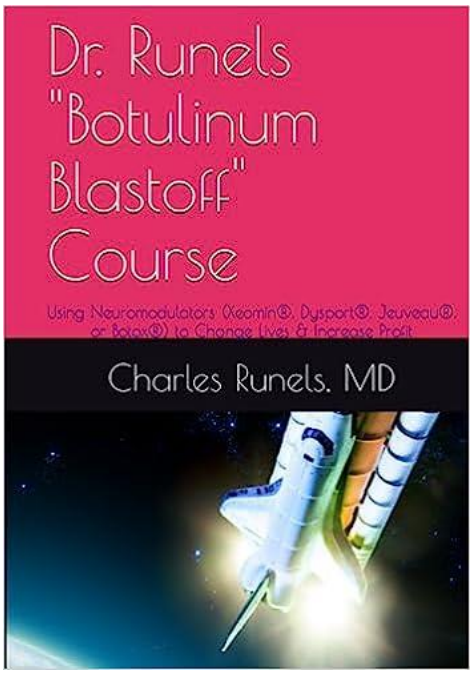
Now one study by Ronald Virag showed that PRP works better than Xiaflex.

I'm still not sure exactly why Xiaflex is being used in the US and still FDA-approved. It's no longer used in Canada and across Europe, Asia, and Australia. My bet is that it's because of the fracture rate. There's a significant risk of penile fracture when you use collagenase (around 1 in 100, if our P-Shot® did that, we'd be shut down). Yeah, it dissolves the scar, but it can also weaken the fascia so that you have a fractured penis. It goes from a bent pencil to a broken pencil.

Of course, our PRP has a great side effect of improved erection (not penile fracture, ever). But there's this idea: you somehow have to use an ultrasound and inject the actual plaque. But we have great success not doing that, just doing a regular P-Shot®. But always, always, always the other trap is not using the pump when treating Peyronie's disease, because the pump helps!.

[75] Casabona et al., "Autologous Platelet-Rich Plasma (PRP) in Chronic Penile Lichen Sclerosus."

Now I won't go into the science of the pump right now, or the vacuum pump, but the old has become new. I think probably by various mechanisms, including hypoxia and activating of platelets within the penis with vacuum, which is what happens when you get a difficult phlebotomy, you can activate the thrombin cascade with vacuum. You're probably making ... I can go on and on, but there's a whole different two-hour lecture easy about the science of the vacuum pump.



But 51% of men who use the pump alone in one British Journal of Urology study canceled their surgery for Peyronie's disease.[76] [77]So we want to use the pump along with it.

(TRAP) A trap is that some people don't use the pump or they overuse it, and they must have a pump, use a pump with a gauge.

I have a whole video about the nuances of the pump on the Priapus Shot® membership website. But you want to keep it less than 10 on that gauge.

Basically, the idea is have them create an erection that's just a little bit larger than what they normally see, and that's going to give ... For about 10 minutes once or twice a day, and that's going to give the best result.

(TRAP) Using a tourniquet. II know that some of our people use a tourniquet and get great results. I think, though ... Again, somebody do the study and figure this out. But I've never used a tourniquet, and I think that you're actually decreasing the effectiveness because you are not allowing the PRP to hydrodissect into the part of the penis that you cannot see.

We don't put a tourniquet on the clitoris when we do the O-Shot®. We don't put a tourniquet on the neck when we do the Vampire Facelift®. It just stays there. Just like when you activate PRP naturally when you scrape your knee or have surgery, the growth factors stay there. There's no tourniquet to keep them in place when you have a cholecystectomy. That's the reason for the platelet-rich fibrin matrix.

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[76] Raheem et al., "The Role of Vacuum Pump Therapy to Mechanically Straighten the Penis in Peyronie's Disease."

[77] Levine, "Peyronie's Disease: Contemporary Review of Non-Surgical Treatment."

Now some people I've heard are saying that, "I recommend a tourniquet because it's showing up in the research." No, it's showing up in the research by people changing our procedure. Let me put something else just as principles to ... There's a couple of principles to watch for

Principles

One, think in terms of systems. Now I don't claim to be ever the smartest person in the room. I mean far harder maybe than most people. Maybe I get up earlier and go to sleep later and maybe I watch less TV, because I haven't owned one since I left to go to college. But I don't know that I'm smarter. But I do have some ideas about what innovation means, and I didn't learn them in medicine. I learned them from working in a research laboratory where if you did not innovate, you lost your job versus, think about it in medicine, if you innovate too much, you lose your job.

So it was an opposite way of thinking. When I left the research arena and went to residency, I learned very quickly, ooh, I need to be careful and keep new ideas to myself, because although I was rewarded them in basic science research, it will cause me to lose my livelihood if I'm too vocal about new ideas in medicine. I'm not saying that's a wrong thing, it's just a thing. But I have thought about innovation now for my adult life and I've thought about it in arenas where without it, you don't survive.

Is it an Innovation or a Complication?

Here's a test...

> ***If the "innovation" makes it more complicated to achieve the same results, that's someone thinking they innovated by complicating.***

True innovation is usually an idea that is so simple, it seems obvious after it's thought about.

So when you see someone particularly with our procedures, complicating them ... Like one of the studies that was out ... I'm glad it came out. But one of the double-blind, placebo-controlled studies, they took a long spinal needle and took minutes to inject each corpus cavernosum by threading the corpus cavernosum. They put a tourniquet on and they massaged the penis for 10 minutes. (none of which is part of our P-Shot® procedures). They stood on one foot and shook a crow's foot ... No, they didn't do that part. But they complicated it--best I can tell, without adding any reasonable strategy that would've made it work better.

> ***It should be as complicated as it needs to be, but no more so.***

So back to the traps with the P-Shot®, I don't think the tourniquet is a thing to do. I could be proven wrong about that. But I think it keeps you from treating the proximal part of the penis, which is inside the body and which contributes to erection and which is significant.

The other easy win for us is ***penile rehabilitation post-prostate surgery***. Finally, we have studies out directly supporting this idea[78] [79] [80] (in addition to the studies regarding the improvement of penile function already discussed).

This rehabilitation is a combination of pump, plus a Cialis, low dose, like 2.5 or 5 milligrams daily, and a P-Shot®. So you combine those three and you have an easy win that's better than no rehab (and you always give all the money back if the patient does not love the results).

You do it after the surgeon has released the patient, they're recovered from their surgery, and then you combine those three.

By doing these three together, you maintain blood flow so that as the nerves regenerate and blood flow returns, you're not left with a contracted, stiff penis that died while it was waiting ... Essentially function died at least while it was waiting for surgical recovery.

I've put people through this protocol sometimes years after they went through just the pump and Cialis protocol, put them back through the protocol again, and they're able to achieve erection again. Not 18-year-old penis, but able to have enough tumescence to have sexual relations with their lover even 10 years post-op.

Vampire Breast Lift® Procedure: Easy & Hard

Okay. For the breast lift, the hard would be they want a bigger cup size. That happens sometimes after the procedure, but I don't promise it, and I won't do it if that's the goal of the patient.

Also, a difficult to help with this procedure patient would be the women with extremely deflated breasts. My best metaphor for it is it looks like the sock that's just hanging down. So there's no lift or

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[78] Lee, Jiang, and Kuo, "A Novel Management for Postprostatectomy Urinary Incontinence: Platelet-Rich Plasma Urethral Sphincter Injection."

[79] Sopko and Burnett, "Erection Rehabilitation Following Prostatectomy [Mdash] Current Strategies and Future Directions."

[80] Lee, Jiang, and Kuo, "A Novel Management for Postprostatectomy Urinary Incontinence: Platelet-Rich Plasma Urethral Sphincter Injection."

thickness in the lower medial or lateral pole of the breast. It's just hanging down thin. In that case, they need surgery, they need an implant if they want that to be better. So those are the hard cases.

Again, hard cases, if you didn't know what we do.

Easy (likely to improve) would be…one of my favorites… ***loss of sensation***. You do the regular procedure and you put a cc of PRP under the areola on each side. The technique is demonstrated on the videos on the website.

Okay, back to the easy and hard with the breast. Loss of sensation is easy.

EASY…If they want increased roundness of the cleavage.

(TRAP) Okay, I just thought of another trap with the breast lift. With the breast lift, ***you need at least 15 milliliters of PRP per breast. Less than this will give an inadequate response.***

I have heard that some are modifying our procedure and they are recommending less than that. Doing this right makes it expensive, because to get 30 cc total of PRP, you're going to need six single spin tubes (with most kits); you'll need at least 60 milliliters of blood, which would be six of the single-spin kits, which would be significant in price. This is one case where the double-spin becomes actually cheaper because you can process more blood.

But the breast lift works with a single spin. I've done it many times with single spins. You just need to spin an adequate amount of blood. The adipocytes, we know from studies, Sclafani's and other others, adipocytes, they enlarge and they multiply to PRP.[81] But you need to infiltrate enough of them with PRP to see a response.

Then with this one also, never ever point the needle at an implant. The technique is shown in the website, but you're always holding the tissue. So, the needle, if it suddenly became three feet long, would still not damage anything. So you're not having to judge depth. You're just pulling the tissue away from the implant, injecting it, but never aiming the needle at the implant.

Let's see. Vampire Breast Lift®, increased roundness.[82] You can correct nuisance defects from implants and surgery. Even though the authors downplayed it, understandably so, it showed that by using PRP to treat the scar tissue from a port after breast cancer, the women who got the PRP versus those who did

[81] Sclafani and McCormick, "Induction of Dermal Collagenesis, Angiogenesis, and Adipogenesis in Human Skin by Injection of Platelet-Rich Fibrin Matrix."

[82] Eichler et al., "Platelet-Rich Plasma (PRP) in Breast Cancer Patients."

not actually had statistically fewer recurrences of their breast cancer.[83] Other studies with fat replacement (often mixed with PRP to improve the survival of the fat) show a trend towards fewer recurrences.[84] [85] [86]

That's a whole different subject matter***. I'm not saying that we're inoculating and making breast cancer impossible, but there are some reasons why PRP might be decreasing the chances of breast cancer*** that have to do with the inflammatory effects of the bacterial milieu of the breast, which is different in those with cancer versus those who do not have cancer.[87]

> ***I'm not saying that we're inoculating and making breast cancer impossible, but there are some reasons why PRP might be decreasing the chances of breast cancer.***

So those are the hard and easy cases for breast lift, P-Shot®, O-Shot®, facial, and facelift. I promised you a five-minute marketing tip before we shut it down, and here's the tip.

A Five-Minute Marketing Tip That is Easy and VERY Effective

You know the saying a picture is worth a thousand words. So here's the formula for an effective email. Put a picture ... It can be a before and after. It can be a diagram of the anatomy. I'm thinking pictures before and after is for breast lift, a scar that you treated. It could be a wing lift. It could be hair that you treated.

1. You put a picture in an email.

Then,

2. Tell the story of that picture.

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[83] Eichler et al., "Platelet-Rich Plasma (PRP) in Oncological Patients."

[84] Sakai et al., "Complications and Surgical Treatment of Breast Augmentation Using Autologous Fat Transfer and Fillers."

[85] Vizcay et al., "Current Fat Grafting Practices and Preferences."

[86] Krastev et al., "Long-Term Follow-up of Autologous Fat Transfer vs Conventional Breast Reconstruction and Association With Cancer Relapse in Patients With Breast Cancer."

[87] Urbaniak et al., "The Microbiota of Breast Tissue and Its Association with Breast Cancer."

> Think about what you just did. What did your mama do when you were five years old (if you were lucky to have a mama when you were five because not everybody does)? But you had a sweet mama at five, and **she opened a book that had pictures, and she told a story about the pictures.**

We don't grow out of that.

A story has a person, a place to frame it, and something happens.

It's a journey.

3. And then the last thing is to tell them what to do.

So your email could be something like this:

It could be a picture of a breast, and the story would be, "These are the breasts of a 30-year-old woman who came to my office last week and told me that she was embarrassed to take off her bra in front of her lover because of this defect that happened when they biopsied her for cancer. The biopsy was benign, but now she's got this depression in her breast tissue. Then we injected it with PRP and now it looks like that."

See that?

So you have a picture that you're proud of, and it could be ... Think of the anatomy picture. It could be, "Oh, here's a picture of your ischiocavernosus muscle, which has to do with your clitoris. When we inject your ... "

We're making a story.

Here’s another:

"So last week, a woman came to see me with decreased orgasm. I want you to see when we injected the body of her clitoris, that PRP would be hydrodissecting down in the corpus cavernosi beneath the

ischiocavernosus muscle. That is part of what contributes to her orgasm. This is why you should come sit on our Emsella machine[88] [89]and get an O-Shot® [90] [91]."

That.

But the picture combined with the story, people love it.

I still love it.

I just bought a new Bible just because it has pictures. Rembrandt made hundreds of paintings that illustrated the Old and New Testaments, and I wanted a Bible that was illustrated by Rembrandt. So I bought one—for the pictures.

Pictures, pictures in a story.

I bought a new version of *Atlas Shrugged* by Ayn Rand just because someone had illustrated it, and I wanted that book with the pictures in it.

So that's your tip.

I hope that was a good journal club hour for you and that it will help you out. Always I'm honored when you show up. Have a great day. Bye-bye.

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[88] Silantyeva et al., "A Comparative Study on the Effects of High-Intensity Focused Electromagnetic Technology and Electrostimulation for the Treatment of Pelvic Floor Muscles and Urinary Incontinence in Parous Women."

[89] "Emsella - A Breakthrough Treatment for Incontinence and Confidence."

[90] 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."

[91] O'Connor et al., "Diagnosis and Non-Surgical Management of Urinary Incontinence – A Literature Review with Recommendations for Practice."

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pictures, story, breast lift, scar treatment, wing lift, hair treatment, PRP, before and after, anatomy, clitoris, tourniquet, effectiveness, innovation, research, low-hanging fruit, Journal Club, facelift, O-Shot, P-Shot, breast lift, pearls, traps, success rate, email method, profit model, hard and easy, dyspnea, bronchodilators

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