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The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of November 11, 2023, with Charles Runels, MD.

The video of this live journal club can be seen here←

Topics Covered

- Why the Testosterone to Estradiol Ratio Matters
- **Penile Length Changes after Penile Implant Surgery**
- **How to Measure a Clitoris**
- **What do penile implants, PDE5is, and Trimix all have in common?**
- **Penile Length Changes after Penile Implant Surgery**
- **How does offering more *non*-surgical procedures lead to doing more surgery?**
- **How to Measure a Clitoris (an update on doppler studies)**
- **Testosterone & Vaginal Function**
- **Does a female transitioning to a male increase her->his chances of breast cancer with the increased testosterone levels?**
- **A coming study makes important points about our P-Shot® procedure**
- **Platelet volumes correlation with the effects of PRP on the corpus cavernosum**
- **The possible evolutionary benefit of a longer penis & the preferences of women who experience vaginal orgasm**
- **PDE5Is and blindness**
- **Does a woman enjoy sex more if she feels like she has a "pretty pu**y"?**
- A quick little trick to empower you to take over your website
- Tell me how to advertise the Vampire Facial

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Welcome to our journal club. I think we have papers today that will be helpful in taking care of our patients. Then, I have a couple of tips about marketing, one question to answer about marketing the Vampire Facial®, and a ***tip about how you can be quicker and more thorough and spend less money on developing your websites.***

So, let's start with the research, and then move over to the marketing part. I'm going to go ahead and put all the references into the chat box. So, if you just copy-paste them, you'll have the references after our meeting. Otherwise, it'll show up when I send the email with an edited transcript in a week or so.

Testosterone to Estradiol Ratio

This one, I wanted to bring up[1] because I was taught that, especially in men, the testosterone to estradiol ratio is important; yet I don't hear that talked about much.

Even if you're not doing hormone replacement, remember our shot; all it does is activate pluripotent stem cells when we do our P-Shot® or the O-Shot®, or any of it, to give a localized effect to make the tissue in the area where you put the injection, healthier: neovascularization,[2] neurogenesis,[3] collagenases,[4] and the remodeling of scars.[5] [6]

But the healthy cell growth depends on other things being in place.

For example, if the person had kwashiorkor or if they even just had no testosterone, then you do not get the same anabolic response as if everything's in order. So, even if you're not doing hormone replacement as part of your practice, it's useful to think about endocrinology and the complete health of the person (our procedures are not magic shots), and this is the first paper I've seen come out in a while talking about ratios of estradiol and testosterone.[7]

I like a 10:1 ratio, at least 10:1 (T: E2), in men.

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[1] Vignozzi et al., "Testosterone/Estradiol Ratio Regulates NO-Induced Bladder Relaxation and Responsiveness to PDE5 Inhibitors."

[2] Sclafani and McCormick, "Induction of Dermal Collagenesis, Angiogenesis, and Adipogenesis in Human Skin by Injection of Platelet-Rich Fibrin Matrix," April 2012.

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

[4] Alves and Grimalt, "A Review of Platelet-Rich Plasma."

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

[6] Alser and Goutos, "The Evidence behind the Use of Platelet-Rich Plasma (PRP) in Scar Management."

[7] Vignozzi et al., "Testosterone/Estradiol Ratio Regulates NO-Induced Bladder Relaxation and Responsiveness to PDE5 Inhibitors."

So, if the man has a 50 estradiol level, he should have a 500 or greater testosterone level, is the way I like to look at it.

And I don't like men to have an estradiol level less than 50 because less than 50 is associated with loss of memory.[8]

In this paper, a rat study, they showed the PDE5Is worked better for the relaxation of the bladder (in response to NO activity) in male vs. female rats. Maybe, that's a stretch to apply that clinically; but I don't think so. It just supports the idea that the T : E ratio matters.

Penile Length Changes after Penile Implant Surgery

This next paper talks about changes in penis size after penile implant surgery. Let's discuss this paper and penile implant surgery in relation to our P-Shot® procedure.

We have quite a number of urologists in our group, and many of them actually integrate our P-Shot® procedure with their penile-implant procedures. In other words, they'll do a P-Shot® two to six weeks before a penile implant with the idea that if the person gets a response and cancels their surgery—that's not a bad thing. I even had one urologist tell me that he had a person who had a penile implant that began to leak, so the urologist removed it; then he gave the P-Shot® to help get the tissue prepped for a replacement of the implant, and the man started getting erections again and canceled the surgery. I think that's a one-off, sort of unusual event. Usually, what happens is the man simply has a faster recovery from the implant surgery and better sensation post-op.

I'm not anti-surgery. Surgery, in my way of thinking, is a natural therapy. You can take out tissue that's unhealthy, and you can re-anastomose things and fix mechanical problems. But, if you are going to do surgery on the penis, you and your patient should know what's going to happen to the size of the penis.

Even if you're not a surgeon, I think if you're taking care of men with erectile dysfunction, you should know the research regarding penile implants. And although we covered a paper here about two months ago where, if you survey the satisfaction rates, it's not 2% or 5% even, it's closer to around 10 to 20% depending on how you survey, of the men who undergo penile implant surgery who wish they had not had the procedure.[9]

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[8] Frick, "Molecular Mechanisms Underlying the Memory-Enhancing Effects of Estradiol."

[9] Wong, Witherspoon, and Flannigan, "Under-Recognized Factors Affecting Penile Implant Satisfaction in Patients."

On the other hand, in this study, they show it's around 50% of the men who do have it done wish they would've had it done sooner—at least 5 years sooner! [10]

So again, I'm not anti-surgery and I'm absolutely not anti-penile implant, but the procedure has its downsides in some people (couples, not just the person receiving the implant) and tremendous benefit with others.

The paper we are discussing today just makes the point that one of the biggest questions people want to know is, "When I get my implant, what's going to happen with the size of my penis?[11]

We should know the answer.

One conclusion of the paper is that (on average) the *fully inflated* penis (post op) was 3.3 cm longer than the pre-op *flaccid* penis; to me this is an apples-to-oranges sort of comparison, but it's interesting.

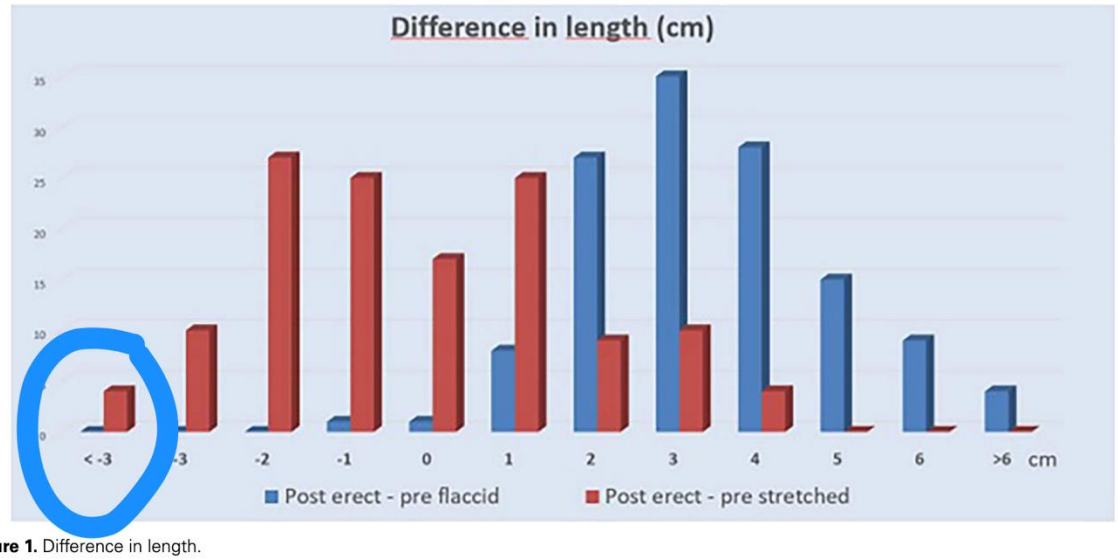

Figure 1. Difference in length.

Figure 1. It appears that the difference between the erect length and the preop stretched length gives a positive number in some; for others, the penis is shortened by 1, 2, 3, and even 4 cm (assuming that the -3 circled in blue was intended to be -4). From Van Renterghem, 2023[12]

[10] Van Renterghem, Jorissen, and Van Huele, "Penile Length Changes after Penile Implant Surgery."

[11] Van Renterghem, Jorissen, and Van Huele.

[12] Van Renterghem, Jorissen, and Van Huele.

For the man and his lover considering an implant, the more relevant conclusion is that the *post op erect penis in this study was (on average) 0.07 cm longer than the preop fully stretched penis—a change in size so small that it would be unnoticeable in the bedroom.*

To save you the pain of the math: The paper showed the penis post-op and fully inflated was (on average) 0.07 cm = 0.7 mm = 0.03 inches longer than pre-op penis when fully stretched. Now we are comparing apples to apples if you assume stretched length equals erection length, and the man gets his answer—on average, the *erection length goes essentially unchanged after a penile implant*.

There seems to be a typo in the graph in the article (see Figure 1) where the x-axis goes -3, -3, -2, -1, 0, 1, 2, 3, 4, 5, 6, >6. Assuming the first -3 is a typo, the most lost in length post-op was about -4 cm, and the most gained was about +4 cm—but the average change was a gain of 0.7 mm.

Though the *average* gain of 0.7 mm would probably be of little comfort to the individual man in the study who lost 1.5 inches (4 cm) in length, it is still useful to know the worst-case scenario.

What do penile implants, PDE5is, and Trimix all have in common?

One side note, the penile implant, PDE5 inhibitors, and TRIMIX injections all have one thing in common: *all three do nothing to address the underlying etiology and pathophysiology of erectile dysfunction,* while shockwave therapy[13] (especially when combined with our P-Shot® [14]) and our P-Shot® procedure[15] [16] [17] do help reverse the underlying pathophysiology and our P-Shot® can also help increase penis length [18] [19].

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[13] "Low-Intensity Shockwave Therapy Improves Hemodynamic Parameters in Patients With Vasculogenic Erectile Dysfunction: A Triplex Ultrasonography-Based Sham-Controlled Trial."

[14] Geyik, "Comparison of the Efficacy of Low-Intensity Shock Wave Therapy and Its Combination with Platelet-Rich Plasma in Patients with Erectile Dysfunction."

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

[16] Francomano et al., "Regenerative Treatment with Platelet-Rich Plasma in Patients with Refractory Erectile Dysfunction."

[17] Schirmann et al., "Pilot Study of Intra-Cavernous Injections of Platelet-Rich Plasma (P-Shot®) in the Treatment of Vascular Erectile Dysfunction."

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

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

The bottom line is that there may be some gain in length from penile implant surgery, but you can't expect more than about a 4 cm increase and there could be a decrease in length.

I send plenty of people for implant surgery. The biggest things I look for to decide between surgery and attempting correction with medications include: (1) does the person show signs of long-standing and significant neurovascular disease, (2) have they been on Viagra for ten years and now full dose has quit working, (3) they suffered with diabetes for 20 plus years (4) Or they take the maximum dose of Cialis and Viagra, and nothing happens.

And even though some people in our group will treat men the preceding with our P-Shot® procedure, I'm inclined to usually not treat them, because I think their success rate is 40% or less, but still if it's 30 or 40%, that's useful. Just be ready to return all of their money if it does not help them.

In recent research using neuromodulators (Xeomin, Dysport, or Botox) for ED, 40% of the people who had no response to PDE5 inhibitors (some of those people had spinal cord injuries and long-standing diabetes) regained erectile function sufficient to enjoy penis-in-vagina sex when they combined only the neuromodulator with continuing the PDE5 inhibitors [20] [21] [22] (no P-Shot was given); this is the idea behind our Priapus Toxin™ procedure and our P-Shot 100™, where do even more and combine the P-Shot® with botulinum toxin and PDE5i's if needed.

So I may have to revise my reluctance to treat the long-standing erectile dysfunction with our P-Shot®. What I hear from the urologists who do penile implants in our group is that ***when they do a P-Shot® procedure in someone with or without shockwave therapy and then the person does not get a response, then the man is more inclined to be pro-surgery since they now feel like they have tried everything.***

How offering more *non*-surgical procedures leads to doing more surgery

They mentioned in this paper that by talking more about non-surgical procedures, more people are having surgery, which is exactly what happened in the facial plastic surgery arena over the past 20 years. As the non-surgical techniques expanded in popularity, like botulinum toxin and HA-Fillers, the numbers

[20] 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."

[21] Giuliano, Joussain, and Denys, "Safety and Efficacy of Intracavernosal Injections of AbobotulinumtoxinA (Dysport®) as Add on Therapy to Phosphosdiesterase Type 5 Inhibitors or Prostaglandin E1 for Erectile Dysfunction—Case Studies."

[22] Habashy and Köhler, "Botox for Erectile Dysfunction."

of plastic surgeries went up because people became more aware of what's possible and more into the culture of the mindset that aging gracefully does not mean neglect.

No one says about their house, "I'm not going to paint it, keep it clean, repair the roof; I'm going to 'let it age gracefully' by doing nothing to maintain it."

When the definition of "aging gracefully" gets redefined as "I'm going to age gracefully by doing everything I can within reason, in a healthy way, to maintain function and beauty," more possibilities come to mind, including surgery.

Said another way, redefining what aging gracefully means (both aesthetically and sexually) happens when people become aware of the non-surgical therapies first and then look more seriously at the surgical therapies.

So the gynecologists in our group who do the O-Shot® tell me they wind up actually treating more women with mid-urethral slings, not less, because more women come to them—the surgeon, who has something non-surgical to offer. And then when that works, they're grateful. When it doesn't work, they're more reassured that they have exhausted all non-surgical possibilities.

Then they choose to go to the surgeon who offered them the non-surgical possibility.

So the plastic surgeon who has a doctor or nurse practitioner in their office doing botulinum toxin and fillers does more facial plastic surgeries, and the urologist who offers the P-Shot® winds up doing more penile implants. That's what I'm hearing. And that's what's suggested in this study about length that we just looked at.

How to Measure a Clitoris (an update on doppler studies)

So then back to this color doppler study, I only bring this one up just out of interest because as we do studies, it's useful for us to know the different modalities for objective measurements, and that's all I'm going to say about that.[23]

Testosterone & Vaginal Function

Many of you have been in my workshops know that I started doing testosterone pellets for women in the year 2000. That is 23 years ago. That's before most people were doing it. I didn't invent it; I was an early adopter after hearing a gynecologist brag about how wonderfully well testosterone pellets were

[23] Maseroli, Vignozzi, and Reisman, "Clitoris Color Doppler Ultrasound."

helping women with menstrual-associated migraines (he had recently published a study, but here's a more recent study[24]). And then, when I started offering testosterone pellets to women in my office, I started seeing clinically all the other wonderful things that would happen—in over 3,000 women patients who came to me for hormone replacement.

Before I dreamed up the O-Shot®, I saw great benefit for women suffering from dyspareunia by using topical testosterone cream in the vagina and introitus. There is a syndrome of dyspareunia that happens in women who take birth control pills, and some postulate that it be because of the assured and always present drop in testosterone levels that happens in women who take birth control pills. And sometimes, that dyspareunia is persistent even if the birth control pills are stopped.

I'm getting deeper into the subject than I intended, but I wanted you to have this paper as a reminder that testosterone is important to vaginal function.[25] There are receptors on the clitoris, the vagina, the urethra, and the labia. Women need testosterone, too, which is the reason for one of my pet peeves: there should be more discussion before prescribing birth control pills. We would NOT drop a developing seventeen-year-old male's testosterone without a long discussion, but we do it every time we prescribe birth control pills to a teenage female.

Does a female transitioning to male increase her chances of breast cancer with the increased testosterone levels?

And this one,[26] I only bring this one up because the idea of testosterone causing breast cancer in women gets batted about sometimes.

I have chosen a handful of diseases to hate with a vengeance. I don't have enough energy to hate all diseases. You just don't have enough bandwidth in your brain. But breast cancer, I've decided to just hate it, and hate it to the point of reading enough about it to be able to think about it.

And it's a roundabout way of making a point, but still, it makes the point when you look at breast cancer in women who convert to men, the high doses of testosterone do not increase the chance of breast cancer.

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[24] Glaser et al., "Testosterone Pellet Implants and Migraine Headaches."

[25] Maseroli and Vignozzi, "Testosterone and Vaginal Function."

[26] Gooren et al., "Breast Cancer Development in Transsexual Subjects Receiving Cross-Sex Hormone Treatment."

When you look at breast cancer in women who convert to men, the high doses of testosterone do not increase the chance of breast cancer.

Similarly, if you look at women bodybuilders who take high doses of testosterone, they get breast atrophy, right? Testosterone and progesterone, they both down-regulate estrogen receptors. So some have argued that testosterone could be protective against breast cancer. That is of course debated and some would debate the conclusion of this paper, but this has been going on for at least 20 years, and this paper just backs up other research supporting the idea that giving testosterone is not carcinogenic to the female breast.

A coming study makes important points about our P-Shot® procedure

I'm not sure what the follow-up on this one is, but it's just some physicians talking about a study they're going to do. This is several years ago, but it makes some points about our procedure, I think, that distinguish us from others that are just proposing PRP for the penis.

As part of our group, you know it, but you may not know what else is out there. The fish in the aquarium is maybe not aware of the air in the room around the aquarium, and so I wanted you to know more specifically what's being talked about with PRP and the penis outside our Priapus Shot® group.

So here's this randomized double-blind controlled study, they don't talk about the results, they're just telling you this is the study they're going to do. They're going to inject either platelet-rich or platelet-poor plasma into the penis. The platelet-poor group, if they don't respond, will also get platelet-rich, and they'll follow erectile function and see what happens.

And they're also going to use Dopplers and look at growth factors in the PRP.

The thing that's different though, about what they do (vs. our P-Shot procedure), is that they're doing the injection every week for six weeks.

But if you look at the wound care studies, or if you just think logically…let's do both:

If you look at the wound care studies, the endpoints are almost always at 12 weeks (after 1 injection) because it takes that long for the growth to happen. Lets think more concretely; if you put fertilizer on your lawn, there's a certain time from which after doing that, before you see growth. So if I fertilize the lawn today, there's no need to fertilize it tomorrow.

So, what would give the more impressive result with a lawn fertilizing study? If you fertilized once a week for three weeks, or if you fertilized it now and then you fertilized it again four weeks from now, and then looked at it eight weeks from now?

It's an obvious rhetorical question because the second scenario of fertilizing once now and then once four weeks from now allows for the growth of the grass; it takes about three or four weeks to get the full growth of one fertilizing.

So, in the wound care studies (we don't have to guess at this), in the wound care studies, where you're trying to regrow skin over a diabetic wound or a surgical wound, or if you look at even the skin cream studies where you're using Retin-A, those endpoints are usually six weeks to 12 weeks!

Because remember, it takes six weeks to grow from the basal layer up, to grow a new layer of skin. Think about that.

So, if you're doing one like Sclafani's study to document with biopsy the effect of PRP on skin, it was a 10-week study.[27]

So, what you're doing if you're doing once a week for six weeks is you're just adding fertilizer on top of fertilizer before allowing the first application to take effect.

So that's a flaw in their design (in my opinion), but whatever, they'll probably still show some benefit.

If you remember, when Ronald Virag did in his Peyronie's study comparing it with Xiaflex, he did it once a week for six weeks.[28] In that case, I think it was more dramatic though that the actual multiples injections, because he was using ultrasound to hydrodissect the scar tissue. So then it wasn't just about the growth factors, he was doing multiple dissections of scar tissue. Remember, hydrodissection alone is therapy (even if done with saline).[29] [30]

This study proposal is just infusing PRP in the corpus cavernosum. So I want to bring that up because when you read studies like this, you might think, well, maybe that's what we should do with the P-Shot®

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[27] Sclafani and McCormick, "Induction of Dermal Collagenesis, Angiogenesis, and Adipogenesis in Human Skin by Injection of Platelet-Rich Fibrin Matrix," April 2012.

[28] 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."

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

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

(inject weekly). And maybe it is, but it doesn't match what we know about cellular growth in that it takes longer than a week to see the effects of migrating pluripotent stem cells in wound care propagated or triggered by a PRP.

Then the other thing they don't do is they don't activate the PRP at all. And we've covered multiple studies in this group showing that PRP un-activated is different than PRP activated, and PRP activated with different materials is different.[31] [32] [33] [34] You get a different spectrum of growth factors when you use a different method of activation. So this (what they propose for their study) is not a P-Shot®, it's something, but it's not a P-Shot®.

And their patient selection! They're choosing not people that no longer respond to PDE5Is; we mostly choose people that have some response to PDE5 inhibitors. There are erections there, but they're having to go up on their Viagra, or it's not working as well as it did, or they're having to begin Viagra, and they didn't use to be on it. That's not the type of person they're choosing to treat here. They're treating people that are no longer responding to the PDE5 inhibitors. And so they could be choosing people with iliac disease, which would not be helped by PRP (which only has a local effect).

So that's my criticism of the paper. It may still show benefits, but that's what I'm seeing about it. Okay. And I think that's all I wanted to say about that. All right, we'll see what they show. But when you see the multiple studies coming out now, because people are all about testing what we're doing. That's some of the ways I think about it; Is this protocol really what we're doing? In this case, it is not.

Platelet volumes correlation with the effects of PRP on the corpus cavernosum

And this was an important paper that was just presented.[35] You can see this just came out July of this year or last year, now 2023, where they did what you'd expect and they just measured the platelet volume and it was directly correlated with the improvement in erectile dysfunction after injecting the

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[31] DeLong, Russell, and Mazzocca, "Platelet-Rich Plasma."

[32] Hamilton et al., "Exercise and the Platelet Activator Calcium Chloride Both Influence the Growth Factor Content of Platelet-Rich Plasma (PRP)."

[33] Magalon et al., "DEPA Classification."

[34] Smith et al., "An Evaluation of the Effect of Activation Methods on the Release of Growth Factors from Platelet-Rich Plasma."

[35] Dr. Davide et al., "(312) PLATELET-RICH PLASMA (PRP) TREATMENT AND PENILE REJUVENATION IN PATIENTS WITH ERECTILE DYSFUNCTION."

corpus cavernosum. They actually gave you a cut-off there. And I think this makes the case for a double spin centrifuge, but it also makes the case that single spin might be adequate if the patient has enough platelets. It also of course goes along with common sense that if you had a thrombocytopenia, maybe it's not the best thing to do.

I love this first part, where they reiterated what I just said. Erectile dysfunction is a common disorder in adult males. "Current therapies are symptomatic and do not influence disease progression." That's assuming they're only including current therapies with what the American College of Urology would list but not what is now becoming common practice with shockwave and our Priapus Shot® procedure.

I think eventually, what will happen in the US is what's now already commonly done across Europe: a cell count goes in the chart when you do a P-Shot® procedure, not just which centrifuge you used or how much blood you collected, but an actual cell count. I think that's where we're headed, and that's a higher standard of care or at least documentation of care.

The possible evolutionary benefit of a longer penis & the preferences of women who experience vaginal orgasm

This is a really fun paper. This one has to do with size. And I like this because they postulate, oh, I'm sorry, that's a letter to the editor about the paper.[36] Here's the real paper.[37] So this one goes all the way back to 2012... And the reason I bring this up is because some of you know I'm working on putting together a very simple, it turned out to be not as simple as I thought, but as simple as I can make it... Delineation of the components of the female orgasm system.

I've been bothered by the fact there's a poster for the cardiovascular system, the nervous system, muscular system, but we don't have one for the orgasm system, which is not the same as the reproductive system. So I'm reading about, well, what are the components and how do they work together? Trying to organize that in some form that would make it easier to discuss with patients and somehow easier for us to think about.

And every now and then I'll just bump into a paper that's just so entertaining and enlightening that I just need to talk about it, and I think you'll find it helpful. And the evolutionary standpoint they mention is that for those women who actually have a penis-in-vagina orgasm, they call it PVI orgasm, penis-in-

[36] Crabill, "Penis Preference Is Not as Simple as It Seems."

[37] Costa, Miller, and Brody, "Women Who Prefer Longer Penises Are More Likely to Have Vaginal Orgasms (but Not Clitoral Orgasms)."

vagina (PVI) sex, penis-vaginal intercourse. There you go—***penile-vaginal intercourse***. I need to start calling it PVI.

So for those women who get an orgasm with PVI, they tend to be women who also are more prone to enjoy a longer penis. And that part was known, but no one had quantified, well, what's a longer penis? In this study, they used the length of a dollar bill, which is 155 or so millimeters. There you go. A dollar bill is 155 millimeters, about 6.1 inches, and a 20-pound note is 149 millimeters.

So they said if that was the survey, and it was mostly to Scottish women, but other countries participated. Their theory is that, evolutionarily, if that was your preference, you might be more prone to get pregnant (with the tip of the penis banging the cervix), and it might evolve into the selection of men with larger penises impregnating the woman or longer penises.

But, then, there's this 5% who want a smaller penis. And I always reassure men by reminding them that ***5% of women don't want a penis at all*** because they're lesbian.

I've met women (I'm sure you have as well) who, either by genetics or post-surgery, have a vagina where a five-inch penis would be painful, and then others where it takes something larger to be noticed.

So, I think the Indians had it right in the Sutras when they talked about genital fit. That's my preference. They use the metaphor of different animals and matching, and I prefer that metaphor. So there are no tight or loose vaginas, there are no small or big penises, there's just a genital fit. And I think to ignore that is probably just ignoring the truth that some people fit; they have a larger vagina that fits a larger penis and vice versa.

But also the idea that some women are having the cervix stimulated by a longer penis and others don't have as much pleasure from the cervical stimulation and prefer more clitoral stimulation—that's one of the ideas of this paper. And somehow, all that together, evolutionary-wise favors evolving a larger penis man.

The reason, of course, I think it's important from thinking about the female orgasm system is just to think about the idea that yes, ***indeed the cervix for some women is part of their sexual response***.

And gynecologists know this from some of the women that'll just say, Yeah, once I had the hysterectomy, there was not as much pleasure. And there are those who would argue with that one and say, yeah, but you have a clitoris, and you have, everything else is there. But no, there it isn't. And for some women that uterine contracture and the stimulation of the penis abutting the cervix brings a different pleasure, they actually talk stimulating different parts of the brain. The part that stimulated by the cervix is not the same as the parts stimulated by the clitoris.

And some women want that and some don't.

Definitely, that's part of the female orgasm system—cervical stimulation. And for those women who find that pleasurable, they're more likely to have a PVI orgasm. And for those women, they're more likely to prefer a penis that's the length of a dollar bill or more.

I thought that was interesting. It's not recent, but it's going to be integrated into our female orgasm system poster; at least, the part about the cervix is also responsive to stimulation.

PDE5Is and blindness

This one,[38] I'm just going to call BS on it, but not for good scientific reason, just my gut feeling.[39] I had an internist mentor back in my residency days. He was lamenting one morning at rounds.

He said, "Charles, at one time, you could believe everything in the *New England Journal,* but now a good portion of it is bull."

So I don't know, maybe this isn't bull, but the point they're making is that, by looking at not just the dose of the PDE5 inhibitors, but looking at the other comorbidities and other medicines, that there's really not a correlation between, or a causal effect of, PDE5 inhibitors and ocular adverse events.

However, they call out the biggest weakness of the study, which is that intake was based on data regarding drug dispensing. So they're just looking at statistics, and because of that, as they point out, they don't have access to the patients' medical records.

So I think trying to tell that guy that took a dose of Cialis and then everything got blue, and then it got black a few moments later (forever), that it wasn't caused by Cialis... To me, this is like the statistician saying that if you have one foot in boiling water and one foot in ice water, you should be comfortable. But still, if you want to make the point that you don't get blind from PDE5 inhibitors, now you have the strong paper that makes that point.

There are other papers that would argue otherwise.[40] [41]

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[38] Belladelli et al., "Use of Phosphodiesterase 5 Inhibitors Is Not Associated with Ocular Adverse Events."

[39] Mostly, I talk about science, but we do get to speculate sometimes as long as I don't try to pass of my speculation for fact.

[40] Ausó, Gómez-Vicente, and Esquiva, "Visual Side Effects Linked to Sildenafil Consumption."

[41] Etminan et al., "Risk of Ocular Adverse Events Associated With Use of Phosphodiesterase 5 Inhibitors in Men in the US."

I think that's all I'll say about that one.

But it's worth knowing because if you're in the sex business, you're prescribing them, and I think I would still tell people it might happen, but it could be that at least some of those cases weren't really the PDE5 inhibitors. It could have been something else that was going on. And that part, I think we could say with confidence.

Does a woman enjoy sex more if she feels like she has a pretty pussy?

This one is the last one I'm going to cover and then we'll go into the marketing piece. And this one is important with our Vampire Wing Lift®. One of my heroes is (I have lots that are in our group) Dr. Michael Goodman. As best I can tell, he's probably the first to document that after you do labiaplasty. When a woman feels like her labia are more attractive, she's more likely to enjoy better sex (FSFI improves). And you would think that would be pretty obvious, but it was argued (heatedly) before he published his paper that somehow doing surgery on the labia, it still argued actually, that doing surgery on the labia is somehow just “mutilation.”

Oh, there he is. There's my man, Michael Goodman. He's one of the co-authors of this paper!

You might argue that it's some sort of mutilation, that we somehow, we are accused both with our O-Shot®, with our wing lift, with labial surgery, of somehow psychologically browbeating women into feeling bad so that then we can comfort them with our money-making procedures. But the truth is, sometimes people just look in the mirror, and they know that things don't look like they did when they were younger; and then they seek help.

And this is a beautiful study. Go, Michael, I'm embarrassed I missed you as second in line on this paper... But I think he probably did the first paper showing this. And what they show is that, as you would expect, if she thinks her vagina/labia is prettier, she's going to have better sex.

But what they call genital self-image is not just about appearance; it also has to do with the smell, the taste of it, and the function of it. And it seems common-sensical, but we have to prove everything to avoid the arrows that are shot our way. And this applies both to surgery and to our Vampire Wing Lift®. If you make the woman feel more attractive, she's going to enjoy better sex.

The other thing that they point out is that, somewhere in here, is that the woman gets a lot of feedback from her lover. Where is it? Big news, right? But it's worth remembering.

Here it is...

> ***"Affirmative reaction from the sexual partner leads to the improvement of genital image and sexual function, creating a positive feedback loop."***

Remember, men are more of an 'every episode of sex has its own history' sort of creature: arousal, plateau, orgasm, refractory period.

But with women more than with men, much more, the arousal part is more easily achieved if the last encounter was a good one, and much more difficult to achieve if the last encounter was a last not-so-good one. So if she had pain or frustration with the last sexual encounter, the next one, it's more difficult for her to become aroused.

And one of the most arousing things that a woman can experience is just ***to be wanted***. That's not me talking as a person, although it is that, too. But that's the research, and that's what they're saying here.

If she's wanted, she wants, but if she feels more attractive, she feels more wanted.

Another of my mottos, which I haven't seen in the Journal of Sexual Medicine or the New England Journal of Medicine, is the following: if it makes your wife want to get naked, you should buy it.

> ***If it makes your wife want to get naked, you should pay for it.***

And so that applies to the toxins, to the fillers, to labiaplasty, and to our Vampire Wing Lift® procedure. If it makes your wife want to take her clothes off, you should pay for it, assuming it's not going to break the bank or make her sick.

And that's what this winds up saying is just that, and it's just so common-sensical, but if a man can feel more attractive with a new tie and a suit, some shiny shoes, and a woman can buy a new dress and feel more attractive, why wouldn't you feel more attractive with a new labia, assuming it's done with a sort of expert.

Dr. Goodman is now on the level where he's mostly just fixing other people's botched surgeries. He's in the wizard category, but yay for this article. And I think with that, I'll stop on the research side.

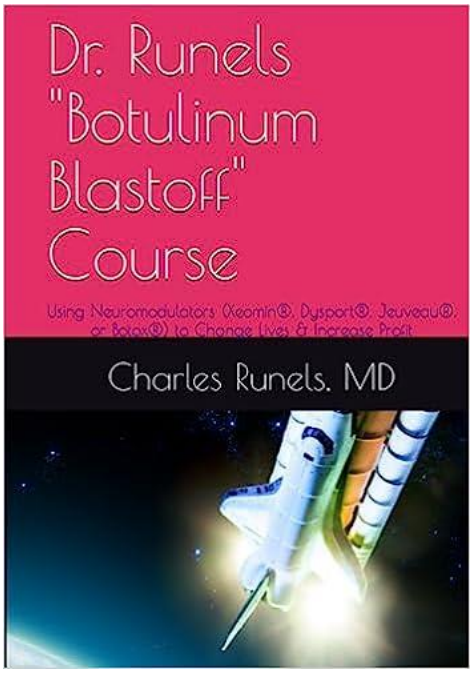
A quick little trick to empower you to take over your website

Let me plow through some of the marketing piece and hopefully I can still finish 10 or 15 minutes before the hour. Okay. I promise you guys something, a quick little thing, that will make you more empowered with your website stuff. And so let me pull that up and show it to you.

I just realized this, actually, helping with someone else's website, and I realized, Oh, wow, now I understand why some people still struggle with their website when it seems so easy to me. Hold on. It's not because I'm smart, which I knew that, but I couldn't figure out what was missing when I was trying, because I've done my workshop on marketing and these procedures almost every month for 13 years. I've only missed a few months. In the beginning, I was just teaching the Vampire Facelift® and Botox and

fillers, and then as we invented and thought of more stuff, we kept adding more things to it. And now it's facelift, facial, O-Shot®, P-Shot®, hair, scars, breast lift, wing lift, and a bunch of marketing. And we do that once a month...

But as part of the class, I always talk about making your own web pages. You need to be empowered to make a webpage anytime you want to and be able to do it in the same length of time it takes you to drink a cup of coffee. You need to be able to take care of your websites. Now, I don't mean building the whole platform and doing everything there is to do with a website, but adding a webpage to a website can and should be as easy as writing a Word document.



If you have to talk to somebody and wait and pay money to add a page or edit a page, you're making life much more difficult than it needs to be. Once the Wordpress platform is there, it shouldn't be that big a deal.

(The following is best followed by watching the video.)

I'm going to call it a 'test webpage'.

I'm going to put a video. All I have to do is go to my Vimeo or anybody's account. I just have to get the embed code to anybody's video. So I could grab this embed code. Then I click on the text. Now you're getting bored already, but my point is, look at how quick that was, and now I can look at the video on the page.

If you can type into a Word document you can make a web page with a video.

I know people want sliders and all sorts of things, but look at the format on NEJM.org, it's just black letters on a white background with some red titles, a few pictures, nothing sliding, flopping around, or trying to give you a blow job, but lots of info.

And people say to me, “Your websites are too busy.”

And I answer, “Yeah, they got lots of info, but they're smart people looking at them, they need lots of info.”

You guys are so freaking smart and your patients are so smart. If you don't give them a lot to look at, they get bored in about three seconds and bounce, which is exactly what happens when I look at my tools, where I can see how fast people are bouncing, how many pages are looking.

Last time I looked, the average stay on BotoxCosmetic.com was about 15 – 45 seconds. And the average page looked at was one and a half pages. Looks beautiful, millions spent, and they're keeping people there less than a minute.

On the other hand, you've got something like this (NEJM.org), and you've got smart doctors; there's something there to grab hold of and keep you going, and your patients are the same way.

So I know this isn't as slick, but that was done. And if I decided I wanted to get this video transcribed and put all of the words here, I could do it that fast.

Now, here's the tip I was going to show you. Most of you, if you've ever been around me for more than two or three days with our webinar or two or three of these journal clubs, you see me talk about that.

But here's what I was missing. I didn't realize if you have a WordPress website, what happens is, there's lots of different themes that can change the way it looks. Okay, I'm going to delete this thing so it doesn't stay looking stupid on here... But what I didn't realize is that I had done something to all my websites that I failed to tell people about.

Oh, by the way, whatever format you have, if you just tell your person, I want a WordPress extension added to my website, then no matter what else they've done, they can add a WordPress part that you can add to. ***Here's the part. Classic Editor, the Classic Editor plugin***, let me go to it now... Whatever, I'm fiddling now. But the bottom line is if you go to where you download plugins, think of plugins for WordPress website, they're like apps on your iPhone.

And the reason the iPhone went so crazy is, Steve Jobs was smart enough, and the iPod, to realize if he made that the hub for everybody else's music and all the programmers who wanted to write software, people would buy it because they wanted the other stuff that goes on it.

Part of what makes WordPress so powerful and amazing is there are many thousands of plugins, just like the apps on your iPhone, that allow you to do things without needing to be able to code. In the beginning, I used FrontPage 98, back in 1998, and then it was a Dreamweaver and it drove me mad. It was hard for me to do stuff. And then WordPress came out and I just started downloading all these apps that make it so I can run my 31 websites with hardly any help. So that's me doing stuff I don't think most doctors would want to do, but it's telling you what to ask for after spending millions on my marketing and the past 24 years now of building websites that... Excuse me, 25 years of building websites.

If you get a WordPress website, if not the whole thing, at least an extension, the thing I had failed to tell you guys is that ***you need to ask for the Classic Editor plugin***, and that's what gives you the option to do this.

Remember, if I wanted to make a new page, I could click new page and now I can just type it in as if I'm doing a Word document, give it a title, put videos the way I just showed you, click publish and I have a new page. If I don't like it, I can change it, delete it, edit it, add to it. So that was the tip was going to give you.

Tell me how to advertise the Vampire Facial

The disadvantage to our procedures are a few when it comes to marketing:

One is that for most people, it's a long explanation... Most people don't know what PRP is. To this day, even though it's more common, most of your colleagues that are not in our group would have trouble giving a good explanation—much better than 10 years ago, but most of your colleagues would have trouble giving a good explanation for what PRP is.

What is it?

And even in the research, when you dive in, there's debate and much research about what it even is. So how can you expect your patients to know? We just got through looking at a paper where we talked about the platelet volume, having to do with whether it's going to work or not when you do a P-Shot®.

So the thing is, you're dealing with long, hard-to-explain procedures that take a long time to explain. That's a big problem.

And the second thing is, they're not paid for by insurance most of the time.

And the third thing is that they often have to do with sex, which will get you banned from most of the click-ad arenas.

And then thanks to, I think probably because of the big lawsuit that happened when someone not in our group got somebody sick out of New Mexico, Google it, Google my name, Charles Reynolds + Vampire Facial® + Rolling Stone and + HIV, and you'll see me talking to the Rolling Stone about what happened when somebody not in our group used a non-FDA approved kits/microneedling pen and transmitted HIV from one patient to the other. You've got to be using FDA approved micro-needling devices. And because of that, right after that happened, Google banned click-ads for PRP.

So you got sex, PRP, which gets your ads shut down, you've got hard and long explanations. So how do you market?

Here's my recipe that works.

My click add budget is 0. It's been 0 or practically 0 for a decade.

I've tried to get other things going and I just get banned and I get shut down. And so I just go back to what's worked for me. And it's all, if you go to the marketing page (on the membership websites), it's all here. I'm just going to run through it real quick.

First of all, send out an email at least once a week. Watch my video (on the membership sites) about how to write them. They're simple, they're quick. They shouldn't take you longer than about 10 minutes to write. You can get them. I'm sending you emails. If you go to our websites and subscribe as if you're a patient, you'll get emails.

Most of the journal clubs, I give you an email that you can copy and paste and send out. So watch this about how to write emails and send them out every week or so and make them educational.

Remember what David Ogilvy said, "Teach the person about their disease and they'll trust you to treat the disease."

I think most providers, not everybody, some of you guys truly are, really are, on TV or movies and stuff and have millions of followers, but most of us aren't. And I think for that reason, most of us should stick to what David Ogilvy said, which is to focus on teaching the person about the disease, and they'll trust you to treat the disease.

So watch my video, which is 15 minutes long, 14 minutes and 30 seconds, about writing emails, and start practicing sending one out every week or so. If nothing else, subscribe to my emails and then rework them, edit them, and send them out. And focus on teaching your people about their problems and they'll trust you to treat them.

This is a good eBook about writing emails you can download (on the marketing page on the membership sites).

Telephone script: You must teach your people what to say because if you're sending out emails and then people call in and your people say the wrong things, I promise you they will talk them out of it. You should watch and have everybody who talks to patients, either on the phone or in person in your office, watch, make notes, and learn to follow this algorithm. You hear me explain in this video how to talk to people so you don't over-promise. It tells you how to find people who need you, how to know quickly if this person needs what you have and how to best engage them so that you're paid and they get treated and you don't run them off.

This works.

So that's the second part. ***You should always have a money back guarantee*** and I'll tell you why: If you don't have a money back guarantee, you're going to over promise. Or also what will happen is you'll be afraid to treat people you might could have helped. Where if you decide in your own brain that

you're going to give people back their money if they don't love what you do, then you're more likely to actually take care of them because you're not afraid of stealing because you know won't keep the money.

So I talk about that right there. So watch that (on the membership websites). This gives you an overall plan and this gives you an overall plan. But the basic idea is that you have a web page with a video on it that talks about the procedure so you don't have to spend time doing it.

Then you send out educational and motivational emails once a week or so, telling your people what you're up to, letting them see what you're reading, letting them know, ***not sales literature,*** if you send them 10% off for happy Valentine's Day, save 20%, and you're not educating and motivating them about how to make their pain go away, how to be healthy, beautiful, and have better sex... If you're not teaching them that, you're going to go into the spam filter. And then you get the email of everybody that comes to see you and you do this whole plan and that works.

That's what's happening with the people that have changed the lives of hundreds of their patients and added an extra zero or two to their bank account. And I think with that, I'll call it a day. I hope that was helpful.

Have a great day. Bye-Bye.

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Tag Words

journal club, patient care, marketing strategies, vampire facial®, website development, hormone replacement, p-shot®, o-shot®, erectile dysfunction, penile implant, sexual health, testosterone therapy, urology, gynecology, prp treatments, medical research, surgical procedures, genital self-image, labiaplasty, patient education, medical marketing, prp procedures, sexual function, web page creation, wordpress

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