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The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of December 19, 2023, with Charles Runels, MD.

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

Topics Covered

- Kegels work better combined with our O-Shot® Procedure.
- *Ideas about How the O-Shot® Was Conceived and How It Might Be Modified*
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- **PRP Science (Why Our Procedures Work When They Work)**
- Sales-Rep Propaganda and Traps That Make Them Money and Lose You Patients
- How to Team Up with a Pelvic Floor Physical Therapist

Figure 1. Charles Runels, MD

Kegels +/- the O-Shot® Procedure for Stress Urinary Incontinence

Welcome to our journal club, with pearls and marketing (JCPM).

In this beautiful study, they formed two groups of women, 30 per group.[1] They disqualified them if they tested strongly for *urge* incontinence. One group only received Kegel training—pelvic floor muscle training (PFMT). The other group received PFMT *and* a close approximation of our O-Shot® procedure. The PRP group also received a second treatment at four weeks.

They measured outcomes regarding improvement of stress urinary incontinence (SUI) with both (a) 1-hour pad weight test (PWT) and (b) surveys, therefore providing objective and subjective data.

The technique they describe is very close to what we do. The following are similarities and differences:

1. We talk about being within one centimeter of the hymenal remnant. They describe a midline injection at 1 cm from the hymenal remnant.
2. We do one midline injection on the anterior vaginal wall; they did three injections—adding two injections on either side of the midline.
3. We also do an injection into the body of the clitoris. They did not inject the clitoris
4. They use one of the kits approved by the FDA for making PRP, the Regen Kit. We also recommend Regen kits as one of the approved kits on our membership site.
5. They used a 27-gauge needle; we use the same.
6. They did not activate the PRP; we do.

So, they got the basics right but changed some very important variables. For example, PRP inactivated is not the same as PRP activated.[2] [3]

(00:55):

Ideas about How the O-Shot® Was Conceived and How It Might be Modified.

I think they complicated the procedure, whatever. Still, they showed a great result. I don't think you need to have three injection points. Here's why I think that: If you wanted to fill a sponge that is 3 cm wide, but all the benefit of the filling would occur in the center of the sponge, would you inject all of your material in the center, or would you inject some in the center and some on each lateral edge?

A Formula Worth Remembering

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[1] Saraluck et al., "Autologous Platelet Rich Plasma (A-PRP) Combined with Pelvic Floor Muscle Training for the Treatment of Female Stress Urinary Incontinence (SUI)."

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

[3] Smith, Travers, and Morrissey, "How It All Starts."

Another idea that helps evaluate the infinite number of ways that PRP could be injected in and around the introitus (variations of our O-Shot® procedures) is to think about the physical dimensions of the area being treated. Also, it helps to remember that 1 ml is equal to 1 cc which is 1 cubic centimeter.

So, for example, if the space between the urethra and the anterior vaginal wall is ¼ inch (less than this for most women post-menopausal in the distal urethra), and the urethra is 4 inches long, and you assume that the lateral extension of the area under the urethra is 0.5 centimeters, then that space is approximately 1.2 cubic centimeters (cc or ml) and we are injecting 4 cubic centimeters (cc) of PRP in the midline when we do our O-Shot® procedure.

> ***If you assume that the space between the urethra and the anterior vaginal wall is ¼ inch (less than this for most women post-menopausal when measuring at the level of the distal urethra); and the urethra is 4 inches long, and you assume that the lateral extension of the area beneath the urethra is 0.5 centimeters, then that space between the urethra and the vaginal wall is approximately 1.2 cubic centimeters (cc or ml); and we are injecting four cubic centimeters (cc or ml) of PRP in the midline when we do our O-Shot® procedure.***

As the research progresses, variations in injection techniques will be evaluated, and we will know more.

They used one of the kits I've used for over a decade. They used the Regen Kit. So, it was a single spin kit.

So if you look at the results, there's the graph. Love the picture (see the video or the paper [4]). The blue line is pelvic floor muscle therapy (Kegels) alone—almost no change at all. Then the red line is the one-hour pad weight test after something close to our O-Shot® procedure times two—very impressive improvement.

This was a beautiful and much-needed study that supports our procedure.. Still, in my opinion, what they did was half of an O-Shot® because they put three CCs divided on either side of the urethra and only two cc beneath the urethra. But it still worked well, and we just calculated that if you put your needle in the correct place, the potential space (counting the layer of muscle in the wall of the urethra) is only about two cc/ml.So they took the CC out that would've been put in the clitoris using our procedure and put a total of 5 in the anterior vaginal wall and spread it over 3 injection points (some of which were less effective in my opinion).

[4] Saraluck et al., "Autologous Platelet Rich Plasma (A-PRP) Combined with Pelvic Floor Muscle Training for the Treatment of Female Stress Urinary Incontinence (SUI)."

When using a Regen Kit, as you may know, you draw about 10 milliliters of whole blood and then you're going to get about five CCs of PRP, give or take, based on the person's hematocrit.

So (when doing our O-Shot® procedure) we normally put one ml in the clitoris, four in the anterior vaginal wall. In this study, they put two midline where the urethra would be and then divided the other three up on each side, which to me was probably not much more effective than squirting it on the wall (the lateral injections).

So you could argue, I am arguing, that they really did half of the volume that we normally use. By putting four CCs in the midline, they still would've had a dissection laterally, but the bulk of it would've been where it needs to be, right there around the periurethral area—creating a "liquid sling" that converts into healthier tissue with time.

(02:33):

Also, there's not a lot of space between the urethra and the vaginal wall, it would be difficult to put needle there without somehow affecting the muscle layers of the urinary sphincter and/or the muscle of the vagina and the associated neurovascular configuration there. So if that's what we're doing, then going lateral to the midline on either side, I think you're less likely to be affecting those muscles of the urinary sphincter.

Still, even with those changes, it worked!

More Lucky Than Smart

When I first came up with the idea for the O-Shot® procedure 13 years ago [5] [6], I was imagining mostly the space between the muscle layers (between the urethra and the vagina) and that somehow PRP might enhance sexual function by enhancing the function of the Skene's glands and the vasculature and the nerve function in the area—not knowing that Delancey and others had done studies showing that distal to the bladder, very proximal to the urethral meatus, there's an abutting of the muscles of the urinary sphincter and that of the vaginal wall; the muscle layers

[5] Charles Runels, MD, *Activate the Female Orgasm System: The Story of O-Shot®.*

[6] "Trademark Status & Document Retrieval."

are juxtaposed.[7] Therefore, distal to the bladder, it would be difficult to inject PRP between the urethra and the vagina without involving musculature of the urinary sphincter.[8] [9] [10]

So***, I was more lucky than smart (13 years ago) when my second patient to receive the O-Shot® procedure (which I gave her to treat dyspareunia) told me that not only did her dyspareunia resolve but she also had started running again shortly after the procedure because she no longer urinated on her leg when she exercised.***

A month later, when she told me that, as I had hoped, her dyspareunia was completely gone; she also added that she had started jogging again because her urinary incontinence had resolved.

I thought, "Oh, wish I would've thought of that—that makes perfect sense!"

The best I can tell is that she is probably the first woman successfully treated for urinary incontinence with platelet-rich plasma.

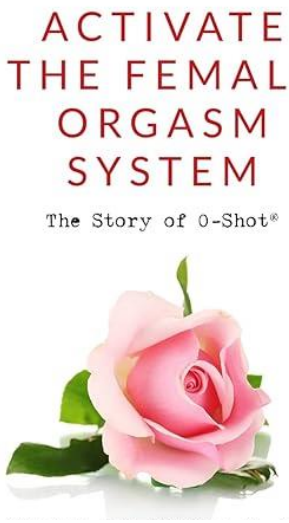

Figure 2. The book that documents the discovery of the use of PRP to help women with sexual function and other problems.

IMPORTANT: The first one to notice it was not me. It was my patient teaching me what I had accomplished. When you are looking for a better way, you will not find the answers in the textbooks: first, you know everything you can in the textbooks; then you read all the research you can absorb; then the next thing that occurs to you may be of value; then, you listen to your patients, and they will teach you the next chapter to put in the books.

I've always said I'm more lucky than smart, but I'm so grateful for this new research because it backs up what we've seen and other research we have done, even though they varied the procedure.

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[7] I had already written a course on how to facilitate a the female ejaculation and the O-Shot® became and expansion of that work.

[8] DeLancey, "Correlative Study of Paraurethral Anatomy."

[9] DeLancey, "Structural Support of the Urethra as It Relates to Stress Urinary Incontinence."

[10] Pipitone, Sadeghi, and DeLancey, "Urethral Function and Failure."

Here we should address a possible elephant in your room: these investigators are in Thailand. If you live in the USA, you maybe should think some about something that William Osler said in an address to physicians in Canada in 1902.

William Osler and Chauvinism

William Osler's spoke to a group of physicians in Canada in 1902; a transcript of his lecture, *Chauvinism in Medicine*, could be helpful to those practicing in the US (our CMA group members are spread over 56 countries).

In his essay, Dr. Osler[11] says, "When a teacher tells you that he fails to find inspiration in the work of his foreign colleagues, in the words of the Arabian proverb—he is fool, shun him!"

As you know, he is the father internal medicine at Johns Hopkins, and he was lecturing to physicians about their prideful stance that somehow in spite of Pasteur and all the best physicians up until not so long ago coming from France, and England, and Germany, and China and not the US and Canada, that we developed a certain destructive pride.

> ***"When a teacher tells you that he fails to find inspiration in the work of his foreign colleagues, in the words of the Arabian proverb—he is fool, shun him!"***
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> ***--Chauvinism in Medicine,*** William Osler

So, this paper about the O-Shot® methods and variations comes from Thailand. Good for them. My humble opinion is that the forces of our organizations (AMA, etc.) browbeat most of us into being afraid to run with research that can sometimes be obvious for fear of actually losing our license and our livelihood, wasting decades of study and work.

Understandable.

Still, when good data that is congruent with previous studies and known principles of cell biology supports a change in methodologies, to offhandedly "fail to find inspiration" in the research because the data came from a place that would require a long plane ride for you to visit—that, in the words of Osler, is intellectual "chauvinism" and could be foolish.

[11] William Osler of course was thought to be one of the leading physicians of his day. He was physician to Walt Whitman. Walt Whitman writes about Dr. Osler and praises him; but Whitman thought Richard Maurice Bucke, MD was the better physician. Bucke also wrote a metaphysics text that many have found inspiring: Richard Maurice Bucke, MD, *Cosmic Consciousness: A Study in the Evolution of the Human Mind*.

Osler would say, actually, he did say that you should avoid doctors who think that way.

Not only did he say it was not a healthy way to think, he said, "If your colleague thinks that way, you should avoid him."

This study does not imply that you don't think about physical therapy/Kegels.

I guess it was six weeks ago when we discussed a study in which they tested women; remember, they graded how hard they were able to contract the levator ani by putting a finger within the vagina and having the woman voluntarily contract. Those who needed the results of the Kegel exercises most were either unable to contract enough to feel movement or had just a slight movement.[12]

(06:53):

Those who didn't need it, who didn't have much in the way of incontinence or sexual dysfunction, could do a nice contraction.

I talked about my grandmother saying, "If you could put salt on the tail of a bird, you can catch it."

Similar to saying, of course, if you can get close enough to put salt on the tail, you don't need the salt, right? So similarly, it seems those who would benefit most from Kegels are not able to do a Kegel and not directly the subject of this paper, but indirectly might illuminate why those who did the Kegel training alone without our O-Shot® didn't do so well.

I'm making you dizzy now, I suppose, relating "salt on a bird's tail" to recommending Kegel exercises, but those who did Kegels alone without our O-Shot® had almost no change. Now, these Kegels (comparing Kegels alone) were not using one of the magnetic devices, the Tesla magnets like an Emsella device, or whatever device you have where you could force the Kegel exercises.[13] [14] Still, one may postulate (because of this study[15]) that even if you are forcing Kegels on those who cannot do them voluntarily, you may see a better result if you combine them with our O-Shot® procedure.

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[12] Omodei et al., "Association Between Pelvic Floor Muscle Strength and Sexual Function in Postmenopausal Women."

[13] Gözlersüzer, Yalvaç, and Çakıroğlu, "Investigation of the Effectiveness of Magnetic Field Therapy in Women with Urinary Incontinence."

[14] He et al., "An Effective Meta-Analysis of Magnetic Stimulation Therapy for Urinary Incontinence."

[15] Saraluck et al., "Autologous Platelet Rich Plasma (A-PRP) Combined with Pelvic Floor Muscle Training for the Treatment of Female Stress Urinary Incontinence (SUI)."

Also, and importantly, one could conclude from all of the above that ***Kegels alone is greatly inferior to Kegels combined with an O-Shot® and probably greatly inferior to an O-Shot® alone.***

We know studies show benefits by forcing many more contractions and much-increased strength in contractions with a magnet.[16] But the ideal would be if you were making up the perfect treatment, part of it might be the combination of our O-Shot® with the Tesla magnet (Emsella, or something simiarl, or a pelvic floor physical therapist).

Of course, this flies in the face of studies that show Kegels do help. Bottom line is I think that if someone has enough incontinence to suffer significant incontinence, you owe them to at least do what this and many other studies are showing that our O-Shot® helps.

Some Tips from David Ogilvy for Finding People Who Need You (Marketing)

I think if you want a nice little thing to send out to your people, you could put a link to this study in an email and say, "Here's some new research", because this did just come out, September of this year, was received, accepted this month.

So that's news.

Remember one of your principles of advertising medical devices, procedures, drugs, straight from David Ogilvy.[17] The guru about whom the Mad Men series was modeled, the champion, end all, greatest of all time, GOAT of marketing was David Ogilvy, and one of his rules is that you should include news.[18]

A few of the other rules are as follows:

- maintain a sensitivity to the pain,
- maintain the doctor-patient relationship, which is why one of the reasons I prefer a less tongue-in-cheek marketing. I think if I were more entertaining, more of a comedian, more of sparkly in front of the camera, I might change my view about that.
- Teach the person about their disease and they will trust you to treat their disease. Most doctors are great teachers and teaching from the perspective as if you were speaking to one of your patients—that is great marketing.

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[16] Omodei et al., "Association Between Pelvic Floor Muscle Strength and Sexual Function in Postmenopausal Women."

[17] Omodei et al., "Association Between Pelvic Floor Muscle Strength and Sexual Function in Postmenopausal Women."

[18] Ogilvy, *Ogilvy on Advertising*.

Here's an email you could send.

Copy and paste the following into a new Word document. Then edit it so that it sounds like you. Add a story or a personal observation if you have time, then fill in the information with your phone number, etc and send it to your patients:

Your email could go something like this:

Hey, hello, (merge mail first name).

A new study just came out showing that our O-Shot® can have tremendous benefit, possibly much more benefit than the Kegels you were trained to do. Certainly, we have some good research now showing that if you're leaking, you should at least consider adding our O-Shot® to your Kegel exercises and then you put a link. It's that simple.

Then you put a link to this paper, which I'm about to give you and you end with "If you think this might help you or someone you love, give us a call."

So if you rephrase that in your words and send that email out today, you won't get 200 calls, but I will be shocked if you don't get at least some appointments.

Those in our group who depend on our directory alone to find patients will see a few people. But those who routinely send out emails like what I just described, routinely as in once every week or so, often make tremendously increased incomes and have hundreds of fans whose lives were changed tremendously for the better because they found them through simple little communications like that.

I have one more paper that won't take even that long to cover and then a quick little tip or two about kits, and then we'll call it a day. I know it's the holidays, and I'm honored that anybody even showed up today.

The Purpose of the Journal Club with Pearls and Marketing

My goal is that when you come to these webinars, you go away better able to take care of your people or at least more reassured that what you're doing is worthwhile and helpful, stronger science and with some ideas about how those who need you most might be able to find you.

If I do that, then that seems like a good day's work.

Okay, putting this in the chat box. Okay. If you click on that, you'll be able to open that paper and then let me show you this one, and then we'll get to the tips about particularly the Selphyl kit, but other ideas in general when you're swapping PRP kits, how you might alter our procedures.

PRP Science (Why Our Procedures Work When They Work)

Even though this study was done mostly to give some stats on this particular PRP kit, which I have not used. It may be wonderful, I don't know. Their numbers are great, but the main reason for showing it to you is that in the process... It's a good review, which we haven't done in a while. ... of what it is you're making when you isolate PRP.[19]

I sometimes get lackadaisical when I think about the platelets, where I describe it to my patients as being containers of growth factors and cytokines that recruit pluripotent stem cells to the area either from the bone marrow, the liver, or the local tissue to regrow new and healthier tissue and remodel scarring with neovascularization, neurogenesis, and collagenases.

That's how I think about it, but that's a very superficial, almost buzzword way to talk about it.

(13:09):

Because when you start breaking it down to what's there and then when you add to what's there that we know the proportions and even the components of what is produced with platelet-rich plasma varies with activation, whether it's done or not, how it's activated, and of course, it's going to vary with the system that prepares it. Whether you have white cells, red cells, the proportion of those, the science is one of those so beautiful that the deeper you get, the more complicated you get until you want to...

I often wind up saying, "Well, it's all there. Nobody needs a centrifuge when I scraped my knee on a bicycle when I was 10. The platelets just knew what to do."

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

I think sometimes we can overthink it, and studies are trying to isolate one or two of the factors that are in the platelets as an example of overthinking it.

Let's say that you're able to make VEG. You can make the vascular endothelial growth factor. That'd be a great drug. That'd be wonderful if you could do that, but have you improved upon the platelets, which can make all of this plus things I'm sure we don't even know about?

I'm not saying we don't think about it, but I'm saying that as you go through this basic science when it gets to be complicated, I think it's reassuring to know that as a clinician, we don't even have to understand a lot about what's happening any more than I have to understand what's going on within the integrated circuits of this computer that I'm using to be able to use it.

(14:45):

But having said all that, I think it's worth remembering all the things we're making because this really isn't magic. These are not magic shots. We didn't invent anything when we're using platelet-rich plasma. We're just recognizing that whether it's embryology and what goes on with growing a baby or if it's healing a wound post-op or after trauma or if it's propagating regenerative processes with PRP, it all has to do with cell biology and the big mystery has always been turning back the clock.

If you think about it, our tissue is aging, but there's something in the gamete. So that when you have a sperm fertilizing an egg, it goes all the way back to zero even though the sperm and the egg is the same age of the woman.

So you have an increasing risk of Down syndrome with a woman over 40 years old because the egg is 40 years old—the same thing with the cells of the male making the sperm. Sperm might be young, but they're being made with older tissue.

But then, when that 40-year-old egg joins together with a sperm coming from a 40-year-old man, the new cytoplasm grows as a new creature, and that's the part we don't know. We don't understand it. We're describing it. We're naming things that happen. We're drawing pictures of it as we see it under the electron microscope. I'm not trying to get metaphysical on you here. I'm just saying that even this degree of description you're looking at in this paper is still description.

It's not really understanding.

I think that's reassuring, at least to me, to know that I don't have to know what it's all doing. It's fun, it's encouraging, but it isn't necessary as long as I know that I have a process that's been shown to work. But it also emphasizes that we are not just doing a shot, and I wanted you to see this paper to remind yourself that there is a lot of nuance and intellectual property.

PRP Sales-Rep Propaganda

In my opinion, if you want to be doing the best medicine, you should be using a kit that's FDA approved for use for preparing plasma to go back into the body, because it's not just where we put the needle. It's not even the number of RPMs and the circumference of the centrifuge. It's not even with the gel kit, the constitution of the gel, the diameter and size and volume of the tube.

It's all of it combined. That formula for that particular kit is what has been shown and measured for them to get FDA approval to be creating something that's of the right concentration and the right sterility and sterility and the proper methods to not cause serum sickness or infection. That's all baked into your kit from this lab testing. Even if you buy a RegenKit or a Selphyl kit and you throw it in your lab centrifuge or you're changing the circumference of the carousel, you're changing the G-forces and you're changing what you're going to have at the end of the time. Then if you just wing where you put in the needle or you decide to do it a different way than what we're doing it, you're doing something but you're not doing an O-Shot®.

You may be doing something better, but you're not doing an O-Shot®.

So when someone calls me and says, "My last three patients didn't do so well," I'll get to ask them, and it's often because of one of the things the rep has said. So I'm going to cover a couple of those things, and this how we'll end today. Let me give you the link to this because one of them has to do with... Here we go. Hold on a second, put this in the chat box. All right. Maybe that's a good kit. I don't know. I haven't heard from them and I don't know anybody that's using it. So if some of you are, let me know. My hope, as you guys know, some of you, I could be selling a PRP kit.

I don't because I like to stay Switzerland and the kit that's offering the best product at the best price, the one we should use as long as it's FDA approved, best product at the best price. We're allowed to swap kits around and the rep that's supporting you, we have our favorite reps that take good care of our people. Jeff Petrillo has been good to us and many others in the region company. Others have deserted us and not been so good to us and taking us for advantage, like the guy running around on his wife, because he just forgot how pretty she is and how kind she's been to him. We have companies that have treated us that way. So you have the individual reps, you have the companies, and you have the science. It all fits together.

The rep, the company in your town may be different than the one in Thailand. The most ubiquitous good service I've seen has been without a doubt, the Regen company. They're just worldwide, and everywhere I go, they're taking good care of their people. They seem to be chunking down the most money for research, but there are many others and shop your best. Just make sure it's FDA approved. Okay. So a couple of nuances and things that the rep may tell you to throw you off track. One of them came from a Selphyl rep. I was told a question from one of our people and what the rep said was that this person did not have to use our recommended volume doing a P-Shot®.

What prompted it is if you look at the volume of the Selphyl kit, the Selphyl kit is I think tremendous. It does one thing better than any other kit I know of. I don't know exactly what it means, but I think it's something good. The Selphyl kit is the only one that comes with calcium chloride. It's the only one, excuse me. So the Selphyl kit is the only one that comes with calcium chloride. The others, as far as I know, all of the others, you have to buy calcium chloride, calcium gluconate, or thrombin, something else to go with it except Regen has a kit that comes with thrombin and another that comes with an HA, non-cross-linked HA to act and that will activate it.

So they actually have two different kits that come with an activator, but Selphyl is the only one that comes with calcium chloride as an activator. For some reason, that Selphyl kit gels faster and I've lost track of the number of kits that I've used. When you add calcium chloride to that Selphyl kit, it turns into platelet-rich fibrin matrix faster than any other kit I have ever used, reliably so, consistently so with every patient. If you go longer than three minutes without getting it out of your syringe after you've activated it, you probably will not be able to push it through the needle. I think that's a good thing. It means to me that whatever their process is, and it isn't just the calcium chloride because you can do this, it's just math.

You can do the calculations, the percentage of calcium chloride and the volume of the PRP. I have and that's how we're come up with that number that I give you to calculate how much calcium chloride to add. It's volume of PRP divided by 20 is how much 10% calcium chloride to add to your PRP to activate it. All that's covered in the membership website. If you're not activating the O-Shot® and the P-Shot® with something either calcium chloride or thrombin or an HA, you're not doing the O-Shot® or the P-Shot®. You're doing something else, maybe better, but you're not doing what we do. Oftentimes when I get word that someone's O-Shot® isn't working, I find out the rep has told them that they do not need to activate the platelet-rich plasma.

It will be a rep that's selling something other than Selphyl and they know their kit doesn't use calcium chloride. As an example, I won't say which kit, but years ago, one of the reps showed up and was pushing me or pushing for me to recommend their kit to our group and it did not come with calcium chloride. They said, "You don't need it to do it." I said, "Well, all the research I've read shows that you may not need it, but you definitely get something different when you activate it." It appears to me that it's a more complete activation and probably a more effective treatment without activation.

You could make the case that because it's incompletely activated, you basically turned it back into non-centrifuged PRP, because let's say you concentrate it to twice the concentration, but then you only activate half the platelet-rich plasma or the platelets and you effectively could have just injected the whole blood. So without adequate activation, you're undoing the effectiveness of your centrifuge. So I said that to him in a briefer, less considerate way, and he said, "Oh, well, you're right, but I couldn't talk about it until you brought it up because it's off-label." I've got some in the car. So you walked outside and came back in with a bottle of calcium chloride, because as you know, the rep is breaking a rule if they bring up something off-label.

But if you bring it up, then it opens up the ability for them to talk about it by the FDA rules. Back to the Selphyl kit, it comes with calcium chloride to me is a huge advantage. The fact that it activates quickly but no quicker for almost everybody than three minutes, so you have time to get the procedure done. To me, I've loved the Selphyl kit. The problem with it, of course, is that for some reason, they chose to make the tubes eight milliliters, instead of 10. Almost every other kit, double spin and single spin centrifuges, their protocols are usually making PRP a multiples of five. So you'll make 5 CCs, 10, or 20. That's why our procedures are recommending amounts in multiples of five.

The first time I picked up a PRP kit, it was a Selphyl kit and their kits back in 2009, 2010 were $375 to spin eight CCs of blood to get four milliliters of PRP. So PRP cost you $100 per CC, roughly $100 per milliliter. I think our group is partly responsible for them coming off of that price because they tried to hold that price point using their uniqueness and having calcium chloride as part of their FDA approved kit. They tried to hold that price point for a number of years and Regen came to town. We swapped over to Regen, which was a much lower price point and eventually Selphyl had to follow. So our person was using a Selphyl kit, talked to the rep, and said, "Hey, my P-Shot® protocol calls for a total of 10 milliliters in the penis."

The man or woman, don't know which one, reportedly, it wasn't on the phone but reported by our member, told the person, "No problem. You don't need that much volume anyway." In other words, cut it from a total of 10 milliliters made with a single spin centrifuge to 8 milliliters total, instead of spinning two 10s to make two aliquots of five, spin two eights to make two aliquots of four. Well, that could be true. We don't really know what the adequate dose of it is, but what we do know is we have 10 years of success with an adequate dose of the platelets they're in most people's blood for. I realize these are not absolute numbers, but there's a range of platelets that most healthy people have.

Our procedures have been done with at least 10 milliliters of blood being spun, coming close to doubling the concentration of that whole blood, 20 milliliters, two 10s, doubling the concentration of that and down 10 milliliters and then injecting that in the corpus cavernosum and the corpus spongiosum, the way it's explained on our website. We had great result. Then you have two double-blind placebo-controlled studies that show that it works along with other studies, and then someone did a double-blind placebo-controlled study and cut the dose in half, cut the volume in half. They used to double spin.

So you could say, "Well, maybe they got the same number of platelets", but when you're trying to infiltrate the tissue of the average-sized penis, it's why I upped it to 10. Remember? I found that that's not enough volume to completely fill the sponge. The corpus cavernosum, as you know, is not just on the outside. A big portion of it is subdermal just like the clitoris. The first time I did the P-Shot®, it was my own penis. I was fearful of what might happen, and I spun a Selphyl kit. I got four CCs and I put two on each side of the penis about a third of the way up. You can see the volume, it plainly did not hydrodissect into the distal penis. So a couple of days later, I could see the difference.

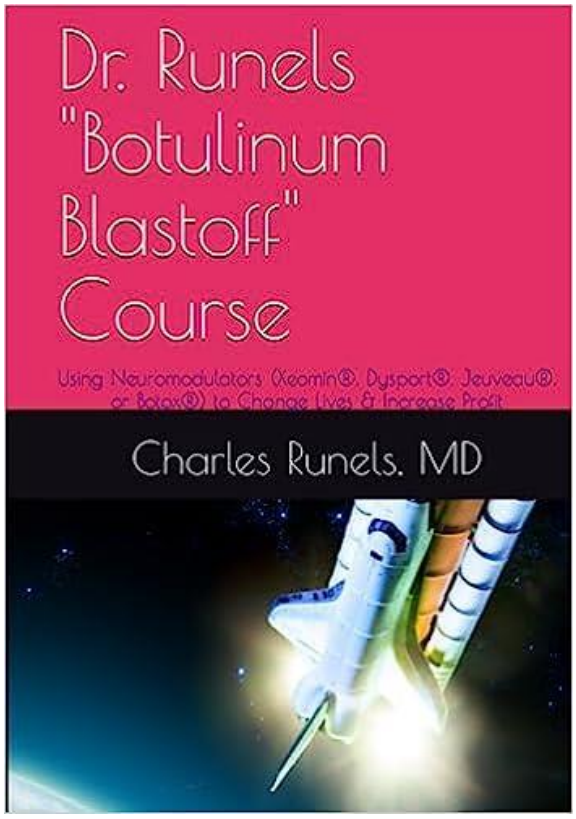
So then I put two injections on each side, third from the distal end and another one into the glands, and then I got a more ubiquitous spread. You can say, "Well, maybe just do one of the studies in and you run the spinal needle, thread it through the corpus cavernosum", and inject over two minutes or whatever they did to torment those poor guys. Well, you could do that or you could just squirt enough volume in there that it hydrodissects without having to torment somebody, or another way of saying it, you could use more to spread it further instead of trying to spread it with this threaded needle tormenting torture session. Spreading a tiny bit throughout more space.

Anyway, here's a rep who's not having a decade of doing this, more than a decade, and teaching literally thousands of doctors, but more importantly, getting feedback from thousands of doctors for a decade deciding it's okay to just tell one of our people, "Oh, 20% less is fine. Don't worry about it." I don't know about you. That just to me is just... I won't even finish that sentence. ... not good. If the procedure is altered, in my opinion, what I look for, because I do recognize there are dangers of very well-defined, well-known dangers to me, to my brain when I've been teaching something for over a decade that I'm in danger of starting to believe everything I say. I have actually altered the procedures with the help of people in our group multiple times and all of them multiple times.

What I look for though is, "Does this innovation make sense biologically? Secondly, is it complicating it, making it more complicated than it is now without any added benefit?" Like threading one of those studies that was published, it was great, showed benefit, double-blind placebo-controlled, but they threaded a spinal needle down the corpus cavernosum when we know it spreads perfectly beautifully well as aqueous without having to do that. So does it complicate it without adding potential benefit? Does it significantly change the amounts or how it's being done? Decreasing the volume by 20% is a significant change with no reasoning, no experience at least to compare what our group has.

So bottom line is there's enough profit built into these procedures for a reason. It allows you to go up on the volume. It allows you to drop a tube. It allows you to give money back when someone doesn't think the procedure is helpful and still be profitable on the next procedure. It's done that way. If you think about it, it's counterintuitive too. The ethics of charging a very low price to everybody are really unethical, because it makes it such that you have trouble staying in business without keeping the money of those who are not helped. But if you have not a scary amount of profit, we're not charging people the price of a car. We're charging people the price of two nights in a good hotel or the price of a transmission repair or a set of tires, not even very good tires.

So with that price point, if we still have enough profit built in that we can refund money to those who are not helped or we can go up and use three Selphyl tubes, instead of two, and still have a nice profit, then that's better than keeping the money of those who are not helped and losing money and therefore going out of business and not being able to offer the procedure. Counterintuitive, right? You still do things for free for those who just wouldn't have enough money to buy a new set of tires, but you don't discount it often, because then I have seen people want their money back just because they have an unexpected bill. If they're really that broke, you just give it to them. Again, you make enough profit to be able to do that.



(33:02):

So those are two ways that the reps can trap you, telling you can significantly change the procedure by either going down on the dosage or by not needing to add something to the plasma to activate it. I think with that, I'm going to end the call unless you guys have questions or comments. Let's see what we got here. Several people told me that kit's mostly used by orthopedics. Actually, the Selphyl kit was a renamed kit that used to be an orthopedic kit and then someone got the idea of rebranding the same kit. I guess these people just weren't smart enough to rebrand it, but that's how Selphyl was originally an orthopedic kit that they gave a different name. Redo the verbiage for the OSHA news. Yeah, I could do that.

Let's see. I'll give you an outline and then I'll type it into the chat box and then you just write this as if you were writing to a friend. The outline would be one, hello. If you just pretend like you're writing to your mother or your best friend, sister, someone who you can imagine having incontinence that you are fond of, then the letter will write itself. Hello. Then if you would say something like, "Hope you're having a good holiday or Merry Christmas" or whatever you say to people these days when you're writing letters. It would be hello and then that. Then it would be the new research and the verbiage for me would be something like, "Hey, this article just came out that supports the idea that I can draw your blood and help your incontinence better than sitting around doing Kegels all day."

How to Team Up with a Pelvic Floor Physical Therapist

I should mention this. If you take this article to one of your pelvic floor physical therapists and say, "I appreciate what you're doing, but what I'm doing could make your therapy work a lot better, so we should team up together", you may get some takers. It's worked for many of our providers. I used to do that back in the days when I had a more active hormone replacement. I'm about to give you a big tip if you're doing hormone replacement. I was a member of five gyms, Planet Fitness, Omni, YMCA, a 24-hour gym and a local gym. I rotated where I went. I didn't just go there. I went and worked out there and people see me sweat there. I would get to know the different personal trainers and the people at the front desk and such.

Then I'd start leaving my cards around with the trainers and say, "If you have someone who's stuck, I'll support what you're doing on the exercise side and your exercise is going to work a lot better when I fix their thyroid and their testosterone levels. Send them my way and I'll send them back." I got a lot of people that way. That same thing can work with your physical therapist if you think of them like a personal trainer for the pelvic floor, and this is one of the studies you take with you to go talk with them. They want to have success too. Problem is many of them, unfortunately, sex therapists and physical therapists, they're I think afraid of us because we think, at least in my case, I've had them tell me that they think that I think this is a magic shot and it makes what they do unneeded.

Truth is oftentimes they need it more when their sex drive goes up, because say on the sex therapy side, when now her sex is outrunning the abilities and libido of her husband and his refractory period, then you have a different sex therapy than when his libido is outrunning hers. We all are worried about our livelihood and those who might threaten it. So it has to be a very cooperative thing. I've had people bring in their physical therapist to the gynecologist office and bring a patient with them so they can see them. The physical therapist can see the doctor doing an O-Shot®. Then you have this conversation, show them that you two could have a good working together relationship. So back to the email, the outline is hello, whatever greeting you would have. It's so much more difficult.

I have to train myself to do this. Even after a decade, I have to catch myself sometime. It helps to even put a picture of one person, pin it up on the screen of your computer, and pretend like you're writing to them. But if you're in your brain, you start writing to all your patients or all your people out there in TV land, it will sound that way and I think it's not as effective. So a greeting that you would give to someone you're fond of. Then this research came out this month and it supports what I'm doing with the O-Shot® for incontinence, however you would say that to your friend.

So new research shows that our O-Shot® works better. If you put the R symbol behind it, which will [inaudible 00:38:10] by hitting Option and then the letter R. If you have a PC, I feel sorry for you that you're still taking that abuse. So shows that our O-Shot® procedure, put the word procedure after it, that emphasizes that it's not just squirting PRP somewhere. That it's everything you do before and after the procedure, how you prepare the plasma before and after the actual shot, how you prepare the plasma, where you put the needle, who you treat, who you don't treat. Everything else you do, that's

the whole procedure. It's not just spinning blood any way and putting a needle somewhere down there between somebody's legs.

It shows that our procedure works better than Kegel's for stress urinary incontinence. Then you put a link to the article, which I just gave you. So that's the news part. Then I like to always put something that downplays the promises. It usually goes something like I know nothing treats everybody. Nothing gets everybody well, or in this case it might be I know that Kegel's worked for many people, but oftentimes the people who need it the most can't even do a Kegel, something like that. So you put the new idea, the news. Next part, you put a disclaimer of some kind that has to be honest humility, and then the next part is but there is some hope here. So then you put the link of the article, a disclaimer. I'm giving you an outline that it's what I use. It works.

Disclaimer, humility and honesty and offer to help. That's part of it. The offer for me usually goes, if you think this might help you or someone you know, contact us, that simple. But then in the closing, put every way to contact. So that would be your email, your telephone number, fax if you take a fax, cell phone, text. If you're doing that with your patients, which I recommend if you're running a cash practice, they should know how to at least text you. Then there you have it. I think that answers all the questions. Let me see what else. On P-Shot® post-radiation, actually, I might can just drop it in the chat box. Hold on a second. Nope, but I can drop it in the handouts. I'm going to drop it in your handouts.

Last journal club, I'd reviewed... No, it wasn't the last, it's been three weeks ago, but I finally actually did the... Good, there it is. Click that right now. It's in the file section. I finally did the transcript. It wound up being 12,000 words and 91 references. So it took me a little time. Look, we're not asking for sympathy. I'm just telling you, it took me a little while to get it done, but that's the journal club we did November 21st, where I went through almost all of our procedures and did include the P-Shot®, and talked about penile rehabilitation post-prostate surgery and some of the disclaimers and what works and what doesn't work, who to treat, who not to treat, some of the urban legends out there that'll get you in trouble, some of the traps with all the procedures.

If I could push a magic button without hesitation, I would pay 50 grand to make sure everybody in our group reached that. I may actually do that in some way by mailing it out, a hard copy of it. But print it out, read it, and it'll keep you out of trouble and it'll make you much more effective. It'll also answer that question you just put, I think. Let me look at it again. The question about post radiation or post-surgery for prostate cancer. Okay, ideas for January and Christmas, Hanukkah marketing campaigns? I'm going to confess to you here something and then we're going to end with this one. My confession is that I have never been able to make a December not the lowest month in my medical practice ever. That's 20+ years of being a physician.

In the ER days, people will stay home. It was crazy. They will stay home and the ER will be so freaking quiet. Many of you guys know this. Then all those people who were determined not to be sick but really should have come to the hospital, they had the chest pain and the vomiting for the past three days, all those people that are dehydrated, they will come to the ER Christmas day evening or the day after

Christmas or the day after New Year's, but the week before Christmas, they'll stay home. So you get this sudden surge and I think people are just so distracted. So the holidays are so rough on people. Everybody's missing the ones they used to see, sad, they're broke. It's just a tough time for grown-ups. That's where I would see the most suicidal attempts in the ER.

I work in a town where there's Mardi Gras and I used to leave town during a big portion of Mardi Gras because there's so much trauma in the ER. I always like to take vacation, just leave mobile during Mardi Gras. But in Christmastime, you don't see that many people except the depressed broke people. So the bottom line is that when you're talking around the last half of December, you do education, but in my opinion, mostly you're priming people up and they're going to call you in January, because that's your question. Any ideas for promotions or campaigns starting in January? My first idea is start in December. So that when January gets here, you've already taught them what you want them to know and they will read it and they'll think about it, but then they'll call you after the first of the year. If you start in the first of the year, they'll call somebody else possibly.

Actually, David Ogilvy did that research. Scientific advertising/marketing was not a thing not that long ago. Ogilvy was one of the pioneers who made a science out of it that can be measured. One of the things he showed was that those who continued to market during the down times benefited and gained more market share. He's looking at big companies, but it works with doctors too. They gain more market share when the downtime is over. So if you're staying in communication with your people, not in any fake way, but just because you're truly concerned and you want them to know the ways you can help them and encourage them, then talk to them through the holidays and you'll start to get the calls in January.

Once January hits, then I think you flip it and you start talking about ways to have a better new year. Very quickly you start adding in Valentine's Day, which of course is mid-February. That becomes your topic about the importance of love and relationships. If you show up to journal club or you see the emails that come out, I'll be giving you fresh emails to write about that and new ideas. But that's your basic overall strategy. I think with that, we'll call it a day. Always just amazing to me that so many smart people have interested in any word I have to say. I hope I've not wasted your time. Good luck with everything. You guys have a wonderful December. Bye-bye.

References

Charles Runels, MD. *Activate the Female Orgasm System: The Story of O-Shot®*, n.d. https://a.co/d/fawyO3y.

DeLancey, J. O. "Correlative Study of Paraurethral Anatomy." *Obstetrics and Gynecology* 68, no. 1 (July 1986): 91–97.

———. "Structural Support of the Urethra as It Relates to Stress Urinary Incontinence: The Hammock Hypothesis." *American Journal of Obstetrics and Gynecology* 170, no. 6 (June 1994): 1713–20; discussion 1720-1723. https://doi.org/10.1016/s0002-9378(94)70346-9.

Gözlersüzer, Özlem, Bestami Yalvaç, and Basri Çakıroğlu. "Investigation of the Effectiveness of Magnetic Field Therapy in Women with Urinary Incontinence: Literature Review." *Urologia Journal*, January 9, 2022, 03915603211069010. https://doi.org/10.1177/03915603211069010.

He, Qing, Kaiwen Xiao, Liao Peng, Junyu Lai, Hong Li, Deyi Luo, and Kunjie Wang. "An Effective Meta-Analysis of Magnetic Stimulation Therapy for Urinary Incontinence." *Scientific Reports* 9 (June 24, 2019): 9077. https://doi.org/10.1038/s41598-019-45330-9.

Ogilvy, David. *Ogilvy on Advertising*. 1st Vintage Books ed. New York: Vintage Books, 1985.

Okumo, Takayuki, Atsushi Sato, Kanako Izukashi, Masataka Ohta, Jun Oike, Saki Yagura, Naoki Okuma, et al. "Multifactorial Comparative Analysis of Platelet-Rich Plasma and Serum Prepared Using a Commercially Available Centrifugation Kit." *Cureus* 15, no. 11 (November 16, 2023). https://doi.org/10.7759/cureus.48918.

Omodei, Michelle Sako, Lucia Regina Marques Gomes Delmanto, Eduardo Carvalho-Pessoa, Eneida Boteon Schmitt, Georgia Petri Nahas, and Eliana Aguiar Petri Nahas. "Association Between Pelvic Floor Muscle Strength and Sexual Function in Postmenopausal Women." *The Journal of Sexual Medicine* 16, no. 12 (December 1, 2019): 1938–46. https://doi.org/10.1016/j.jsxm.2019.09.014.

Pipitone, Fernanda, Zhina Sadeghi, and John O. L. DeLancey. "Urethral Function and Failure: A Review of Current Knowledge of Urethral Closure Mechanisms, How They Vary, and How They Are Affected by Life Events." *Neurourology and Urodynamics* 40, no. 8 (2021): 1869–79. https://doi.org/10.1002/nau.24760.

Popova, Maria. "10 Tips on Writing from David Ogilvy." *The Marginalian* (blog), February 7, 2012. https://www.brainpickings.org/2012/02/07/david-ogilvy-on-writing/.

Richard Maurice Bucke, MD. *Cosmic Consciousness: A Study in the Evolution of the Human Mind*, 1902.

Saraluck, Apisith, Orawee Chinthakanan, Athasit Kijmanawat, Komkrit Aimjirakul, Rujira Wattanayingcharoenchai, and Jittima Manonai. "Autologous Platelet Rich Plasma (A-PRP) Combined with Pelvic Floor Muscle Training for the Treatment of Female Stress Urinary Incontinence (SUI): A Randomized Control Clinical Trial." *Neurourology and Urodynamics*, December 18, 2023, nau.25365. https://doi.org/10.1002/nau.25365.

Smith, Oliver J., Selim Talaat, Taj Tomouk, Gavin Jell, and Ash Mosahebi. "An Evaluation of the Effect of Activation Methods on the Release of Growth Factors from Platelet-Rich Plasma." *Plastic and*

Reconstructive Surgery 149, no. 2 (February 2022): 404–11. https://doi.org/10.1097/PRS.0000000000008772.

Smith, Stephanie A., Richard J. Travers, and James H. Morrissey. "How It All Starts: Initiation of the Clotting Cascade." *Critical Reviews in Biochemistry and Molecular Biology* 50, no. 4 (July 4, 2015): 326–36. https://doi.org/10.3109/10409238.2015.1050550.

"Trademark Status & Document Retrieval." Accessed December 29, 2023. https://tsdr.uspto.gov/#caseNumber=90975954&caseSearchType=US_APPLICATION&caseType=DEFAULT&searchType=statusSearch.

Tags

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