JCPM2024.01.09

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of January 9, 2024, with Michael Goodman, MD, FACOG, and Charles Runels, MD.

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

Topics Covered

- Self-Image Improves Sex in Women
- *How Long Does It Last?*
- **Cosmetic Surgery is Not Just for Appearance**
- ***The Female Sex Muscles***
- ***Dr. Goodman's Speculation about a Subject in Need of Research***
- ***More about Energy-Based Therapies***
- ***How to Turn Your Word Document into a Web Page***

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Charles Runels, MD:

Welcome to the Journal Club. Today, we have three papers and one marketing trick. I'll save the marketing trick for last.

I notice a huge difference in income and satisfaction between physicians who are empowered to add content to their websites quickly and easily—and the other extreme: those who spend lots of money and sometimes wait for a week or a month to add something extra to their website and feel oftentimes abused by their webmaster. I've lost track of the number of physicians I have met who have spent 40, 50, or 100 grand on a website and found out it's non-functional. But, once you have the right structure, it's very easy to add content, and I'd like for you guys to be able to do that.

That's the marketing trick: I'll show you one of my best, most recently discovered hacks for being able to ***take a Word document and turn it into a functioning webpage quickly and easily.***

We have Michael Goodman on the phone, who I think is a legend in the cosmetic and gynecology space. So, let's bring him on the call.

Self-Image Improves Sex in Women

Hello Michael, we covered one of your papers last week, and I can pull that up for those of you who are not familiar; then, let's discuss the other paper you recently published.[1]

Figure 1. Dr. Michael Goodman, MD, FACOG

Just a quick introduction. Dr. Goodman: I heard about him before I met him; one of the leaders in the sexual medicine field was speaking to a large group that I attended, and he said, "Some of us may not like it, but the fact is that Michael Goodman did the research and whether you like it or not, we now know that improving the appearance of a woman's labia improves her sexual function."

And that idea, when it was born, was a major, major shift, an earthquake of a shift in female sexual medicine.

And Dr. Michael Goodman fought that battle with his research. And now he's to the point where a large part of what he does is teaching and redoing other people's not-the-best outcomes.

With that, I think you [Dr. Goodman] can probably see the paper I have pulled up here[2] ; if you want to talk about that paper or anything else, go for it. And while you're talking, Michael, I can put a link to this paper so everybody can have the reference when we're through. Thank you for showing up today.

Michael Goodman, MD, FACOG:

Sure. I'm seeing which one you have.

I always like to give credit where credit is due. And I think if you're interested in looking at the literature about body image and sexuality in women undergoing genital plastic and cosmetic procedures, you

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[1] Alavi-Arjas et al., "The Strength of Correlation between Female Genital Self-Image and Sexual Function."

[2] Alavi-Arjas et al., "The Effect of Female Genital Cosmetic and Reconstructive Procedures on Body and Genital Self-Image."

really should look an article from about 10 years ago. I believe, the Journal of Sexual Medicine; it's out of Cindy Meston's Group and her group is in University of Texas in Austin, and the lead author is Yasisca Pujols.[3] *That group was really the first group that proves that a woman's experience with her body image, especially those parts of her body that have sexual connotations like her breasts, her belly, her butt, her genitalia, directly influenced her sexual satisfaction.*

And that got me thinking about doing research, prospective with a control group. And that resulted in my article of 2016[4] [5], which still is the largest article in the literature, which followed women for two years. It was 120 women and paired with a control group of 50 women.

Anyway, that's my area of special interest: body image and sexuality in women undergoing female genital plastic and cosmetic surgery. You've got that article that you have up on the screen, if anyone happens to be interested. There are other articles I can recommend.

Again, there's my article from 2016. Also, if you're interested in the field, look up a researcher named Gemma Sharp and her partner, whose last name is Tiggemann. They're both from Melbourne. I've done some research with Gemma. I think the article you have is written with Gemma.[6]

Charles Runels, MD:

Yes, it is.

Michael Goodman, MD, FACOG:

I've recently worked with a group from Tehran in Iran, and that's one of the articles you have up there. There's actually a series of three articles. One you have up top is a meta-analysis and systematic review. In other words, what it does is, it looks in the entire literature the past 25 years, both things I've written and Gemma's written and other people have written, there's some good people from Turkey, Erdogan from Turkey, and it looks at all the articles and it reviews them. So the series of three articles is, the one

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[3] Pujols, Meston, and Seal, "The Association Between Sexual Satisfaction and Body Image in Women."

[4] Goodman et al., "The Sexual, Psychological, and Body Image Health of Women Undergoing Elective Vulvovaginal Plastic/ Cosmetic Procedures: A Pilot Study," 3.

[5] Goodman et al., "Evaluation of Body Image and Sexual Satisfaction in Women Undergoing Female Genital Plastic/Cosmetic Surgery."

[6] Alavi-Arjas et al., "The Effect of Female Genital Cosmetic and Reconstructive Procedures on Body and Genital Self-Image."

in Journal of Sexual Medicine, talks about the strength of correlation between female genital self-image and sexual function.

Charles Runels, MD:

I have that one too, by the way, Michael. I have it pulled up now.

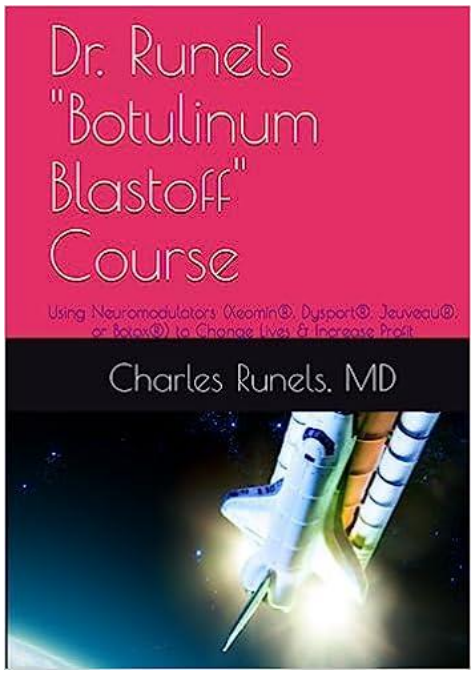
Michael Goodman, MD, FACOG:

You see, it reviewed 146 articles and showed pretty clearly that there is a correlation between female genital self-image and sexual function. Okay, fine. So then there's these other two articles which shows the effect of the surgery self-image on both labiaplasty, and there's another article that's being prepared for publication, on vaginoplasty.

How Long Does It Last?

Michael Goodman, MD, FACOG

My whole thing is evidence-based research, and the burr under my saddle is marketing, which may be of questionable ethics, where people say, oh my goodness, we're going to do this energy-based device procedure, and it's going to make you all better. It's going to make you tighter, and it's going to make you look better. And there's no evidence-based research behind it.



They may have done three, they may have done 33 procedures, and the patients say, "Oh, hey, we love it. We're doing well."

And you find out their follow-up is one month or three months, maybe. The studies that have followed for six months or more show that there aren't any long-term benefits from these energy-based device procedures.

So, what you need is, I think, ethically, practitioners using these devices that have wonderful applications just to be honest about the kind of follow-up there is. And one of the things you mentioned is research ideas. There is so much hype in marketing these procedures, and there are so many people using these procedures that certainly a group can get together under my aegis, your aegis, ISCG, to do the studies. And the question is, okay, if you're doing a vaginal rejuvenation and you're using radio frequency or you're using laser or you're puffing with fat transfer, how long does it really last?

And taking a group of women with similar demographics that have a surgical procedure and a group of women with similar demographics that have energy-based procedures and follow them over time, not three months, not six weeks, but a year or two years, and find out how things are after time. How much did it cost them? What the side effects were? Compare the two groups.

So I just want to throw that out there. I think the pearl that I wanted to offer is that we clinicians just be honest about evidence-based results and be honest about our results.

How many patients and how long?

There's something called cognitive dissonance. And you know what that is, Charles. In other words, someone has paid $2,500 or $3,000 for a procedure or a series of procedures. They don't want to say, "Hey, it didn't work at all." They put out money. So, they'll tend to say, "Yeah, I think it's a little helpful," especially if you see them six weeks or two months later.

Charles Runels, MD:

Let me add to some of what you've said.

One of my heroes is Michael Faraday. And even though he was a mathematician, he wrote an essay about education in general.[7] And ***even as a mathematician, he thought we should be very strict about words.***

Similarly, Richard Feynman said that if you can't explain it, even explain it in non-scientific words, and if we can't all agree on what the words mean, then you don't understand it.

And the next thing Faraday said was that he wanted people to challenge everything he did and said: he looked for people to disagree with him so that it kept his thinking sharp.

I've always thought we're better if we have a few true, at least, intellectual enemies. I don't like people looking for me with a gun, ***but I like intellectual enemies because they make me think***. Or maybe a more benign way of saying is people who violently disagree with something I say that's great because it makes me think. And I see a lot of emotion over, not from what you're saying, but just when I'm in the room with people, the emotion between what “works” and what “doesn't work” and what's valuable and what isn't.

Just to clarify the way, I like to sort it out—one rule I follow—is that (my number one rule) nobody can say, “I think it worked.”

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[7] Jenkins, *Michael Faraday's Mental Exercises*.

They have to be so excited that they're jumping up and down almost. Or I don't keep their money, or I figure out something else to do to bring them value.

As a surgeon, you're not going just to quit dealing with someone if they're not happy. A lot of what you're doing is revising surgeries that other people are not happy with.

So, I absolutely agree with everything you're saying: we must be super honest with our words, super honest in describing what we're able to do and what we're not able to do.

The best I can tell, if you go to regenerative therapies with cellular medicines like stem cells and PRP and you look outside sexual medicine and you look at Sclafani and others, who've done wound care and scar studies with biopsies, oftentimes, the remodeling ***is permanent***.[8] [9] [10] [11] [12] [13] [14] [15]

But if the etiology is still present, then the effects of PRP may only last 9 months to 18 months.

For example, there was a paper in *Menopause* about treating dyspareunia with PRP, and they showed benefits.[16] These were women who had had breast cancer. In that case, if the woman cannot be on estrogens, it's one of our low-hanging fruit, and we have more than one paper that shows that lubrication and dyspareunia get better, but it's only good for nine months to a year and a half. And then,

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[8] García-Sánchez et al., "Platelet Rich Plasma and Plasma Rich in Growth Factors for Split-Thickness Skin Graft Donor Site Treatment in the Burn Patient Setting."

[9] Deng et al., "Efficacy and Safety of Autologous Platelet-Rich Plasma for Diabetic Foot Ulcer Healing."

[10] Li et al., "Self-Healing Hyaluronic Acid Nanocomposite Hydrogels with Platelet-Rich Plasma Impregnated for Skin Regeneration."

[11] Spanò et al., "Platelet-Rich Plasma-Based Bioactive Membrane as a New Advanced Wound Care Tool."

[12] Kelm and Ibrahim, "Utility of Platelet-Rich Plasma in Aesthetics."

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

[14] Refahee et al., "Is PRP Effective in Reducing the Scar Width of Primary Cleft Lip Repair ? A Randomized Controlled Clinical Study."

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

[16] Hersant et al., "Efficacy of Injecting Platelet Concentrate Combined with Hyaluronic Acid for the Treatment of Vulvovaginal Atrophy in Postmenopausal Women with History of Breast Cancer."

because the etiology is still present, you have to do it again. Now, that's still a win if the woman can't be on estrogens, and it's working better than K-Y jelly, but she needs to know that before we ever do it.

By the way, that trilogy of papers that you just mentioned is wonderful; they should come in a binder or something. And we covered, as you saw, pulled up the other one that's been published, we covered that in last week's Journal Club.

Cosmetic Surgery Is Not Just for Appearance

Charles Runels, MD

But when I'm invited to speak to a group of surgeons I feel honored to be in the room because I'm not a surgeon. But one of the things that I think is worth noting is that when you guys do cosmetic surgical procedures, the woman benefits from self-image improving which results in improved sexual function; but there are also mechanical and health tissue improvements (more than appearance) like when you're treating phimosis with someone with lichen sclerosus and you free that clitoris up, it looks prettier, but it also just works better.

I've lost track of the number of doctors who called me. I've seen a few patients myself who come in for anorgasmia, and the poor woman and her partner don't even know that her clitoris is buried up under all the scarring from her undiagnosed lichen sclerosus. And in that case, to me, it's an understatement to say that's a cosmetic procedure because what it's doing there is also extremely functional.

And then the other thing to back, and then I'll quit talking because I want to hear from you, but I just want to add to what you're saying from the non-surgery perspective. If you look at what goes on with the sensation, best I can tell, Grafenberg was the first to talk a lot about it, but most of the pleasure is happening in the anterior vaginal wall with the corpus cavernosi coming down the pubic rami, the urethra being super sensitive and all that goes without in periurethral glands and posterior vagina. It's pleasurable but not like the anterior. So Grafenberg documented female ejaculation, way back in the '50s by stimulating the anterior vagina in the area of the urethra.

So now, back to the topic at hand. When you do a reconstructive procedure, one of the daggers that gets thrown at us is that we're somehow doing that for the pleasure of the man. And I want to bring this up before we go further with your research, in ***that there is no pressure from the penis in the vagina unless there's some structure to pull it forward***. If you imagine the extreme case, if there was nothing in the posterior vagina, if it was just a upside down "U"—no posterior structure at all, there would be nothing holding pressure there.

So when you do a reconstructive procedure, some might say we're just doing this so the man will have more fun. No, we're not, because the woman, it's not just self-image, there's a structural thing that

happens no matter what the size of the man's penis in relation to the vagina. If there's no structure there to pull the penis forward against the anterior vaginal wall, there's an extreme attenuation of pleasure.

So anyway, that's my main pet peeve about or my main, maybe, noticing burr under the saddle, as you said, around this whole area of cosmetic genital surgery. I think it's much more than cosmetic. And I agree no matter what it is we're doing; all the plus minuses should be talked about.

As you know, Irwin Goldstein and others did a study looking at what happens when you do a mid-urethral sling, and you're going right through the innervation of the G-spot when you put something there in one of their cadaver studies.[17] Still, it's a great procedure, and there's only a 10% incidence of failure or significant adverse sequelae, but there is that 10%. And I may have the numbers wrong, but that's my memory of that research.[18]

Michael Goodman, MD, FACOG:

It's both the bottom and the top.

If you look at the biomechanics of lovemaking, whether that lovemaking is with a finger, whether it's with a toy, whether it's with a strap-on, whether it's with a good old penis, the biomechanics involve stimulation, and they involve friction. And the friction is all with using some object in the vagina.

We'll talk about penile vaginal intercourse. So the friction is from the penis, and it's from the pubic bone, and it's from your fingers and whatever else is down there to produce friction. And while there are erotic nerve endings in the cervix, that's why some women enjoy it when their lover puts his or her finger deeply into the vagina and puts it into the cervix.[19]

So there are receptors in the cervix, there are receptors in the posterior vaginal wall, but most all of them are in the anterior vaginal wall in Grafenberg's area.

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[17] Gaudet et al., "249 Midurethral Sling Placement Disrupts Periurethral Neurovascular and Glandular Structures near Anterior Vaginal Wall."

[18] Jang, Jeon, and Kim, "Changes in Sexual Function after the Midurethral Sling Procedure for Stress Urinary Incontinence."

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

And for a long time uro gyneas and general gyneas, really didn't think that much about where they were putting their sutures for their bladder repairs. There are no studies that I know of that look at both suture placement and any loss of orgasmic potential. But it's theoretical and it's anatomic.

So it makes sense. And this is what you just discussed. So if we're talking about posterior and anterior, and you can do something both posteriorly and anteriorly, and whether you do that something posteriorly just by building up the perineal body or you build up the whole vagina itself, depends on the muscles, depends on what kind of separation you have with the levators. Depends on what kind of destruction you have of the perineal body. But by doing a procedure, which was a surgical procedure, because all that energy-based devices do is improve the collagen and elastin fibers of the skin.

And that's all well and good. That's nice. They do that temporarily maybe for eight months, maybe for two years. No one knows exactly how long. But somewhere around a year or two it improves. It's like reweaving the trampoline a little bit. Well, wonderful. You can reweave that a little bit, but if the trampoline still sags, if there isn't any repair of the superstructure, then it's not going to work as well as a surgical procedure that basically builds up that pelvic floor.

So if you're building up the bottom, then you're producing more pressure of the dorsum or the top of the penis or the toy or whatever, more pressure against the goodies in the anterior vaginal wall. So what's there? The root of the clitoris is there, the pruri and the bulbs of the clitoris all anchor in Grafenberg's area. The clitoris that the woman sees or a man sees externally is just the tip of the iceberg. Most of the iceberg is down low.

But also in that same area, there's an autonomic nerves supply and it's been proven with women that have had spinal cord transection at L4 and L5, this is the work of Beverly Whipple and Barry Komisaruk from New Jersey, that showed in women that had spinal cord transection, which means they have no pudendal nerves, there's no innervation to the clitoris at all. They still can have vaginally activated orgasm because of the autonomic supply to that area. So anything that's going to produce more pressure to that area is going to be good.

Also, if the perineum has fallen down. And so with intercourse, the dynamics are such that there's not much pressure up top. That means that the dorsum of the penis and especially the guy or if it's female on female, the strap on and the female partner or his, usually his, pubis rubs against the external clitoris. If everything has fallen down, then you're not going to get that rubbing.

So anything that raises the bottom is going to help.

And as you very well know, anything that increases the thickness of Grafenberg's area is going to result in better odds of vaginally activated orgasm. And how do we say this? This all sounds really theoretical.

Of course, if you go ahead and put platelet-rich plasma aka O-Shot® into Grafenberg's area because of what platelet-rich plasma does, by increasing growth factors, by increasing angiogenic factors, you're going to get more tissue there. It makes actual sense also. Because studies have been done by Pierre Foldes and others who have measured the size of Grafenberg's area between urethra and anterior vaginal wall. And they've correlated that with the percentage of vaginally activated orgasms. And the premise is, if that area is thicker, either because it's naturally thicker or because there's more tissue there or because Charles Runels has done a couple of injections of platelet-rich plasma in that area and that area becomes thickened and evidence-based research shows that the thicker that area, the greater the odds are of vaginally activated orgasm.

The Female Sex Muscles

Charles Runels, MD:

Yeah. That plus some. For example, if you look at the definition of the "pelvic floor", it doesn't really include bulbospongiosus (BLS) ischiocavernosus (IC), or deep and superficial, transverse perineal muscles. I don't know, maybe the superficial transverse perineal is included.

Michael Goodman, MD, FACOG:

Yeah, that's outlet.

Charles Runels, MD:

So, if you look at those muscles in studies of males, those seem to correlate with and be activated by ejaculation[20]. Pouring through the research, I see vague mentions, but I don't see a lot of research talking about how those muscles function in females.

And I don't think our Maker, whatever name you want, adds many extra parts—so why do women have BLS & IC muscles (maybe the appendix, but I don't see many extra parts)?

We know from sports medicine that you can treat damaged muscles with PRP.

[20] Schmidt and Schmidt, "The Ischiocavernosus and Bulbospongiosus Muscles in Mammalian Penile Rigidity."

It bothers me that we have a vast amount of research that shows if an NFL quarterback hurts his thigh, you can help prevent scarring and accelerate recovery of his muscle with platelet-rich plasma.[21] [22] [23]

That is in the sports literature. Yet, when Mama delivers a baby, she doesn't get the benefit of that research. That, to me, should at least aggravate most people on the call.

My question is: If you now know that, and you know that some of these muscles, not just the pelvic floor, but ischiocavernosus and bulbospongiosus might be damaged, then what research would you do to see what else we can say about what those muscles do?

And then, would that dictate a modification of our O-Shot® procedure?

Michael Goodman, MD, FACOG:

Oh, Charles, that's lovely.

Well, first, why has so little research been done with women and the uses of PRP in indications such as you just talked about?

It has to do with money.

Charles Runels, MD:

Of course.

Michael Goodman, MD, FACOG:

There's all sorts of money. All those sports, all sorts of money. Come on.

Charles Runels, MD:

Yeah. If you've got somebody making 20 million a year and they take a day off, it costs you some money.

So you don't wait for the FDA. You do what gets them back on the field.

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

[22] Graca et al., "Platelet-Derived Chemokines Promote Skeletal Muscle Regeneration by Guiding Neutrophil Recruitment to Injured Muscles."

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

Michael Goodman, MD, FACOG:

And it also has to do with attitude.

Orthopedists have a far different attitude about platelet-rich plasma than OB-GYNs do. We're just way behind in the Middle Ages about that. When we hear about platelet-rich plasma, God forbid when an OB-GYN hears the word O-Shot®, we just think, oh no, we shouldn't.

Charles Runels, MD:

I know it's a trigger.

Michael Goodman, MD, FACOG:

Yeah, it's a big trigger. For the OB-GYN establishment who are ostriches with their heads as deep in the sand or up their butts, as they can put them. But that's a study waiting to happen. And I'm not sure who would be the person to reach. Maybe Rachel Rubin might have some say in that. A couple of other people that are part of the OB-GYN establishment.

Of course that's the study that can be done. You'd have to demographically dot your I's and cross your T's as far as the groups. But to my knowledge, at any given moment, hundreds of women are giving birth across the United States. I don't know how many are born in a day, but it's a shitload. That's a medical term. But you've got a lot of women that are giving birth. Sure, you have to have similar demographics as far as, okay, did this woman have a first degree tear, second degree tear, and so forth and so on.

But it can be so easy to get two groups, one group, that just has a standard repair after their delivery, whether that delivery is no tear, no episiotomy, whether that's delivery is first degree or small episiotomy, second degree, third degree.

You can separate the groups and you have to have high numbers because there is some heterogenicity that's just definitely going to be going on. So you have to have high numbers. But the numbers are there.

And you give half the people PRP and half the women don't get PRP. And if you really want to do it, be fancy about it. You give a third PRP, a third, a saline injection and a third nothing, and you follow them up according to certain parameters, whether that parameter is urinary incontinence, whether it's sexual satisfaction, whether it's body i

mage. That's part of the protocol. In doing a study like this, the most important thing is the protocol. Because if you don't quite get it right, you think you have this wonderful article and then you spend two years getting data and writing it, maybe three years. You finally submit it and these reviewers say, hey, you didn't do this and this. And you go, oh my God, my study is toast.

Charles Runels, MD:

Yep, it happens.

Michael Goodman, MD, FACOG:

So writing the protocol is so important. But your thoughts, in other words, using PRP prophylactically for prevention of some of the things we've been talking about is a wonderful idea. But right now, it's all theoretical.

Can the research be done? Of course, it can. If there's the will.

Charles Runels, MD:

Yes, and done post-injury, just like with the NFL quarterback.

I'll change the subject and want you to, I feel like I'm not letting you, I want to know more about your thoughts about those two papers we pulled up.

How would you answer if someone said, “What function, in a normal child-bearing age female, does bulbospongiosus and ischiocavernosus serve?”

Michael Goodman, MD, FACOG:

I know where those muscles are. I can point them out probably on a three-dimensional model. You've done that very elegantly recently. What function do they have?

Michael Goodman, MD, FACOG:

I can guess, and I'm sure you have your thoughts on the subject.

Charles Runels, MD:

Here's the point we're both making. No one's really written about that.

Michael Goodman, MD, FACOG:

Not at all.

Charles Runels, MD:

And I've spent, I don't know if you know my wife Alex, and she laughs at me because for the past six months I've spent most early mornings poring through every textbook and paper I can find about the subject.

Michael Goodman, MD, FACOG:

How did you attract such a beautiful and intelligent woman, Charles?

Charles Runels, MD:

I don't know. I have no idea what she sees in me. I think maybe she just felt sorry for me. But she laughs at me because I get up trying to figure out how the thing works. I'm like a caveman who discovered a rocket engine or something. I don't think the literature answers that question. I was hoping you would have a.... Let me put it a different way. We both know the literature doesn't talk about it a lot, but if you were allowed to speculate for five minutes and let everybody know you're speculating-

Michael Goodman, MD, FACOG:

Oh, I can speculate.

Dr. Goodman's Speculation about a Subject in Need of Research

Charles Runels, MD:

What would you speculate?[i]

Michael Goodman, MD, FACOG:

The body is built for preservation of the species. When a woman has intercourse and she becomes aroused, the proximal or upper vagina dilates, it almost becomes like a little cup so that the ejaculate is held there at the top of the vagina by this dilation. So it's the cervix which changes position during intercourse and after intercourse, so that the cervix can dip into this pool of semen and lo and behold, the species is preserved.

What do the bulbospongiosus, bulbocavernosus transverse, deep and superficial transverse perinealis muscles do?

And by the way, the transverse perinealis is a fairly thin muscle sheet.

What on earth do they do?

Well, they help support the outlet. They help support the perineum and the distal vagina. So one might speculate that these muscles help hold the penis inside the vagina so that that penis in the joys and permutations and ups and downs and ins and outs of intercourse, it helps hold that penis inside so it doesn't bounce out. And so when the guy ejaculates, the ejaculate is inside. So that's what I would

speculate, is that those muscles help hold the penis inside and it's for preservation of the species. And I may be full of, you know what?

Charles Runels, MD:

Well, it's the most beautiful and most articulate explanation I've heard so far. Anything else?

And, by the way, before we change topics also, are you still taking on people who want to come mentor with you for the actual surgical part or are you-

Michael Goodman, MD, FACOG:

Oh, let's see. I guess you'd call me partially or mostly retired. I still do clinical work. I do revisions of other people's work and I'm back doing some primary work since Dr. Reed and I parted company, I'm back doing some primary work and I probably do one or two cases a month, just a little bit.

So I'm doing some clinical work. I'm still training. I have formal classes in February, June and October, but mostly my classes are one-on one or maybe one on two or one on three. People that make their own arrangements. And we just find a time that works for them and for me. They come out here. It's a two to three-day course. It's a two-day course. Sometimes, we'll add on a third day, and we'll have some live surgery. The course includes several full-length videos with soundtracks of labiaplasty, a couple of labiaplasty wedges, vaginoplasty, how to interview patients, and all of that. There are full-length videos and live surgery and animal lab.

I train surgeons, and part of the training is that they have availability for the entire training course online for one year. And anytime they have a case and they're not sure how to deal with it, they're always welcome to send me pictures so that I can help them draw lines and so forth. So, I continue to train, and I continue to do medical-legal work with expert witness work. And that, plus maintaining five acres of rural land and a lot of fruit trees and the big garden, is what I do.

Charles Runels, MD:

You have to keep the soul happy, too. Is there a website I can send people to where they can see your upcoming schedule or just give them an email of-

Michael Goodman, MD, FACOG:

Yes, it's easy. Its labiaplastytraining.com.

Charles Runels, MD:

Okay, beautiful. You guys got that. Labiaplastytraining.com.

Okay, I'll put that in the chat box.

Michael Goodman, MD, FACOG:

And as far as people doing this research, there's a guy in the UK named David Veale, V-E-A-L-E. You should look up his research. Again in Melbourne, Australia, is Gemma sharp, S-H-A-R-P. There's another wonderful article that you guys might look at; you might look at it, too, Charles. It's in the Journal of Bioethical Inquiry in 2018. Spriggs and Gillam.

Also from Melbourne, they are part of Gemma Sharpe's group, see the *Journal of Bioethical Inquiry*. It's entitled "**I Don't See That as a Medical Problem": Clinicians' Attitudes and Responses to Requests for Cosmetic Genital Surgery by Adolescents."**[24]

"

Charles Runels, MD:

Okay.

Michael Goodman, MD, FACOG:

It's a wonderful article. Definitely should look at it.

Charles Runels, MD:

When I put out the transcript for this, guys, I'll make sure I have links to all those papers you just mentioned, Michael. So, there'll be a PDF file that goes out in a week or so and I'll find all the papers and put links to them. Go ahead.

Oh, one other thing guys. If you're new to the field, you may not know it, but you really are talking to, I just call him, in my mind, you're the godfather of cosmetic vaginal surgery and there's really only a handful of people that do excellent trainings and you're one of them.

The Pelosi's also have a great course and they have a conference coming up. I'll put that link in the box.

Michael Goodman, MD, FACOG:

Definitely. Anybody that's interested in genital plastic should be at this meeting.

[24] Spriggs and Gillam, "'I Don't See That as a Medical Problem.'"

Charles Runels, MD:

Wherever I go around the world, they know the Pelosi's and they know, Dr. Goodman. Okay, anything else? And if not, I'm going to show them this quick marketing trick and call it a day.

More about Energy-Based Therapies

Michael Goodman, MD, FACOG:

One very short thing is, I'd put the plea out there for a paired study with energy-based devices. In other words, non-surgical treatments paired with surgical treatments. And I'd be happy to help write a protocol and lead such a study. That's it.

Charles Runels, MD:

I guess I have to just make one more comment about that. When I look at, as you said, when you look at just the physics of it, and if you look at lasers, we'll take lasers first. The last time I looked, the lasers do a depth that's about the depth of a calling card.

Michael Goodman, MD, FACOG:

It's about 60, it's like 0.6 millimeters.

Charles Runels, MD:

Yes. I had one of the more prominent lasers, and I zapped a notebook paper with it; and the holes went through, but it wouldn't go through a business card.

So that's about what you're looking at. So, if you look at a depth of that, it makes sense that it might be good (even though UV therapy does the same thing), but it would make sense that a laser might be good for lichen sclerosus because we know, just like psolarens and UV light helps psoriasis, light energy also helps lichen sclerosus and that paper was done: UVB helps lichen[25], why shouldn't a laser?

But then if you look, if you're affecting the depth of a piece of paper or a business card at most, really what can you do for restructuring?

And it makes sense that maybe not so much.

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

Michael Goodman, MD, FACOG:

Here's another idea, Charles, and I'll try to end with this.

We both know that using laser energy and radio frequency energy on the anterior vaginal wall, again reweaves the trampoline a little bit and temporarily helps with mild to modest urinary incontinence; If you're putting a material that's going to bulk up the base of the bladder, one would suspect that it's going to help with incontinence. The question is how much, how long?

And also, a question, you and I, when we're doing our O-Shots®, do them in a similar way. We put a little bit of material into the clitoris and most of it underneath the anterior vaginal mucosa, between the mucosa and the urethra--wonderful. Helps with incontinence.

What about if you have a woman that is known to have incontinence and she's having an O-Shot® for other reasons?

What about drawing more serum, more blood, more whole blood, instead of getting maybe five, six mils of platelet-poor plasma plus the platelet layer-

Charles Runels, MD:

Back to the radio frequency. With that one, as you know, you do get some depth to it, which is one of the reasons why it needs to be the doctor running that machine because you can get great benefits but with that one, I think you're more likely to cause harm if you don't know what you're doing.

Michael Goodman, MD, FACOG:

Yeah, I've seen harm.

Charles Runels, MD:

But again, how much restructuring can you do?

Back to the PRP part, we haven't talked about this either; I don't think so, but part of my misunderstanding of the anatomy was when I first just got lucky with this O-Shot® idea more than smart. I was imagining the old Netter pictures where there's a significant space between the urethra and the vaginal wall, both proximal and distal to the bladder. But as you know from

Delancey's work and others: there becomes an abutting of the vaginal wall and the urinary sphincter distal to the bladder.[26] [27] [28] [29] [30]

So I think what we're doing is two different things, Michael. I think what we're doing is when we're near the introitus, and if you watch me do the procedure, I seldom go deeper than literally a second or a third rugae past the hymenal remnant, so I'm half a centimeter or less from the introitus.

And in that area, I think, we may be inadvertently, and luckily without my intention in the beginning, I think we may actually be injecting some of the muscular layer or the urinary sphincter and doing what we talked about with athletic research: maybe we're changing the actual muscular function of the urinary sphincter.

Michael Goodman, MD, FACOG:

I suspect it's feasible, and I wonder if it would help at all to put in platelet-rich plasma through a twenty-five gauge endoscope.

Charles Runels, MD:

Maybe!

I think there's so much research regarding the way the thing could be done. As you know, there's an infinite number of variations, but all the questions you're asking need to be answered.

The only time I've seen an actual ultrasound study was when David Harshfield, MD was in my office. He's a radiologist, and he brought his ultrasound machine. He is a very bright guy who knows a lot about stem cells and has his own IRB—heavy into the research.

He used ultrasound and watched as I injected the body of the clitoris, which I usually get a little behind the glands and inject the body. He actually saw the waveform change with his visualization of the corpus

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

[27] DeLancey, "Structural Aspects of the Extrinsic Continence Mechanism."

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

[29] DeLancey.

[30] Perucchini et al., "Age Effects on Urethral Striated Muscle II. Anatomic Location of Muscle Loss."

cavernosum, saw the waveform change, but he saw more prominently when we went up on the volume and went, I think, around three to five cc's in the clitoris.

So the volumes might need to be changed, the location, additional locations, maybe eventually we're putting stuff in the corpus or into the bulbospongiosus or something. I don't know how this looks 10 years from now, but you brought up a lot of questions that keep me up at night.

Anyway, I'm honored, as always, to have you on the call.

If you guys want, I'll show you real quick, just a trick I learned about how to turn a Word document into a web page and we'll call it a day.

Thank you very much, Michael.

How to Turn Your Word Document into a Web Page

Charles Runels, MD:

Oh man, the hour's almost up. All right, let me just show you this trick in five minutes. Real quick.

If you've ever worked on your car, there's a tool to take off the oil filter, and without that tool, it's either impossible or a mess. But if you have that tool, it makes it super easy. Similarly, I am going to show you tools that once they're on the computer, you can very easily make a webpage if you can write in a Word document. All right, so let me pull this up. Hold on. Okay, here we go. (See video and screen shots of how here←)

So this is a final edit in a Word document of one of our Journal Clubs. You guys know I get them transcribed, then I edit out the uhs and the ahs and the things that I say that might be too obscene and then I put that in a transcript with references.

So then if you look at, on the Word itself, on the software, at the top, there's a place where you can share it.

Figure 2. Oil filter wrench: the right tool makes any job easier.

So if you go all the way to the top, in your left upper hand side of the whole page, let me show you what I'm doing here. Let me go to a different screen. Hold on a minute, okay, here now.

The Frustrating Way

All right. You're working in a Word document, and you want to turn it into a website or a webpage. Then you would go to, by the Word software, which I don't recommend you do. But if you go and you click on File and then you click on share, one of the possibilities, you'll see, send an HTML. And I looked at fricking 20 different videos, and I've looked off and on for the past two years because when you do that, it goofs up your formatting, changes your titles, throws your pictures all sideways, and it's just aggravating. And you then must deal with HTML code.

So I finally figured out a way to do it. So here's what you do.

The Better Way (this only makes sense if you see the video here<-)

You take it and you go to your Google Docs. All right, let me do that for you. So you go, pull this back up into that same screen.

Okay, there we go. So you're in your Chrome, and you go through there. Okay.

So you just pull up a new tab and you click, and you go to Google Drive.

And what you're going to do is you're going to get your Google Drive to change the Word document to a website, but you have to do a roundabout way.

So you click add New File and then you upload your Word document.

All right? So let's get that Word document that I just pulled out.

Okay, here. So there's this Word document.

All right, so you just find the file, open it. Now I'm uploading my Word document. Now once you get the Word document, okay, so let me just quickly say what I've done. I had a Word document. I want to make

a webpage out of it. I go to my Google Drive and I upload the Word document. Then you click, File Download. If you click the Publish to the web, it still goofs it up. So it's still in a Word document, even though it's on your Google Drive. So at this point you click File and this is the big secret. Then you say, wait a second, File... There, Save as a Google Doc. So you're [inaudible 00:46:34] it from a Word doc until a Google Doc. So it's in Google Drive, but it's still a Word file.

Then you say File, Save as a Google doc. Now you've got the same file, but it's not a Word document anymore. Now it's a Google document. Then you click File and you download it as a webpage and you just save it. You see it is putting it on my... I'm going to put it on my desktop and save it as a webpage. And then you're almost done. Then you go to the thing you just saved, which is right there and it's in a zip file. Pictures are in one thing and the website is in the other. So you see it just opened up this HTML code. So you went Word document, uploaded to Google Drive, and then you converted it to a Google Doc and then you downloaded it as HTML code. Now watch, when I click it, it opens it up on the website and if I had pictures they would be in there or titles or formatting.

And then all you do is, you'd click Edit Copy, and then you paste it into your website. Click Edit, select the whole thing, edit copy it, and then after you copy it, you open up a page in your WordPress website and you just paste it in there. And that was probably confusing, but you'll have the step-by-step on the video and you'll have the step-by-step in the transcript. To paste it in there, you'll need to have a classic editor as a plugin on your WordPress website.

So I'll have the screenshots and I'll have this whole thing in the transcripts that comes. You guys have a great day.

Thank you very much, Michael, for being on the call. I'll see you all later.

Michael Goodman, MD, FACOG:

Thank you, Charles. I'll join you guys again.

Charles Runels, MD:

Yes, sir.

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Tags

Email communication, personalization, patient outreach, rehabilitation, penile endothelial cell growth, PRP injection, vacuum device, daily Cialis, Trimix, artificial erection, Meta-analysis, systematic review, literature review, female genital self-image, sexual function, Journal of Sexual Medicine, financial considerations, FDA, sports medicine, platelet-rich plasma (PRP), OB-GYN attitudes, O-Shot, body

image, sexuality, female genital plastic surgery, Gemma Sharp, Tiggemann, Tehran, Iran, ethical practice, device applications, vaginal rejuvenation, radio frequency, laser, fat transfer, surgical vs. energy-based procedures, side effects, regenerative therapies, cellular medicines, stem cells, PRP, wound care, biopsies, scar remodeling, neovascularization, collagenesis, dyspareunia, breast cancer, cosmetic genital surgery, adolescent patients, clinicians' attitudes, training programs, Pelosi, Aesthetic Surgery Journal, female genital cosmetic and reconstructive surgery, body image, sexual satisfaction, Cindy Meston, University of Texas in Austin, Yasisca Pujols, Grafenberg's area, vaginally activated orgasm, platelet-rich plasma, growth factors, angiogenic factors, Pierre Foldes, Paris

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[i] Speculation is needed to even begin to do research. No speculation, no postulate in need of testing.