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The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of March 19, 2024, with Charles Runels, MD, and Red Alinsod, MD, FACOG

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

Topics Covered

- **Vampire Marketing**
- **Female Genital Mutilation (FGM) Becomes Legal & How We Can Help the Cut**
- ***Why FGM still happens and is promoted by women more than by men.***
- ***Marketing Emergencies***
- *Red Alinsod's Recommended Female Genital Mutilation (FGM) Reversal Specialists Worldwide*
- **Review of Regenerative Therapies for Erectile Dysfunction**
- **Botulinum toxin for pelvic floor pain does not work?**
- **How Botulinum Toxin relieves migraine (it's not about the muscle)**
- **PRP vs PRF (another look)**
- **Injecting the Bulbospongiosus with botulinum toxin for premature ejaculation**
- **Exercise for Premature Ejaculation**
- **The Schwann Cell Facilitation of the axonal transfer of botulinum toxin--how it could change everything**

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Vampire Marketing

Welcome to the Journal Club. Today, we have what I call a marketing emergency: it means that something is in the news that is worth talking about, but if you wait a week, it will no longer be news, and people are less likely to pay attention to your comments about it. Instead of trying to be big, try to plug into something that is already big and let that carry your ideas.

To name this idea, I've used the term "Judo Marketing," where, as in martial arts, one can use another person's strength against them. Or you can use the term "Vampire Marketing," where the vampire gets her strength from somebody else's blood. But this strategy does not work if you let the news to which you plan to attach your ideas become stale.

So, here's the new, which is very important, relates to what we do, and to which you can attach to let people know how you can help them (market) by using the power of something bigger then your email list—the New York Times.

Female Genital Mutilation (FGM) Becomes Legal & How We Can Help the Cut

The New York Times reported today that the Gambian politicians have decided to reverse their ban on genital mutilation.[1] More than 230 million women currently living are estimated to have suffered genital mutilation according to UNICEF. 2 It's throughout Africa, Egypt, and Somalia, and it's difficult to understand. And, our O-Shot® can help those who have been subjected to it. We have studies to back that up, and some of our providers have been very involved.[2] [3] [4] Their ability to help these women has been solely marketed by word of mouth among the women who have suffered from this problem.

The best explanation I've heard for why it still takes place and is promoted more by women, mothers, and grandmothers for their daughters than men is the following…

Why FGM still happens and is promoted by women more than by men.

The New York Times article mentions part of the reason FGM is still done; they quote a man as saying that without FGM, it can be difficult for the man to keep up with his wife's sex drive. But there is more to the reason. I probably had half a dozen women come through my workshop who underwent genital mutilation—they were there for both treatment and to learn new ways to help other women who have suffered. For very personal reasons, many of the women in our group are very passionate about helping other women. Some of our providers were raped. For some of them, helping women who have been abused, including FGM, is a primary focus of their medical practice. But some of them underwent genital mutilation for their 9th, 10th, or 11th birthday.

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[1] Maclean, "Gambia Moves Toward Overturning Landmark Ban on Female Genital Cutting."

[2] Dardeer et al., "Platelet-Rich Plasma."

[3] Manin et al., "Autologous Platelet-Rich Plasma for Clitoral Reconstruction."

[4] Tognazzo, Berndt, and Abdulcadir, "Autologous Platelet-Rich Plasma in Clitoral Reconstructive Surgery After Female Genital Mutilation/Cutting."

One of our providers who attended my workshop describe her experience like this:

> ***She said, "For my 10th birthday, three of my friends and I lay down in the grass, on our backs, naked. Then a man, with a knife, walked by each girl, and with no anesthesia, and no antiseptic, he cut off each girl's clitoris and her labia minora."***

She was crying as she told the story.

There's not a lot of measuring and bright surgical lights like Dr. Alinsod would do in the OR, it's just done literally with a non-sterile knife, with the girl lying supine in the grass and some variation of the glans cut off and the labia minora depending on who happens to be cutting clitorises that day.

So, why?!

I've never seen what I'm about to tell you described in print. I do not know why. But this is what a physician told me, and a crowd of people at a lecture at a large meeting of physicians who care for women.

> ***She said, "Imagine you're not in a city; you're in a very rural place in Africa. There is no 911 number to call. No policeman is 10 minutes away, and the law is almost like gang rule.***
>
> ***Now, the culture is that all the women undergo some genital mutilation to abide by what's perceived to be religiously and culturally cleaner—and if you do not do this, you are perceived as a slut. Now, as the mother, you decide that your daughter will not undergo this procedure. Because of your decision, because the community knows, your daughter now has a target on her back that says, "Slut."***
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> ***Remember, there's no 911 number to call. There's no policeman with a badge and a gun 10 minutes away. You're in a very rural setting, and your daughter is identified as the one who did not undergo this cleansing, sexual attenuating procedure—very dangerous for your daughter."***

That was the explanation that I heard from the podium for why the mothers and the grandmothers push FGM onto their daughters. It's out of fear.

A law that tries to prevent FGM didn't work. The reason they're reversing the law is that the people who are providing the procedure had some hefty fines and therefore there became a push towards getting the law reversed. Much easier to do than changing a centuries-old culture.

Again, I haven't had genital mutilation. I've talked to women that I've treated who've had it, but to me, that's the best explanation I've heard for understanding why mothers and grandmothers push this onto their daughters, more than do the husbands.

Then they immigrate to our country. They interviewed a woman here that doesn't even realize that what she had; she didn't even know the term genital mutilation or that she was different until she came to the United States.

Now, you're seeing the New York Times article, and I texted a link to it, and before I get into it, this is how to handle one of these marketing emergencies; then I'll get back to the science part.

Marketing Emergencies

If you put out a link to the New York Times Article in an email (that's the simplest way) to your people and say, "Hey, this just came out in the New York Times. This is tragic, and it still goes on, and I have something that might be of help." Add your own stories and understanding of the research.

And then you can put a link to the research side of the O-Shot®, oshot.info/research. PRP was known to help scarring and remodel scar tissue for a decade before we picked it up and started using it in gynecology.

You will get a few calls, and you will help some women who need you.

The person in our group I know who has done, probably, the most on a non-surgical basis to help these ladies who have suffered FGM is Brenda Skaggs, a nurse practitioner who was in Ohio, where there happened to be a lot of Somalian women. By word of mouth, she had a large following there by using our O-Shot® procedure to improve sexual function for women who suffered FGM.

In one of our journal clubs, probably two years ago, she gave in detail how she helped them and how she facilitated the conversations with her patients. Then her patients who were helped spread the word that she could help. Amazing woman. She was the rape exam nurse when she worked in the emergency room; she has a real heart for helping women, and that translated into a very busy practice. Now she's in Florida continuing to help women.[5]

We also have Red Alinsod in our group, who is an expert in offering surgical help to women who have suffered FGM. I see he just showed up on the call.

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[5] For more details about how to use variations of the O-Shot® procedure to help women who suffered female genital mutilation, log into our membership site (https://oshot.info/members/wp-login.php), and type FGM into the search bar; you will find multiple articles. If you are not yet a member of our O-Shot® provider group, you can see apply for training here: https://oshot.info/members

I will unmute his mike in a second so he can tell you about when it might be helpful to take a surgical approach. If you're not a surgeon who does the surgeries around labia and the clitoral hood, etc., how to find someone in our group who is. But I wanted to show you this article.

Okay, so how can you leverage this? If you want to care for these women, they will appreciate you. And one way to leverage this is, as I said, you write a little email with a link to this, you send it out to your people or you put a post on social media and a week from now, this is no longer news, now you're just bringing up a topic. But if you do it within the next week, you are commenting, you're tapping into flow instead of trying to be big, you're tapping into something that is already big, which is the flow of this topic through the New York Times onto social media.

Then there is another way that some of you will not want to do, and some of you will be maybe too hesitant to do, but if you haven't tried this, you may be shocked. Imagine that you are a news person in your city and you have to come up with news every day. That is pretty difficult to do because how many things happen really that are news. Evidence of that is to watch the news and notice how often the news is reporting on the news. It's interesting when you see journalists ... think about the people who got a journalism degree at your university. They might've been the Oxford scholar, but more likely they were playing Frisbee a lot more than you were and yet we are looking to them to tell us how we should think about the events of the world. Often when you watch them, they're interviewing each other, so there will be three news people interviewing each other, or it'll be Fox talking about CNN or CNN talking about Fox. It's difficult to come up with something new to talk about so the news people just talk to each other.

So, help them out!

If you call your local news channel and you say, "May I speak with whoever reports on the health topics and medical topics?"

Then you tell them, "This is out in the New York Times, it's a hot topic now, and I have some things to say about it if you want to interview me."

That is tapping into the flow and doing vampire marketing and it will allow you to connect with some of these women so you can help them. They're not walking around with flags or T-shirts that say, "I've had genital mutilation," they mostly keep it secret. But most likely there's a number of them that live near you that would love for you to help them.

Next, let me unmute Red Alinsod, who as most of you know, he has a group of doctors that he teaches how to operate on the female labia. I'd like for him to comment on female genital mutilation and how to know when you might help the person by referring them to a surgeon versus just injecting with platelet-rich plasma.

Red, are you there?

Red Alinsod, MD, FACOG:

Yeah, I'm here.

Charles Runels, MD:

Wonderful. I know you have an organization where you teach doctors how to deal with some of this. Advise the non-surgeons about when to send someone who has suffered FGM to one of your trainees and any other advice that may be of help to the surgeon or non-surgeon.

Red Alinsod, MD, FACOG:

It's more common than most expect. For example, there is a doctor in San Francisco who specializes in sex change surgery but has a whole clinic where he offers his time for free to manage these patients that fly in from all over the world. Do you remember in 2015 he spoke at our meeting, our CAVS meeting, Marci?

Charles Runels, MD:

Yes.

Red Alinsod, MD, FACOG:

So, in California, there are doctors who are doing it pro bono and helping these patients who have these issues. I've been doing these for 20 years. I do it in my practice, formerly in California. I'm in Dallas, Texas now. We do specialize in this kind of stuff, and I have a network of doctors all around the world who will help with these female genital mutilation cases. The foremost one is my dear friend Amr Saif-Eldin in Cairo Egypt. This is his practice, he not only takes care of FGM cases, he also does cosmetic gynecology, but he is our representative in the WHO. He just went to the meeting a couple months ago at the WHO meeting and the eyes are finally getting open that FGM is something that we can treat, that doctors can learn about.

He was there protecting the interest of cosmetic gynecologists (because the WHO was identifying labiaplasty as female genital mutilation); he was speaking on our behalf. I was so slammed in that meeting a couple years ago, this time, this year I wasn't too attacked. He's a good friend of mine, so I really appreciate him. In London, Dr. Alex Bader takes care of these types of cases. We do have a network of doctors and I probably should get that out there for our general doctors and practitioners who may need a list of experienced doctors. I think your advice to me of getting that list out and easy to find is pretty good advice. I've never done it, it's just been by word of mouth. So I think it's a great idea, Charles.

Charles Runels, MD:

If you put together a list, I'll attach it to the email that goes out to our Cellular Medicine Association members.

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Red Alinsod's Recommended Female Genital Mutilation (FGM) Reversal Specialists Worldwide

1. Red Alinsod, MD Dallas and Las Vegas red@gynflix.com

2. Marci Bowers, MD Burlingame, CA, USA marcibdoc@gmail.com

3. Amr Seifeldine, MD Cairo, Egypt a.seifeldin@gmail.com

4. Joao Jaenisch, MD Porto Allegre, Brazil jaenisch2402@yahoo.com.br

5. Alexander Bader, MD London, UK doctorbader@gmail.com

6. Sejal Ajmera, MD Mumbai, India drsejalajmera@gmail.com

7. Rafal Kuzlik, MD Warsaw, Poland rafal.kuzlik@gmail.com

8. Massimiliano Brambilla, MD Milan, Italy dr@massimilianobrambilla.it

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Red Alinsod, MD, FACOG

Sure thing.

Charles Runels, MD:

I mentioned Brenda Skaggs, who has treated many women by injecting PRP for neurogenesis[6] [7] [8] [9] [10] side—doing our O-Shot® by injecting PRP in the anterior vaginal wall and into the remnant of the clitoris, which as you know, most of it's still there (only the glans is gone). She and other in our group have seen an improvement in function and largely just an improvement in overall feeling of attractiveness and well-being by just doing the things that help by injecting that area with PRP.

But how would the non-surgeon recognize someone, on exam, who might benefit from the corrective surgeries? Talk to us more about what surgeries you would do after we injected with platelet-rich plasma so that we'll know who we just keep in our clinic and who we should refer.

Red Alinsod, MD, FACOG:

The ones that you can refer and perhaps have a chance of having a normal sex life, are those with a palpable little bump where the clitoris should be. If you know the genital anatomy and you look, you can usually see a clitoral bulb. You raise the hood and you can see a clitoral bulb. But if they've had FGM, that's all closed and you may not be able to see a bulb at all.

> ***"But if you're able to palpate a little nub, those are the kinds of patients that we can explore and expose the nerve of the clitoris and create a new skin over it that acts like a bulb of the clitoris and they can be completely fully functional." –Red Alinsod, MD, FACOG***

Charles Runels, MD:

Okay.

Red Alinsod, MD, FACOG:

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

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

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

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

[10] Yasak et al., "Electromyographic and Clinical Investigation of the Effect of Platelet-Rich Plasma on Peripheral Nerve Regeneration in Patients with Diabetes after Surgery for Carpal Tunnel Syndrome."

They have a little bit of clitoris left. If they have something that you can palpate, they have a higher chance of achieving function again. If you can't palpate anything, it could still be there, it's just that you must do more dissection. So if someone's had it completely covered, send them to one of us. If you can feel it, great. If you can't feel it, then it'll just be a more challenging surgery and sometimes we can't find it.

Charles Runels, MD:

All right. I think what you're saying is that it would be like a phimosis of the hood, even though the hood may be gone, but what remnant of the clitoris of there is covered and so your surgical procedure would be to expose that remnant so that it's available for stimulation again?

Red Alinsod, MD, FACOG:

Yes, that's exactly right. This phimosis, we typically see with lichen sclerosis is a very similar surgery. If you have GYN surgeons out there who have done surgery to find a buried clitoris ... I have a lot of these buried clitoris surgical videos on my Gynflix website if anyone wants to see it ... but it's the same surgery, you just have to go know where the incision is. You do the incision and you find that little bulb, whether it's from surgical closure, from the genital mutilation, or from its closure from lichen sclerosus. The procedure is very similar.

Charles Runels, MD:

What's the website, again?

Red Alinsod, MD, FACOG:

Sure. The website that you can find some of these type of buried clitoris surgeries is called Gynflix; it's basically a Netflix for gynecologic surgery. So gynflix.com.

Charles Runels, MD:

Some of you know my wife trained with Red, and her practice has greatly expanded because of the training.

Red Alinsod, MD, FACOG:

Yep. Charles, if you can go to the search tab, Right there. And then you can type in let's say clitoral hood and you'll find all the clitoral hood surgeries there.

Charles Runels, MD:

Okay.

Red Alinsod, MD, FACOG:

This is my 20 year collection of surgeries that I've curated.

Charles Runels, MD:

Yeah, it's shocking the amount of instructional videos you've made. It's really phenomenal. I highly recommend to you guys, if you're surgeons that you check this out. Quite a number of people in our group have trained with Red and it's expanded their ability to help people tremendously.

All right, let's run through the research. I know some of you have heard there's something coming with botulinum toxin. I'll give you more of a preview of what that's going to look like. Let me pull up, I've got I think five papers. The links to all these are in the chat box by the way. All right, thanks for jumping on Red. If you need to go, I understand because I know I just last minute let you know we're talking about this today because I just saw it in the New York Times this morning. But if you want to hang on another 10 minutes and comment, you are definitely welcome.

Red Alinsod, MD, FACOG:

Well, thank you. I'm going to hang on until you're done.

Review of Regenerative Therapies for Erectile Dysfunction

Charles Runels, MD:

Okay, let me change what we're looking at: it's pre-publication, *The Sexual Medicine Reviews, and so I couldn't get to the article,* but I have the abstract.[11] They gave us a nod. They reviewed Shockwave Therapy, Stem Cells, and PRP for erectile dysfunction (our P-Shot® is a specific way of doing that). I can't get to the article yet, but their conclusion was all three therapies work, but they're still not quite ready to push the button and say it's okay to start doing this as the standard of care (unless it were their penis, in which case, I'd bet they would do all three), which isn't unexpected. But at least they're not throwing the idea under the bus. And so another supportive article showing that what we're doing is helping.

But the confusion is that it's not like you're running a race where you can see the finish line.

It's always been a mystery to me: what does it take to make it standard of care? ***What does it take to say, "Okay, you've reached the finish line; now this is standard of care?"***

I don't know, especially for something that's never going to be acknowledged by the FDA, such as PRP. If a drug becomes FDA-approved, there's the finish line. But for something that's not looked at by the

[11] Narasimman et al., "A Primer on the Restorative Therapies for Erectile Dysfunction."

FDA (PRP is not a drug so is not governed by the FDA[12] [13] [14]), I think it just comes down to when does each individual physician decide it's ready to go.

Still, this new article is supportive. It's not even in print yet. I couldn't even get to the online version. It's the March 17th Sexual Medicine Reviews. The link is in the chat box. I try to limit what we talk about here to stuff that either supports what we're doing, so we feel more confident about it, or gives us another practical way to think about it, or another way to communicate to our patients that we know what we're talking about. So, this would be a nice article to share with your patients if you're doing the P-Shot® or Shockwave Therapy.

Botulinum toxin for pelvic floor pain does not work?

This article reviewed botulinum toxin for pelvic floor pain, and they decided that it doesn't work.[15] They did a systemic review and a meta-analysis and decided by looking at the placebo studies, when you factor that in, it didn't work that well.

If you look at the sports medicine literature, you will see studies demonstrating cells within the muscle that function like stem cells.[16] [17] [18] In the sports medicine literature, when you inject injured muscle with platelet-rich plasma (PRP), you see regeneration, less scarring, and pain recovery, which is done with every NFL football player's thigh muscle.

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[12] Beitzel et al., "US Definitions, Current Use, and FDA Stance on Use of Platelet-Rich Plasma in Sports Medicine."

[13] "Regulatory Considerations for Human Cells, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous Use; Guidance for Industry and Food and Drug Administration Staff,."

[14] Darrow, "Explaining the Absence of Surgical Procedure Regulation."

[15] Knapman et al., "Botulinum Toxin for the Management of Pelvic Floor Tension Myalgia and Persistent Pelvic Pain."

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

[17] Bernuzzi et al., "Use of Platelet-Rich Plasma in the Care of Sports Injuries."

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

I like to remind women that NFL football players' muscles are getting better care than mama's pelvic floor muscles in most doctors' offices.

Any comment on that, Red?

Red Alinsod, MD, FACOG:

Well, I think if you just rely on botulinum toxin for pelvic floor injury, it probably won't help long-term. In my practice, I combine the injection of botulinum toxin with pelvic floor physical therapy. Once you reduce the pain and they're able to tolerate pelvic floor physical therapy, I think that's the long-term benefit of it. But if you're just injecting botulinum toxin to reduce muscle tension and avoid pelvic floor physical therapy, it's not that helpful.

What you have to do is defeat the cycle of pain that goes from the brain to the pelvis and cut that signal off and botulinum toxin. Usually. I take them to the OR because I can't even touch them, they're jumping off the table. When they're asleep, I'll inject Exparel, that's a long-acting bupivacaine coated in fat.

That gives them about three days' worth of relief and at the same time I'll give their botulinum toxin (BoNT), because the BoNT doesn't work right away. Typically, the first time you get it to work is about three days later. So right when the Exparel is wearing off, the BoNT is starting to work, and it breaks that pain cycle, and now they're able to be examined, and now they're able to get pelvic floor physical therapy. If you combine it, I think it works. If you rely on BoNT, I don't think it's going to work for you long-term.

Charles Runels, MD:

So the BoNT must be part of a multifactorial treatment. I get a lot of anecdotal calls from our group confirming that if you can find a specific trigger point and inject it with PRP, then it'll get worse for a week, and then it either gets better and you repeat it, or it goes away. So, it might be a third thing to add in.

Red Alinsod, MD, FACOG:

Yes, we typically inject PRP near the pudendal nerve now with a spinal needle. It's easy to do if you know your anatomy in the pelvis.

How Botulinum Toxin relieves migraine (it's not about the muscle)

Charles Runels, MD:

Interesting. Okay, let's do the next paper.[19] This one relates to a study we have coming out soon regarding female sexual dysfunction and botulinum toxin. These days I'm mostly using Xeomin for a variety of reasons, but this is the picture that opened up the universe to me in researching my textbook for cosmetic use of botulinum toxin. I added a chapter on migraine, and in trying to understand how it helps migraine, I learned how BoNT can affect the autonomic nervous system.

If you look at this picture (see the paper[20] or the video), you will see that it's no longer thought that the botulinum toxin (BoNT) relieves the pain of migraine by relaxing the muscles. What's thought to happen is that BoNT is taken up by endocytosis, travels along the axon to the trigeminal ganglion and then to the caudate nucleus, trigeminal nucleus caudalis, which runs along with the afferents from the pain fibers from the meninges. You see this question mark here where they have a line drawn from one ganglion to the other; it's thought that somehow there's cross-communication by changing the neurotransmitters at the ganglion.

Even though you're injecting the procerus, you're affecting pain signals from the meninges and you're also changing parasympathetic and sympathetic tone.

So if you get right down to it, what you're doing is you're using the procerus as a port to inject the caudate nucleus.

That idea that you could affect the ganglion by injecting somatically, that you might affect the parasympathetic nervous system by injecting superficially, is what led to what we're hopefully rolling out this month. I don't want to get too far into it because I want to do a rollout that creates buzz so that we can get some press, which will get some attention to our group and our procedures so that we can connect with people in a way and help more people versus just see the idea fizzle it out. It's like turning on the water hose after the pressure builds up. I'm going to put some stuff online so that, hopefully, by the last day of March, we can tip the dominoes and just have an explosion of new attention to the group. All boats go up because, as you notice, every time the press talks about one of our procedures, they'll talk about the others.

I'll be communicating with you guys by email. If you're reading my emails, you won't be surprised by seeing an article in one of the online news venues before you've had a chance to put some things in line. But that's the functionality that gave rise to some of the stuff we're going to be doing.

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[19] Ramachandran and Yaksh, "Therapeutic Use of Botulinum Toxin in Migraine."

[20] Ramachandran and Yaksh.

PRP vs PRF (another look)

This one I put up here because I get a lot of questions about PRF versus PRP.

This is a very recent article.[21]

It's from the Periodontist, and they go over all the different PRP, PRF, and PRFM in different ways. I wanted to show you this is one thing because it's almost like saying, do you like a Ford or a Chevrolet? Are you a Lamborghini guy or are you a Volvo guy? When you get right down to it because people want to argue sometimes because they have their favorites. I know I'm biased, I have my favorites, but ***when you get right down to it after studying this, they admit no one really knows what works the best.***

They make another plea for people to document exactly what they did so we can get to more apples to apple studies.

But the other thing is that ***if you're a Periodontist or you're trying to fill in a wound of some type, the PRF is a better choice. But when you're trying to inject through a 30 gauge needle into the clitoris, maybe not as good.***

I had an email from a patient, a patient, not a provider, a patient complaining that someone was trying to use PRF to do a P-Shot® and they weren't able to get it all in because it was clotted, so they brought them back and did it again, and they only got half of it in.

The other thing is, I don't know if you've seen this Red, but you teach somebody something and they go back and before they do it one time, they change it six ways from breakfast and they think they got a better way figured out before they get home. Maybe they do, but I've always wanted to try what was taught to me until I see that it works and then alter it. Bottom line is we now have a decade of knowing that PRP is working in the O-Shot®, if you activate it in the P-Shot®. PRF, not so much history. At this point I would say if you're using PRF and it's working, go for it. But if it's not working or if something goes wrong, I can't really say that's the P-Shot®. Any comments on PRF versus PRP, Red, if you had experience or from your providers that you've trained?

Red Alinsod, MD, FACOG:

No one has really tried PRF use much in the ones I've trained. We have used it if we wanted a little, for example, bulking in the mid urethra for stress incontinence reasons. But the PRP that you have taught us is working well and I haven't changed it.

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[21] Calciolari et al., "Differences between First- and Second-generation Autologous Platelet Concentrates."

Injecting the Bulbospongiosus with botulinum toxin for premature ejaculation

Charles Runels, MD:

All right, couple other articles. This one, injecting the bulbospongiosus with BoNT to help with premature ejaculation, which makes sense of course, because the muscle is helpful for ejaculation.[22] The bottom line is it didn't work.

A fun question I like to ask to my gynecologist buddies, Red, is what exactly is the bulbospongiosus doing in women? I guess it helps with congestion of the clitoris, but I don't think there are any extra parts in the body.

Red Alinsod, MD, FACOG:

I think it just gets engorged. I'm not exactly sure.

Charles Runels, MD:

It's a fun question to ask when you're having lunch with your gynecology buddies because unless you're assuming there are extra parts, then the questions needs a good answer. In the male, of course, you can see what it would do.

Red Alinsod, MD, FACOG:

An interesting thing is, for example, we have women patients who've been on steroids and testosterone, and they have very large clitorises, and they want it reduced. One of the main surgeries that are spoken about is to remove the spongiosus tissue below it, leave the nerve bundle intact, and then after you remove the spongiosus, you put the clitoral bulb next to whatever's left over of the spongiosus and you reduce the length of the clitoris, you bundle up the nerves and the vessels, but it reduces the appearance of it. That's the standard repair for a clitoris that's too big

Charles Runels, MD:

Interesting. I didn't know that was an option!

[22] Almekaty et al., "Effect of Bulbospongiosus Muscle Injection with Botulinum-A Toxin for Treatment of Lifelong Premature Ejaculation; a Randomized Controlled Trial."

Exercise for Premature Ejaculation

Okay, two more quick ones. This is a review article, but one of many studies on the topic.[23] One of the questions I get from our providers often is, the man can get an erection, but it goes away while he's having sex. He wakes up, he's got morning tumescence, but then he's having sex, and it goes away.

My theory is that the oxygen required to have reasonable sex is about walking upstairs, from what I've read. So, I've always coached men to walk upstairs, and however long they can go before becoming dyspneic (their anaerobic threshold), that's about how long they're good in the bedroom. The bottom line is if you increase your VO2 max or your aerobic capacity, you can last longer in bed, and you're less likely to have premature ejaculation.[24] [25]

The Schwann Cell Facilitation of the axonal transfer of botulinum toxin--how it could change everything

I have one more paper.[26] This is another paper that relates to what we're rolling out this month. I wanted to show you this one picture, and then we'll quit talking and call it a today. They took botulinum toxin, and they took Schwann cells in vitro. Botulinum toxin caused increased proliferation of the Schwann cells, and the mechanism is thought to be that when acetylcholine goes down, Schwann cells multiply more. This was in mice; they injected where the whiskers were, tagged the botulinum toxin, and measured its travel along the axon, documenting that it did travel.

This is an older study. This came out in 2012, so it came out 11 years ago. This idea of botulinum toxin migrating was one of those landmark studies; botulinum toxin migrating along the axon hasn't been recognized for that long. The idea opens new therapeutic strategies that may be yet to be explored. We're going to start exploring them.

Anything else, Red, and then let's call it a day?

Red Alinsod, MD, FACOG:

No, nothing else for me.

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[23] Niu and Santtila, "Effects of Physical Exercise Interventions on Ejaculation Control."

[24] Cooper et al., "Behavioral Therapies for Management of Premature Ejaculation: A Systematic Review."

[25] Khera, Bhattacharyya, and Miller, "Effect of Aerobic Exercise on Erectile Function."

[26] Marinelli et al., "The Analgesic Effect on Neuropathic Pain of Retrogradely Transported Botulinum Neurotoxin A Involves Schwann Cells and Astrocytes."

Charles Runels, MD:

Thank you very much for jumping on the call, Red. Send me the list, and I'll make sure that when I send out the email and, on the website, there's a link to your list and a link to your website. Thank you very much. You guys have a great day.

Red Alinsod, MD, FACOG:

Thank you, Charles. Bye-Bye.

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Tags

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