JCPM2024.05.21

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of May 21, 2024, with Charles Runels, MD.

>-> The video of this live journal club can be seen here <-<

Topics Covered

- Persistent genital arousal disorder and the Clitoxin® procedure
- **Spinal Cord Infarction from Viagra**
- **Why You Are Unethical if You Do Not Market What You Know**
- **Does Persistent Genital Arousal Disorder (PGAD) Occur After the O-Shot® and Clitoxin® Procedures?**
- **HIV and the Vampire Facial®--an Update**
- **Quick Marketing Tricks Using ChatGPT**
- **If You Offer the O-Shot®, Do Not Miss this Opportunity**
- **References**
- **Helpful Links**

Charles Runels, MD
Author, researcher, and inventor of the Vampire Facelift®, Orchid Shot® (O-Shot®), Priapus Shot® (P-Shot®), Priapus Toxin®, Vampire Breast Lift®, and Vampire Wing Lift®, & Clitoxin® procedures.

Transcript

Welcome to the Journal Club. We're going to talk about the treatment of persistent genital arousal disorder (and how it relates to our Clitoxin® procedure), then a quick review of the latest press regarding HIV and the Vampire Facial®. And then, I have a tip for you regarding one way of using artificial intelligence in your marketing. There are some places where it works wonderfully well and others where it doesn't.

Persistent Genital Arousal Disorder and the Clitoxin® Procedure

There was a smart question sent to me about this study where botulinum neurotoxin (BoNT) injections near the clitoris (not into the clitoris, but near the clitoris) were used as a treatment for persistent genital arousal disorder.[1]

That paper brings up the following question: if BoNT is used to treat persistent genital arousal disorder (*decrease arousal*), then what causes BoNT to help *increase arousal* and orgasm in our Clitoxin® procedure?

We'll look at the paper, but I wanted to enlarge these pictures from the paper for you since they do not show up well on it.

If you expand it to where this photograph is as large as you can make it, you'll see that the injections are *near* the clitoris, *not into* the clitoris. The idea of the procedure is to interfere with pain receptors regarding persistent genital arousal disorder.

So, this research targets *somatic nerves*, not the *autonomic* nervous system. In contrast, when we do the Clitoxin® procedure and inject directly in the corpus cavernosum, we think what's happening is that it's hydrodissecting into the body of the clitoris following the corpus cavernosum, and then migrating along

[1] Nazik et al., "A New Medical Treatment With Botulinum Toxin in Persistent Genital Arousal Disorder."

the autonomic nerves, the cavernous nerves, into the inferior hypogastric plexus and the ganglion lining the wall of the vagina.

Injecting near the clitoris would not do that—there would be no migration to those same ganglia.

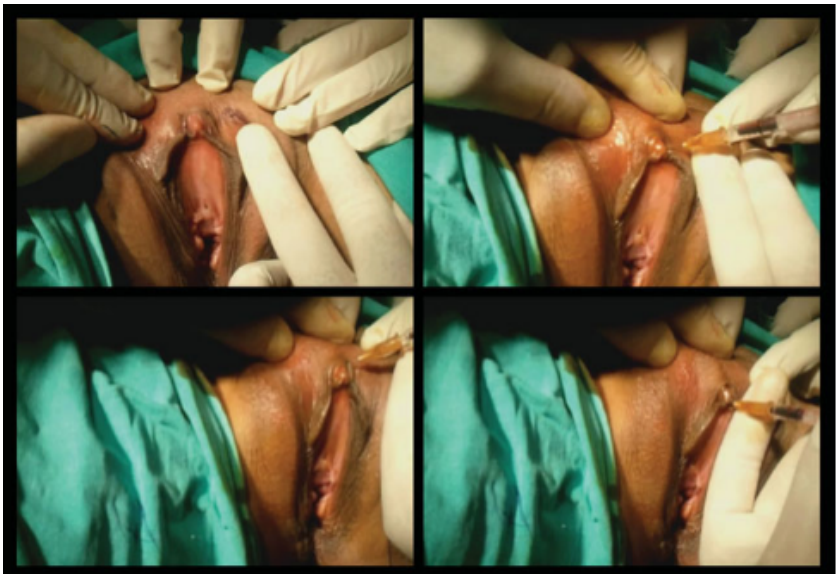


Figure 1. The injection of botulinum toxin near the clitoris affects the somatic nervous system for the treatment of persistent genital arousal disorder.

When thinking about female sexual function, it helps to remember that all the same parts are there in both sexes. You have the glans clitoris, the glans of the penis; you've got the foreskin and the clitoral hood; you have the prostate and the periurethral (Skene's) glands.

There's an analogous part in both males and females for every part.

So, to understand this recent research, consider the treatment of male sexual dysfunction. We have me dications (like Caverjet and Trimix) that, when injected into the corpus cavernosum, will cause an erection. We have multiple FDA-approved medications for injecting the penis, but we have no FDA-approved medications for injecting the clitoris.

Thinking about the man (to understand women), if you injected Caverjet or Trimix near the penis but not into the penis, there would be no erection. It is not the same to inject into the penis as to inject near the penis.

For another example: look in Figure 1 at the space directly posterior to the urethra, but anterior to the vaginal opening; that is in heart's line and is very, very sensitive to pain and touch. But as soon as you move just a few millimeters to the other side of the hymenal remnant and within the vagina, there's almost no sensation to touch and pain.

The pleasure that happens with sex has more to do with pressure on the structures anterior to the vagina, stretch, and pressure on the urethra and the hidden parts of the clitoris, but the actual tissue, the surface tissue within heart's line and outside the vagina is innervated a different way.

So, one reason that there is a difference in response to injecting near the clitoris instead of into the clitoris is that different nerves are being affected. But now that you've seen the picture, let's look at the

methods and outcomes after injecting BoNT near the clitoris (Nazik, 2014).[2] I cannot find another paper that talks about treating persistent genital arousal disorder with botulinum toxin except in reference to this paper (which came out 10 years ago).

Dr. Nazik starts by defining persistent genital arousal disorder, which is worth deep consideration, even though most of us will come across only maybe one or two people suffering from this in a career unless you're in a tertiary center or being referred to as if you were. But there is much to learn from the disease, so let's look at the criterion first described in 2001:

(1) obviously, it must be "persistent" to count as "persistent" genital arousal. But for how long?

Symptoms must persist for "hours, days, or months."

That seems vague to me. If it only persisted for hours, you might think it would be fun, but not so because look at the rest of the definition…

(2) It does not go away after one or more orgasms.

(3) And (here is the main differentiating factor), it's ***unrelated to subjective feelings of sexual desire***.

So, with hypersexuality, there's true arousal and desire for sexual intercourse. But, with persistent genital arousal disorder, it feels intrusive and unwanted, hence the last criterion:

(4) It causes distress.

Women and men who suffer from persistent genital arousal disorder have a higher incidence of suicide than people with chronic pain because it's so distressing, uncomfortable, and intrusive.

So there is the need for orgasm, but you have an orgasm, and there is no relief. So, it's very distressing. That's the differentiating factor.

Because of that, it's been compared with vulvodynia or even something like restless leg syndrome or *restless genitalia syndrome*.[3] [4] [5] So, it's gone by different names. The etiologies are thought to include psychogenic; but, in some cases, a type of cyst happens in the spinal cord that can be treated with surgery for complete relief. You really come across as a hero when you find one of those.

---

[2] Nazik et al.

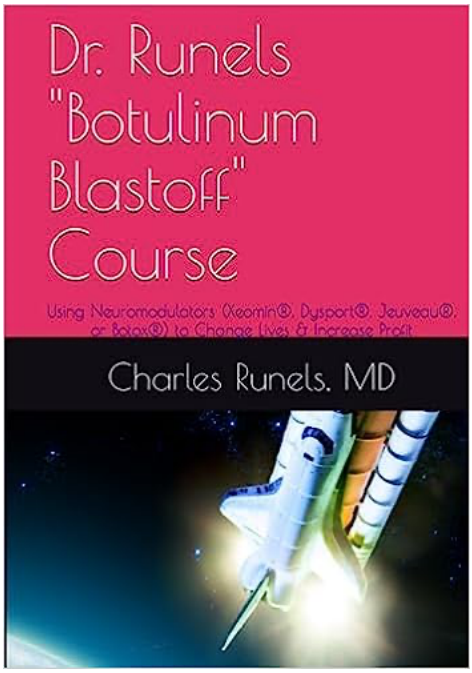
[3] Aswath et al., "Persistent Genital Arousal Disorder."

[4] Cohen, "Diagnosis and Treatment of Persistent Genital Arousal Disorder."

[5] Jackowich et al., "Persistent Genital Arousal Disorder."

If you look at their methods,[6] they took 100 units of BoNT (Cosmetic Botox) and then diluted it with 2.5 milliliters of saline, the amount discussed in the package insert with that brand of botulinum toxin.

Then, they injected 5 mm from the center of the clitoris (around the clitoris) at 1, 5, 7, and 11 o'clock positions, only two units per injection for a total of eight units. When I teach cosmetic botulinum toxin, I recommend you put only one cc as the diluent so you have less spread.[7] So, the study uses shooting with a shotgun rather than a rifle (much spread around the tissue) and a total of only eight units.



Results: there was some relief (though not complete), and at eight months, it started to come back, but then it felt more bearable, so they canceled the treatment. In the discussion, they talked about affecting the dorsal nerve. They treated ***two*** people, and both seemed to get better.

So, the main things that differentiate this from what we're doing when we do the Clitoxin® procedure are as follows:

(1) They injected near the clitoris; we injected into the clitoris.
(2) Their strategy was to target the somatic nervous system, hence they're not injecting the clitoris. We intended to affect the autonomic nervous system.
(3) They injected eight units, whereas when we injected Clitoxin®, we injected 50 units.[8] I cannot find another study where botulinum toxin has been used to treat persistent genital arousal disorder.

I also included this review article in your handout.[9] It's a nice review article about botulinum toxin for various female sex problems. And you can see its scope is entirely targeting the somatic nervous system:

---

[6] Nazik et al., "A New Medical Treatment With Botulinum Toxin in Persistent Genital Arousal Disorder."

[7] Runels, *Dr. Runels "Botulinum Blastoff" Course: Using Neuromodulators (Xeomin®, Dysport®, Jeuveau®, or Botox®) to Change Lives & Increase Profit.*

[8] Runels and Runnels, "The Clitoral Injection of IncobotulinumtoxinA for the Improvement of Arousal, Orgasm & Sexual Satisfaction- A Specific Method and the Effects on Women."

[9] Dick et al., "Application of Botulinum Neurotoxin in Female Sexual and Genitourinary Dysfunction."

persistent genital arousal disorder, vestibulodynia, vaginismus, dyspareunia, all those having to do with the somatic nervous system.

IMPORTANT: You know there are going to be critics of everything and anything new. So it is very important to pick up the shield that they hand you with their discussion of using botulinum toxin for persistent genital arousal disorder: they say, "Owing to the disruptive nature of this disorder and the fledging state of clinical understanding, it's reasonable to offer the therapy as one of many potential options for persistent genital arousal disorder treatment."[10]

"Owing to the disruptive nature of this disorder and the fledging state of clinical understanding, it's reasonable to offer the therapy [BoNT injections] as one of many potential options for persistent genital arousal disorder treatment."

That same reasoning could be applied to much of what we do with our regenerative procedures:

"Since none of the current FDA-approved treatments for male and female sexual dysfunction improve the degenerative changes that account for the etiologies of dysfunction, 'it's reasonable to offer' potentially etiology-reversing cellular therapies."

We do not even have an FDA-approved testosterone for women. Of the three drugs that are approved for women to help with sex, two are psychiatric drugs (no effect on the genitalia), and the remaining drug (topical DHEA) is not indicated for orgasm (and I think it is just a weak way of providing testosterone with the conversion of DHEA to testosterone).

You could, I think, make the same statement (as we do) with our Clitoxin® procedure (since options are few, it's reasonable to offer this option to suffering women). It's for the same medication, botulinum toxin, and it's in Sexual Medicine Reviews, a high-impact, respected journal.

So, the shield they hand you: if someone said, "No, we don't think you should be injecting the clitoris with botulinum toxin," you could quote this paper back to them: "Because of the incredible disruptive nature of anorgasmia, and the fact that we have ***not one*** FDA-approved treatment for it, then (considering the results of our study[11] and the implied mechanism of action), it seems reasonable to offer botulinum toxin therapy as a treatment."

[10] Dick et al.

[11] Runels and Runnels, "The Clitoral Injection of IncobotulinumtoxinA for the Improvement of Arousal, Orgasm & Sexual Satisfaction- A Specific Method and the Effects on Women."

But in our case, we're targeting the autonomic nervous system, not the somatic one.

So, these are the main studies that I found digging into persistent genital arousal disorder. That gives you a nice survey of the various treatments for persistent genital arousal disorder. And you'll find that it goes away, as you might expect, sometimes, no matter what you do. And in one of these review papers, the same treatment, marijuana, in one case treated it and, in another case, caused it. So, the point I'm making is it's a very complex, very poorly understood disorder.

There are no placebo-controlled studies of the treatment of persistent genital arousal disorder.

None.

So, should we not treat it?

There are no placebo-controlled studies of the treatment of persistent genital arousal disorder.

None.

Some would say that without a double-blind, placebo-controlled study, we have no treatment available. But I would not say that to a person suffering from persistent arousal disorder while holding in my hand much research showing possible benefits from multiple therapies.

All worth noting when the arrows come our way about cellular therapies.

An important point about placebo studies: Some people think pelvic floor problems are similar and that vulvodynia problems are similar in mechanism to persistent genital arousal disorder, and so are worth thinking about to try to figure out the treatment for persistent genital arousal. This is from the American College of Obstetricians and Gynecologists. This is a high-impact systematic review, a high-impact journal about using botulinum toxin in the pelvis. But notice this: although this may reflect a placebo effect, there are several confounders in existing randomized control studies that make these difficult to interpret because first, all clinicians assess measures to determine myalgia or tone involve internal manipulation, ***both the treatment and control, which can mimic a treatment. Second, they can involve needle insertion and physical examination, which is a documented intervention for muscle spasticity***.[12]

So, none of the existing randomized control studies use a true placebo control, which is the same argument, that I make that you can't do a randomized control study of PRP because if you use saline,

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

hydrodissection with saline is not a placebo.[13] It's used to treat scarring,[14] [15] leishmaniasis,[16] and joint problems[17], so it's not a placebo.

So, I thought it was beautiful to have someone else call out the fact that sometimes placebo studies are not using placebos, which makes the results bunk.

I can put this link in there, too, because even though it concerns pelvic pain, it discusses botulinum toxin. If you're going to do the Clitoxin® procedure, you should know what you're injecting and that placebo studies can be impossible. Unless you've been doing bladder treatments or cosmetic studies with BoNT, reading about what you're doing is helpful.

Spinal Cord Infarction from Viagra

Our group is involved with cosmetic work and sexual work, which to me is the same thing, particularly as it involves cellular therapies. I look for studies for our journal club that might change the way we practice medicine, encourage us to do what we are doing with no changes, or alert us to potential disasters that we can avoid.

So, this study caught my eye. I've never seen this before. I think this is the first time it's been reported. But the idea was that if you get an infarction of the spinal cord, it's usually from profound hypotension, and it's thought that this 65-year-old man who was taking a hundred milligrams of Viagra three times a day, not from a doctor, has a documented infarction of his spinal cord, and it was thought to be from an episode of hypotension triggered by his Viagra.[18]

I think most of the people on this call can remember when you used to risk going to prison if you practiced telemedicine, writing prescriptions for Viagra after only a telephone call. It was thought that you cannot be someone's doctor unless you see them in person and do an actual physical exam; and now what would send you to jail has become a whole new specialty (telephone medicine). It's amazing

---

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

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

[15] Bagherani and R Smoller, "Introduction of a Novel Therapeutic Option for Atrophic Acne Scars."

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

[17] Saltzman et al., "The Therapeutic Effect of Intra-Articular Normal Saline Injections for Knee Osteoarthritis."

[18] Gholami, Fard, and Poursadeghfard, "Sildenafil-Induced Spinal Cord Infarction."

how much COVID and time has changed things. But this used to be a prison sentence when doctors made money filling Viagra prescriptions by online and telephone medicine.

But yeah, bad things happen when people buy medicine and self-prescribe.

So, what can you do with this research?

Why You Are Unethical If You Do Not Market What You Know

Marketing is a way to educate your patients in new and better ways to be healthy or motivate them to do what they already know to do. If that is how you think of marketing, then you're obligated to do that in the most effective way possible. If that marketing/educating is sitting in your office talking to people one at a time as in 1980, then so be it. But if you have a free tool that allows you to talk to all of your patients at once with an email newsletter or occasional post or whatever social media account that you can swallow and not vomit, then that's what you should do, in my opinion. I think you're morally obligated to do that to help your patients. To your patients, you're more reliable than the Mayo Clinic newsletter because they trust and know you. They want you to show them what's right.

So here's something you could show them: You can send an email with a link to that research[19] and say, "Hey, this is just a warning to let you know that it can be dangerous to take medicines even though they seem safe when you receive them from someone other than a physician. There's a reason they're considered prescriptions," and then you've warned them.

So that's something you could send out, and it is news because, you see, it came out in February of 2024, and that's the first time a spinal cord stroke has been reported as a side effect of Viagra.

But who knows how many people had strokes that just were labeled as a stroke because they bought a big bottle of Viagra online?

There's no way to know the answer to that.

When it comes through the mail, Grandpa's not going to put it out on the coffee table; he's got it stashed somewhere, and he takes a few extra ones, and he has a stroke, and everybody thinks he just had a stroke.

So, this is worth letting people know, and it stood out this week.

[19] Gholami, Fard, and Poursadeghfard.

Does Persistent Genital Arousal Disorder (PGAD) Occur After the O-Shot® and Clitoxin® Procedures

I would be very fearful of using long-acting botulinum toxin to do a Clitoxin® procedure or our Priapus Toxin® procedure (at least on the first treatment) because what's bad for a short time is also bad for a long time. When the studies were done injecting the penis with botulinum toxin, there were no cases of priapism, and so far, we've had no cases in our group, and quite a bit of it's being done now.

With our O-Shot® procedure, I've lost track of the cases that I've personally seen where someone ***enjoyed*** *hypersexuality* (meaning there is desire and pleasure associated with the increased need for orgasm, not lack of desire and distress as in PGAD) for anywhere from a few days to a week or two, but it doesn't turn into persistent genital arousal disorder that I know about except for one case. I had one case of a woman who called crying the day after her O-Shot® and said that she couldn't stop masturbating and was considering some immoral activities with her next-door neighbor because she just couldn't get relief, and it was distressing her. Thankfully, it went away after a couple of days, and she just had a great, amazing outcome, and great sex went to amazing sex. But I only know of one case of many thousands of O-Shots®. It could happen with our Clitoxin® procedure, and it's on our consent form for that reason.

Okay, let's swap over to the HIV and the Vampire Facial®.

HIV and the Vampire Facial®--an Update

Wetstone et al. published a paper in Dermatology[20] discussing the incidence of HIV in people who went to a hair salon falsely advertising the Vampire Facial® when they were, in fact, doing something that was not a Vampire Facial® and very dangerous. We have talked about it in our Journal Club several times now.

When we do a Vampire Facial®, we use FDA-approved devices and centrifuges, and we have the license, and we do things the right. It's their own blood (autologous) and everything's kept sterile, but something bad happened, and as you guys know, this was back in 2019, two women got HIV from the same spa. A man then caught it from one of those women. Then a third and a fourth woman was identified recently by the CDC, all from the same spa.[21]

Thankfully the owners of that spa are in prison.

---

[20] Wetstone and Grant-Kels, "Microneedling Facial Gone Wrong."

[21] "Don't Fear the Vampire Facial. Just Keep It Safe."

When this sort of thing happens (a bad outcome from someone falsely advertising), our business usually goes up because it teaches people that, "Hey, you should go to the people who are legally advertising it." That's our group, and we have protocols.

And as part of the paper, it looks like they're trying to start their group to call it some spa safety thing, and I think they have 20 members or something in it. So, we have over 2,500 members in our group (the Cellular Medicine Association, CMA). But their heart is in the right place, except that they're saying that only dermatologists and plastic surgeons should be doing microneedling, even though of course when you get there, it will probably be an RN working for the dermatologist who does the procedure. But this is not a bad thing. It is a good thing that people are talking about this. There's a need for protocols. And that's exactly the main reason our group exists.

To remind you guys that, if you haven't looked at it yet, I got an article into Medscape that talked about the purpose of our group and how it helps protect people from these bad outcomes.[22]

It explains a service mark and how it differentiates us from people who may not know what we know. It has links to our group and to research about different good things you can do with microneedling: scars, keloid, alopecia, striae, and in addition to anti-aging effects.

So, it's all there and makes a good strong case for why we exist. You may want to shoot a link to that to your people and let them know that you're one of the ones doing it right.

To show you another reason why, or another example of why we exist, there was an article in JAMA that was slandering people who do PRP injections for ED. But they lumped us together with everybody else and said that we don't have protocols. So, when I pointed out that we have protocols and licensing restricting who can advertise our procedure, they printed this correction to their paper.[23]

So, it puts us in a different class in all our procedures. I think people are finally starting to realize what the people in our group realized 14 years ago when we started the group, which is that there needs to be a group overseeing protocols and providing some documented way for potential patients to know who has agreed to follow those protocols. And that's easy to do if it's a hysterectomy because you find someone who's a gynecologist. But if it's something across all specialties, like PRP or botulinum toxin, and none of those specialties govern it, then there's a need for what we do.

So that's another example of it. Let me give you a link to this one, too. I don't know exactly how you'd use this in marketing unless someone challenged your P-Shot®, but seeing what we do is useful.

---

[22] "Don't Fear the Vampire Facial. Just Keep It Safe."

[23] "Errors in Text."

When you report someone not in our group, we average 1.6 social media accounts and websites that we take down per business day. In other words, we took down around 500 websites and social media accounts in 2023. But if you happen to report someone whose website is hosted by an internet service provider in a country that doesn't pay attention to intellectual property law, then it becomes more difficult and may take longer. We use our attorney at a big firm in Chicago and Brandshield.com (which is international) to police our marks.

So if you've reported someone and they haven't gone away, let us know because those people will have to see us in court, and it'll take a while, but I don't have a way to make the law go faster. But most of them are gone within a few days to a few weeks, and they're punished by losing their whole website or social media account. But some take longer, and if you see that happening, let me know so we can see and talk about ways to make that up to you.

Oh, another thing I wanted to mention about the HIV and Vampire Facial® drama is that we were in the National Enquirer magazine last week. Believe it or not, they had a picture of me teaching a class and discussing the need to see one of us in our group to get a Vampire Facial®.

And this week, I'm in National Enquirer again, the May 27 issue, talking about Ben Affleck's face. And when I do that, I hope it brings more attention to our group and you guys; every time I'm in the media, I refer, without a doubt, at least 5 to 10 of our people to be in the media. But now and then, they call me up, and I'll say yes, and I'm about to show you some other ways to make that happen. But the main way is to tell your staff you want to be brought to the phone immediately if the press calls. I go on and on to those two cases of *National Enquirer*, *Rolling Stone, Cosmo* several times, and *The New York Times*. Very few of those articles would've happened (at least $100 million in free advertising) had I not gotten on the phone immediately.

Usually, the reporters are working with deadlines that could be anywhere from a few hours to a few minutes long, and if you wait till the next day to return their call, you miss the opportunity for both teaching potential patients how to be well and millions of dollars into the advertising. And that is exactly what happened with this paper. In Medscape, had I not quickly answered my cell phone and been willing to deal it, write the article, get it done, accept any edits, and back and forth it and make it the top priority for a few days, it would've never happened.

Quick Marketing Tricks Using ChatGPT

Now, a quick marketing trick I haven't shown you before has to do with ChatGPT. Someone did a study where they looked to see how to use chat as a tool for doing medical research.[24] They discovered exactly what I discovered. I will show you how I use it, but it's not good for researching a topic. And

[24] Gwon et al., "The Use of Generative AI for Scientific Literature Searches for Systematic Reviews."

that's what they found: just a person going into PubMed or looking something up on Google does tremendously better than asking ChatGPT.

Make a Summary

I sometimes use the ChatGPT to summarize things. You upload the article and then copy and paste the summary. This is where it's good.

I'll tell you two more things I use it for, and I promise I'll stop.

Make a Web Page or an Email by Pushing One Button

Let's say you're going to make your web page about the Vampire Facelift®. You could go to somebody else's page and then copy that into a document.

Then go to ChatGPT and say, "Summarize the following."

Then, take the summary and edit it, and you have unique written content for your web page or email.

I could say, "Now turn that summary into an email that promotes Vampire Facial® for melasma."

There you go. It just wrote you a marketing email!

Is that not crazy?

Then you can edit that to sound like you, add your name to it, and send it out. There you go. It's crazy. That is amazing.

So that's how you can take something from one of our Journal Clubs, including this one. You could take a research paper, summarize it, or turn it into an email.

Now, what about some pictures?

Make an Illustration

Now, if I take that last summary, go to the SketchWow app, and post it right there, I can say, "Make a visual summary or make an infographic of that."

This is called SketchWow, which is all one word, and they have an AI version.

There you go! (see video)

So now, use whichever infographic suits your taste; you can save it to your computer. And there you go. We could do the same thing with a visual summary and do that same thing. So, they have a number of

templates. So that just showed you how to take any information and turn it into a website, an email, or an illustration.

You can take the website, edit it, summarize it, and make pictures. In about 10 minutes, you can create astounding information for your website. I teach techniques like this monthly during my hands-on workshops, and I try to include useful marketing tips every time we do this Journal Club. So, I hope that helped.

If You Offer the O-Shot®, Do Not Miss this Opportunity

If you look at our O-Shot® directory, you will see that we now have a Clitoxin® icon. If you're an O-Shot® provider, it costs no money to have that icon.

Someone from Oklahoma emailed us this week, and we receive these emails regularly. She wanted to know where to get the Clitoxin® procedure.

We have multiple O-Shot® providers in Oklahoma, but no one has yet done the test to document understanding of Clitoxin®, so this woman will leave the state for her procedure elsewhere.

If you're an O-Shot® provider, it costs you no money. Just log in to the O-Shot® membership site, click on that link on the dashboard, watch the video, and then send us the answers to the short test that comes afterward. And then those are the questions. That video shows you how to do it; it's 30 minutes long. And then you watch that and send us the answers. People are looking for this now. And if they go on here and don't see that Clitoxin® icon by your name, they won't call you. So do that if you're an O-Shot® provider; it costs you nothing.

If you're not an O-Shot® provider, this is going crazy, and it works. If you haven't seen the paper, it's in the handouts.[25]

Or you can visit clitoxin.com and look at the video and the research. But this is going to be big by the end of the year. So go ahead and take the test to have that icon, and you'll start getting phone calls. It's easy if you know how to do an O-Shot® —it's easy. And we're not letting anybody else offer it unless they're an O-Shot® provider.

All right, that's all I have. Have a great night. Bye-bye.

---

[25] Runels and Runnels, "The Clitoral Injection of IncobotulinumtoxinA for the Improvement of Arousal, Orgasm & Sexual Satisfaction- A Specific Method and the Effects on Women."

References

Asghar, Aneela, Zahid Tahir, Aisha Ghias, Usma Iftikhar, and Tahir Jameel Ahmad. "Efficacy and Safety of Intralesional Normal Saline in Atrophic Acne Scars." *Annals of King Edward Medical University* 25, no. 2 (June 24, 2019). https://doi.org/10.21649/akemu.v25i2.2867.

Aswath, Manju, Lakshmi V. Pandit, Karthik Kashyap, and Raguram Ramnath. "Persistent Genital Arousal Disorder." *Indian Journal of Psychological Medicine* 38, no. 4 (2016): 341–43. https://doi.org/10.4103/0253-7176.185942.

Bagherani, Nooshin, and Bruce R Smoller. "Introduction of a Novel Therapeutic Option for Atrophic Acne Scars: Saline Injection Therapy." *Global Dermatology* 2, no. 6 (2016). https://doi.org/10.15761/GOD.1000159.

Cohen, Seth D. "Diagnosis and Treatment of Persistent Genital Arousal Disorder." *Reviews in Urology* 19, no. 4 (2017): 265–67. https://doi.org/10.3909/riu0784.

Dick, Brian, Caleb Natale, Amit Reddy, Kole Prasad Akula, Ayad Yousif, and Wayne J.G. Hellstrom. "Application of Botulinum Neurotoxin in Female Sexual and Genitourinary Dysfunction: A Review of Current Practices." *Sexual Medicine Reviews* 9, no. 1 (January 2021): 57–63. https://doi.org/10.1016/j.sxmr.2020.01.003.

El-Amawy, Heba Saed, and Sameh Magdy Sarsik. "Saline in Dermatology: A Literature Review." *Journal of Cosmetic Dermatology* 20, no. 7 (2021): 2040–51. https://doi.org/10.1111/jocd.13813.

"Errors in Text." *JAMA Network Open* 5, no. 11 (November 4, 2022): e2245075. https://doi.org/10.1001/jamanetworkopen.2022.45075.

Gholami, Mohsen, Maryam Fard, and Maryam Poursadeghfard. "Sildenafil-Induced Spinal Cord Infarction: A Case Report." *Acta Neurologica Belgica*, May 18, 2024. https://doi.org/10.1007/s13760-024-02573-2.

Gwon, Yong Nam, Jae Heon Kim, Hyun Soo Chung, Eun Jee Jung, Joey Chun, Serin Lee, and Sung Ryul Shim. "The Use of Generative AI for Scientific Literature Searches for Systematic Reviews: ChatGPT and Microsoft Bing AI Performance Evaluation." *JMIR Medical Informatics* 12 (May 14, 2024): e51187. https://doi.org/10.2196/51187.

Jackowich, Robyn A., Leah Pink, Allan Gordon, and Caroline F. Pukall. "Persistent Genital Arousal Disorder: A Review of Its Conceptualizations, Potential Origins, Impact, and Treatment." *Sexual Medicine Reviews* 4, no. 4 (October 1, 2016): 329–42. https://doi.org/10.1016/j.sxmr.2016.06.003.

Knapman, Blake Lawson, Fiona G. Li, Rebecca Deans, Erin Nesbitt-Hawes, Sarah Maheux-Lacroix, and Jason Abbott. "Botulinum Toxin for the Management of Pelvic Floor Tension Myalgia and

Persistent Pelvic Pain: A Systematic Review and Meta-Analysis." *Obstetrics & Gynecology* 143, no. 1 (January 2024): e7–17. https://doi.org/10.1097/AOG.0000000000005388.

Medscape. "Don't Fear the Vampire Facial. Just Keep It Safe." Accessed May 21, 2024. https://www.medscape.com/viewarticle/i-invented-vampire-facial-heres-how-keep-it-safe-2024a10008qt.

Nazik, Hakan, Murat Api, Hakan Aytan, and Raziye Narin. "A New Medical Treatment With Botulinum Toxin in Persistent Genital Arousal Disorder: Successful Treatment of Two Cases." *Journal of Sex & Marital Therapy* 40, no. 3 (May 4, 2014): 170–74. https://doi.org/10.1080/0092623X.2013.788109.

Runels, Charles. *Dr. Runels "Botulinum Blastoff" Course: Using Neuromodulators (Xeomin®, Dysport®, Jeuveau®, or Botox®) to Change Lives & Increase Profit*, 2023.

Runels, Charles, and Alexandra Runnels. "The Clitoral Injection of IncobotulinumtoxinA for the Improvement of Arousal, Orgasm & Sexual Satisfaction- A Specific Method and the Effects on Women." *Journal of Women's Health Care* 13, no. 3 No. 715 (March 20, 2024). https://doi.org/10.35248/2167-0420.24.13.715.

Saltzman, Bryan M., Timothy Leroux, Maximilian A. Meyer, Bryce A. Basques, Jaskarndip Chahal, Bernard R. Bach, Adam B. Yanke, and Brian J. Cole. "The Therapeutic Effect of Intra-Articular Normal Saline Injections for Knee Osteoarthritis: A Meta-Analysis of Evidence Level 1 Studies." *The American Journal of Sports Medicine* 45, no. 11 (September 1, 2017): 2647–53. https://doi.org/10.1177/0363546516680607.

Wetstone, Rachel, and Jane M. Grant-Kels. "Microneedling Facial Gone Wrong: Navigating Safety and Regulation in the Rise of Medical Spas." *Clinics in Dermatology*, May 2024, S0738081X24000774. https://doi.org/10.1016/j.clindermatol.2024.05.003.

Tags

arousal, disorder, persistent, genital, persistent genital arousal disorder, clitoris, botulinum, Clitoxin®, marketing, treatment, vampire, procedure, facial, study, pain, sexual, nervous, system, HIV, somatic, Viagra, orgasm, hypersexuality, nerves, corpus, cavernosum, medicine, autonomic, spinal, cord, vagina, erection, sensation, vulvodynia, infarction, female, innervation, hymenal, remnant, cyst, medication

Helpful Links

=> Next Hands-On Workshops with Live Models <=

=> Dr. Runels *Botulinum Blastoff Course* <=

=> The Cellular Medicine Association (who we are) <=

=> Apply for *Online Training for Multiple PRP Procedures* <=

=> Help with *Logging into Membership Websites* <=

=> The software I use to send emails: ONTRAPORT (free trial) <=

=> Sell O-Shot® products: You make 10% with links you place; shipped by the manufacturer), this explains and here's where to apply <=