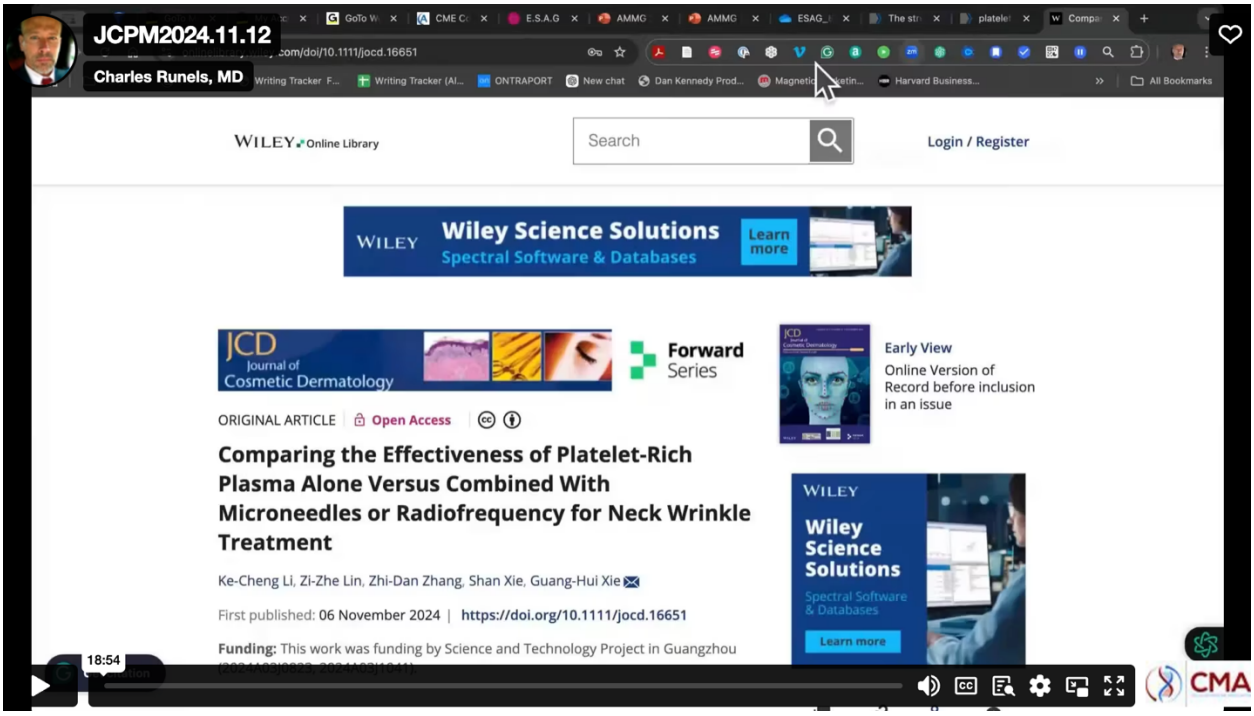
JCPM2024.11.12

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of Novemeber 12, 2024, with Charles Runels, MD.

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



Topics Covered

- **Which is Best for Neck Wrinkles: (1) Injecting PRP, (2) Microneedling PRP, (3) Radiofrequency + PRP?**
- **Seven Variations of the O-Shot® Procedure**
- **Urination with Orgasm in a Man**
- **References**
- **Helpful Links**

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Transcript

Hello. I hope you can hear me tonight. I'm in the Atlanta Airport. Can you just, in the text, let me know if you can hear me? Yeah, good. Okay, thank you, Barbara. Thank you, Heidi. That's amazing because they're playing John Mellencamp here at the gate

I just got back from lecturing at the meeting of two amazing groups (ESAG and AMMG). We will get to that shortly.

Which is Best for Neck Wrinkles: (1) Injecting PRP, (2) Microneedling PRP, (3) Radiofrequency + PRP?

First, look at this paper (in the past week, I think it is the most helpful to come out). I've done all these different ways of treating wrinkles mentioned in the article; they had three groups.[1] One was just injecting PRP, which you can do; just inject the wrinkles like they're a scar (intra-dermal and sub-dermal injections). The other group was microneedling with PRP. The other is radiofrequency with PRP. The group with radiofrequency combined with PRP gave the best result.

All of them worked. But at six months out microneedling with PRP beat PRP injections. And that's even with a less-than-optimal microneedling device. If you look at the device they're using it's not the sort of thing that you guys are using with using a Skin Pen or a Rejuvapen. You have a much more effective device. But even with that microneedling one, so over just injecting and radiofrequency beat the other.

So that's a useful reference to look at and you can share that with your patients (open source).[2]

[1] Li et al., "Comparing the Effectiveness of Platelet-Rich Plasma Alone Versus Combined With Microneedles or Radiofrequency for Neck Wrinkle Treatment."

[2] Li et al.

Seven Variations of the O-Shot® Procedure

I lectured at two groups in the past two weeks. One of them was the European Society of Aesthetic Gynecology (ESAG). For those of you who are in Europe, this group. Alex Bader runs the group—an amazing surgeon and teacher. I went there with my wife, Alexandra Runnels, MD, ACOG.

But I want to bring up the group because if you're in Europe especially, it's a really strong group for cosmetic gynecologists or plastic surgeons or gynecologists about all the magic they can do in the surgical specialties. I'm sort of a mascot by talking about the PRP part of it. This is more of an organization for surgeons, but it is very strong, with the top teachers and researchers in Brazil, South Africa, and Russia from all over the place, and of course, we saw many of our members there as well. And Alex Bader teaches our stuff. He's one of our members, too.

I highly recommend that our surgeons take a close look at esag.org.

I've included in the download one of the lectures we did there. Because it's so loud here, I'm going to just give you the highlights of it, but it's in the download section for you to look at.

We summarized the ways to vary the O-Shot® depending on the patient's condition and chose the top seven variations.

Here's a link to the PowerPoint slides for that presentation (including videos of the variations)<=

It includes videos you can watch, and the variations include pearls and references. All of this we've talked about here in the journal club, but it's scattered all over the place over the past few years. And I thought, well, if I can quickly summarize it for this group, then I should make it available to you, too.

Now, the videos don't go into some of the details that you learn on the membership sites and here in the journal club, but it's pearls that, if you put it on top of what you already know, can help you a lot.

Alex, my wife, was up there. We talked back and forth, and it seemed to be well received. So here are the different things we covered.

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Stress incontinence, labia majora, lichen sclerosus, decreased orgasm, dyspareunia from dryness, pelvic floor tenderness, and posterior fourchette pain. Again, we've talked about all these problems, but they're summarized.

So, for example, for stress incontinence, again, you can get a link to this and watch it for anyone or all of them. But for example, here's patient selection, PRP preparation for the best results and little pearls about injection technique. And then showing a video.

Again, our membership sites are more detailed, but sometimes it's useful to have just a quick summary all in one place. Hopefully, this provides that quick summary overlay for members of our group who have already studied the details and heard on the call every night.

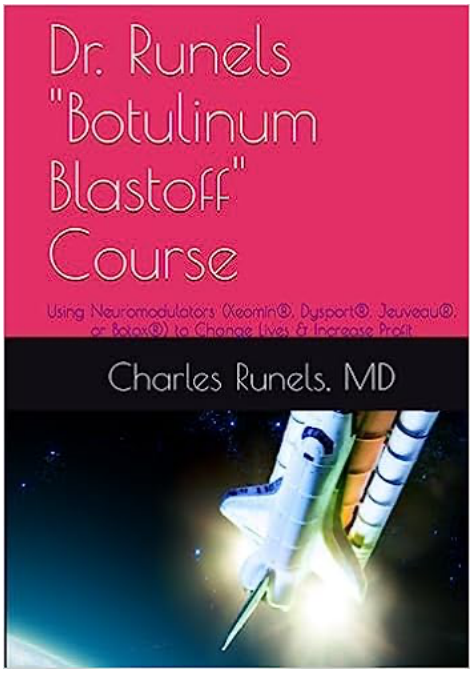
So, for example, this was noticed by my wife, many of her patients had horrible urge incontinence that went away when she treated them for sexual dysfunction just with the botulinum toxin in the clitoris (Clitoxin®).,

So, the ganglion effect on the autonomic nervous system seems to have an effect on urge incontinence.

The PowerPoint also covers the Vampire Wing Lift®, the things we do differently, injection technique, and there it is all in one place for you. And some of the pearls, this is probably the main one. Let them know that they might have a nodule that will be there for a week or two.

This is a nice video of injecting the body of the clitoris. Alex likes to come over at three o'clock, even down around two or eight o'clock. And you can see how she does that and slides the needle into the body of the clitoris; you might try that as an alternative to what is shown on the membership site.

This video shows injecting the pelvic floor—very easy.



You've got a link in the chat box to the whole presentation. Hit the link before we shut down the webinar; you'll have that as a nice reference.

Now, the other meeting I went to, the Age Management Medical Group, I'd recommend for everybody. Alan Mentz and others started this group over 20 years ago. It is a strong and thought-provoking progressive group and solid science that focuses on slow aging (and sexual function falls into that category).

We also presented there. Bill Song, MD (one of the leaders in the CMA) is strong in that group, and others have played a big role in it. I highly recommend this group as well.

I know you've thought of it this way, too, but the way I like to think about categories of health goes like this: First, you have "almost dead." And that's what I did in the ER, bringing people to where they're not almost dead anymore, from critical to stable condition.

And then you have stable but sick, and then you have well—not sick.

But then there's a different level where you go from being well to preventing aging or the diseases associated with aging or ***from being well to superior health***.

That idea of going from well to superior health is a little trickier (politically) because our medical boards, in some ways, condemn this approach (for example, you cannot prescribe testosterone solely to increase muscle strength).

But this group stays with solid conservative science. And I was honored to be able to go there with Alex and present a summary. Again, not the sort of details you know, but a summary of reviewing the research for male and female sexual function and how it compares with the other options of using PRP or botulinum toxin.

You can see those PowerPoint slides here<=

You have many of the details of this presentation on the membership site, but hopefully, this summary will be useful.

Here's an old Netter picture of the autonomic and somatic nervous systems within the pelvis (see the video or the PowerPoint slides). The only somatic nerve there is this yellow pudendal nerve that leads to the dorsal nerve of the clitoris. The rest of those nerves are afferent and efferent nerves for the sympathetic nervous system and afferent and efferent nerves for the parasympathetic nervous system.

And you think, "Well, that's a lot of nerves."

Yes, it is!

When you look at it on cadaver dissection (see video), there it is: there's inferior hypogastric plexus. In other words, ***the anatomical mass of the autonomic nervous system is tremendous (compared with the somatic nerves), which seems out of proportion when you think about how we actually think about the function of the nervous system within the pelvis.***

I've always thought about the pudendal nerve and never even contemplated the autonomic nervous system.

And then, in the fetal stain, you can see the green is the autonomic, and the red is the somatic. And so, a huge volume.

We don't have "extra parts."

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And so to think, well, you've got all this stuff down there (autonomic nerves), maybe we should think about how to manage it for optimal sexual function.

And, of course, we just made a stab at it with our Clitoxin® procedure, but hopefully, people on this call will help us think about it. This is really, really the beginning, I think, of something that could be even

more important than our PRP procedures or at least as important, and like the PRP, the world needs you as thought leaders to help us think about it.

Okay, you've got a link to this one again.

Because of the loudness here in the airport, I won't go through every slide.

Urination with Orgasm in a Man

And then the last thing, I had an amazing question from one of our members that has puzzled me as well. I'll present the question and my stab at answering it, which you'll find is not very satisfying, but I'm interested in if others in the group have found science about it.

And here's the question:

A man has prostate surgery for cancer, and then afterward, he finds that when he ejaculates, he expresses urine even if he empties his bladder. In other words, he's urinating on ejaculation. And now, this has fascinated me on the female side because some of you know I've written and thought and read about female ejaculation for 30 years. There continues to be some debate about whether there is such a thing as female ejaculation.

But there is.[3]

There is female ejaculation documented coming from the periurethral glands[4] (Skene's glands), which stains positive for PSA. It's like the ejaculation from the male's prostate gland, but then there's also urination with female orgasm, and that can also be pleasurable or embarrassing depending on the woman's (and her lover's) attitude towards it.

So, is there a reason to make the distinction?

From a functional standpoint, I think there can be, although in the bedroom, when you're having fun, it may not make that much difference.

But the way I think about it, there's a cross-innervation. I'm giving you a paper; here it is, the *Journal of Anatomy, and it* is open source.[5] I'll put the link to it in the chat box.

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[3] Rodriguez et al., "Female Ejaculation."

[4] Korda, Goldstein, and Sommer, "SEXUAL MEDICINE HISTORY."

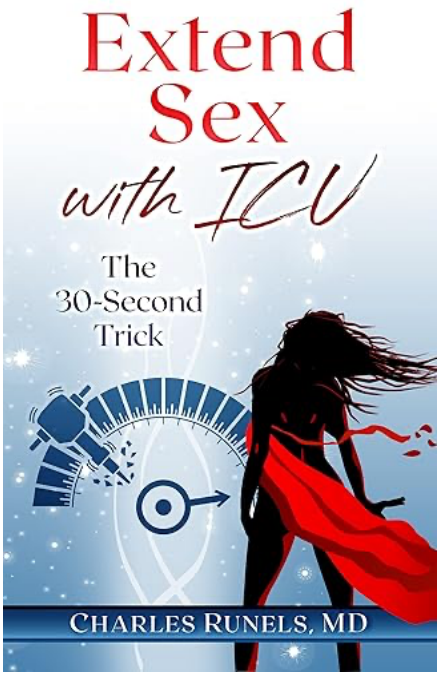
[5] Karam et al., "The Structure and Innervation of the Male Urethra."

We know that the innervation of the urethra and the urinary mechanism in a male and a female is cross-innervated with the innervation of the mechanism of ejaculation in a male and a female.

Where I found that to be most useful as a person and not a physician is that if the bladder is empty, so there's less urge to urinate, it becomes easier to control ejaculation and makes it easier to have sex for a longer period if that's what you want to do if your bladder's empty.

But in trying to figure out exactly how the mechanism works, I have found it's not well delineated. As this paper points out, there's a lot of room for understanding the actual physical anatomy and the function of anatomy. This is one of my favorite papers about the idea of a clinician.

Let me put it in the chat box and I want to open the mic to see if you guys have anything to teach me about this, and then we have to think, well, what do you do with this person?



There's a link, it's in the chat box.[6]

As a clinician, I try to stress that, with women, it doesn't really make that much difference. We have ultrasound studies that show it does come from the Skene's glands, and we have physiologic chemical studies, but if a woman's having pleasure and part of it is urine and part of it is coming from Skene's glands, who really cares? The main thing is that she's having pleasure.

But in this case, you have a male who's embarrassed (not having pleasure) because he's urinating when he has an ejaculation. So, how do you deal with that?

I have two ideas and then I'm going to open it up for hopefully you guys will have more to teach me.

One is that I don't know why, and I don't know how. Still, we have anecdotal reports of our P-Shot® helping with urge incontinence, so I haven't heard this exact scenario of incontinence with ejaculation. Still, it could be that the same idea might help.

This is one of those where I have no idea if it's a 20% or a 90% success rate, but I think it's worth trying.

The other idea is that if there's congestion in the prostate so that there's some urinary retention even after surgery, then the usual things you do to relieve that, whether it's a hot tub or a prostate massage of some kind even from the outside, I never found it pleasant to have. I mean, it depends on your

[6] Karam et al.

preference, but even if you're a male and prefer nothing in your rectum, you can massage the prostate from the outside and help release that congestion so that you're able to urinate more and leave less in the bladder.

I suppose there's the possibility of an in-and-out cath pre-coitus, but who wants to do that?

So I don't have a good answer for it except that reassurance and the possibility of a P-Shot® procedure helping suppose could also be used, even though he's had surgery for his prostate cancer, one of the blockers, Proscar or Propecia might help, or even just saw palmetto might help the prostate stay uncongested. But, if there is no residual prostate (prostatectomy rather than radioactive seeds), then this would not likely help.

What I think is happening, and I'm going to shut up and see what y'all can teach me, what I think is happening is that his bladder's not completely emptying because of something that's gone on with the surgery. So then it does empty when he ejaculates because it's the same innervation that's causing the same sort of propulsion of material.

So that's all I got for that. Not very helpful.

I think I'm not going to torment you anymore with the background noise and bad music they're playing here in the Atlanta Airport—and we will end the call.

Let's see. It's crazy that you wake up in Istanbul one morning, and then that night you go to bed in Alabama. What an amazing world we live in.

Let's see, hold on a second. Let's see what kind of comments. Surely someone else, hopefully in the group has had this same thing happen.

Just hoping somebody has a... nobody else has any ideas. I'm sorry Stephen. That's the best I got.

I think if you look through one of those PowerPoint presentations I gave you about botulinum toxin and PRP in men, we actually do have a few studies now on how it's helpful in penile rehabilitation post prostate surgery to inject PRP in the penis.[7] [8] [9]

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[7] Lee, Jiang, and Kuo, "A Novel Management for Postprostatectomy Urinary Incontinence: Platelet-Rich Plasma Urethral Sphincter Injection."

[8] Matz, Pearlman, and Terlecki, "Safety and Feasibility of Platelet Rich Fibrin Matrix Injections for Treatment of Common Urologic Conditions."

[9] Wu et al., "The Neuroprotective Effect of Platelet-Rich Plasma on Erectile Function in Bilateral Cavernous Nerve Injury Rat Model."

So, I think it's worth a try, but this is one where, if it helps him, I would definitely do a case report. Everybody on this call has demonstrated two or three things. One, you have the courage actually to read the science and follow it, and most people wait until it's in the textbook, but if something's safe and it's in the science and you follow it and you're doing it before it makes it into the textbook, that takes courage.

You're doing sex medicine, which takes courage, and you're on this freaking call, so you're trying to stay up-to-date and share ideas with your colleagues. So that's the person that's going to do the case report. It could be one of the open-source journals. People don't really pay much attention anymore.

Sometimes, when I read the New England Journal, I feel more like I'm reading the New York Times, and 30 years ago, one of my mentors told me (he just shook his head while talking), said, "Charles, there was a time you could believe everything in the New England Journal of Medicine, but that has passed."

He was the best diagnostician I ever met. He was truly saddened by the errors and politics slipping into our literature.

And that was 30 years ago.

The bottom line is that if you do this and it helps him, please do a case report (and do not worry if the NEJM does not accept your paper), and I can help you. There are a few journals that have reached out to me wanting to know when we have something new. I can give you those names. I would follow up with him, do the thing, follow up at three weeks, three months, six months, publish it at three, and do a follow-up at six months if it helps him. And then, hopefully, there'll be enough other people to do it that it can be of help to our collective toolbox.

I know we have some urologists in our group, but I've never heard of any of them talk about offering this for this kind of problem of urination on ejaculation in a man.

And I think I'm going to go with that. Thank you for putting up with the Atlanta Airport. I hope that was understandable, and I hope those two PowerPoint presentations help you. The one about the tips on the O-Shot® seven variations has some videos, so combining it with the membership sites may be helpful.

Have a great night. Thank you. Bye-bye.

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Tags

Atlanta Airport, John Mellencamp, wrinkles, PRP, microneedling, radiofrequency, Clitoxin, O-Shot, Alex Bader, ESAG, European Society of Aesthetic Gynecology, Age Management Medicine Group, AMMG, stress incontinence, labia majora, lichen sclerosis, decreased orgasm, dyspareunia, pelvic floor tenderness, posterior fourchette pain, Vampire Wing Lift, sexual function, aging prevention, autonomic nervous system, somatic nervous system, pudendal nerve, Skene's glands, female ejaculation, prostate surgery, urination during ejaculation, P-Shot, botulinum toxin, penile rehabilitation, case report, sex medicine, New England Journal of Medicine, urology, Charles Runels

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* <=

=> FSFI Online Administrator and Calculator <=

=> 5-Notes Expert System for Doctors <=

=> 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 <=