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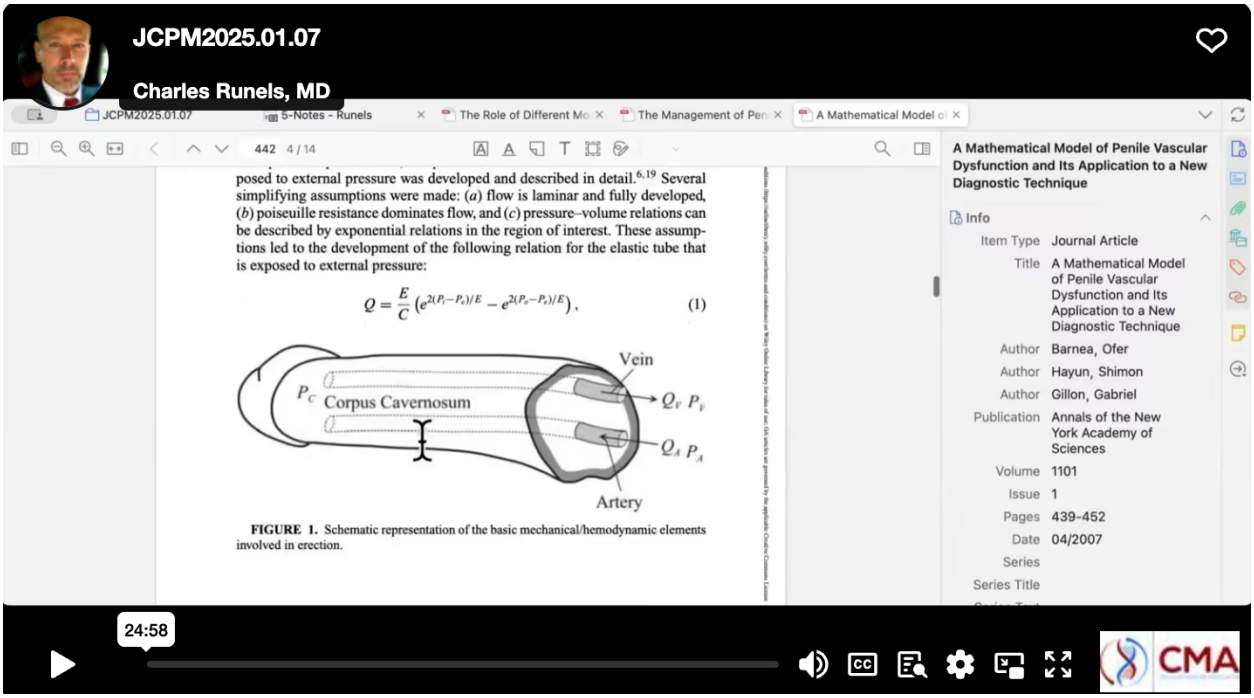
The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of January 7, 2025, with Charles Runels, MD.

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



Topics Covered

- **Mathematical Modeling of Male Tumescence with a Suggested Implementation, Measurement Device**
- **The Mysterious Disappearance of Xiaflex from Almost Every Country but the USA**
- **The Negative Effect of TMJ Pain on Sexual Function (the Conversation You Need to Have That You May Not Have Ever Had)**
- **Survey of Doctors Treating ED with Regenerative Therapies**
- **The Painfully Slow Adoption of PRP by Rheumatologists**
- **A Way to Tap My Marketing Brain**
- **The 80-Year-Old Book That Will Help You Think**
- **An Easy Way to Make Any Procedure Hurt Like Crazy!**

Charles Runels, MD
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Transcript

Charles Runels:

Welcome to our journal club. We enjoy a continuing, logarithmic growth in the number of papers that are coming out regarding our area of interest.

From that stream, here are the things that I thought might be most helpful this week. Then we'll get to the book of the week. I have a question about marketing that I want to show you.

Mathematical Modeling of Male Tumescence with a Suggested Implementation, Measurement Device

This one was just a little fun article for those of you who are math geeks. I like seeing math. It's too complicated for me to quickly read and maybe too complicated for me to even understand. But some of you know, a couple of years ago, I drew a diagram; we're modeling the penis, which is basically a glorified water balloon looking at pressures and external and internal, and like any other balloon, it expands to the place where external pressure matches internal pressure, and there's your erection.

Or if internal doesn't match external or exceeds it, you're left with a flaccid penis.

Not a lot of people have modeled it, and these people did it in a very elegant way.[1] So if you're in the math, you might enjoy looking at this. But more importantly, they came up with a device to try and determine, without ultrasound, the degree of venous leak versus arterial insufficiency in the face of erectile dysfunction using this little device. I've yet to see if that's even obtainable. This is not really a new article. You can see this one came out quite a while ago, but I stumbled on it and thought it was interesting. If you like math, you'll like reading this article.

This one I was looking at because I finished a text book chapter on male sexual function and PRP. I'll ask you guys to keep it confidential. I sent out a rough draft of it, but I have the final draft of a chapter for a textbook that'll be coming out and I'm just going to give that to you right now. It's a PDF file. Hold on a second. And all I ask is that you just keep it to yourself. (This was only for attendees of the seminar, it will be out in print form soon). This is a chapter that summarizes the progression of the research

[1] Barnea, Hayun, and Gillon, "A Mathematical Model of Penile Vascular Dysfunction and Its Application to a New Diagnostic Technique."

regarding PRP for erectile dysfunction and how our P-Shot® fits into the history of it. So I think you might find it helpful. It'll be in the download section.

It's PRP in male sexual medicine. You'll find it in the download section. And hopefully, you'll find it in structural. Lots of references in regard to things we've covered here and new stuff that I turned up in the process of firming up the bibliography, which is what I'm getting to. But it covers erectile dysfunction, Peyronie's disease, infertility, as well as the growth of the penis, and more. So, hopefully, you'll find that helpful.If you want to share it, all I ask is just sort of redo it in your words and then put it out to your patients. And you can use the references. And there you go, hope that's worth your trip tonight to our webinar.

The Mysterious Disappearance of Xiaflex from Almost Every Country but the USA

But back to what I was about to show you. In the process of finishing up that chapter, I was looking more about rehabilitation of the penis and trying to find out what happened. Xiaflex is still FDA-approved, but it was pulled from the market through China and Asia, the remainder of Asia and Europe, and it's not on the market in Canada.

I can't really find a good explanation for why it was pulled from the market in those places. So I was reading up on it, and here are some of the things I came across: I looked at the studies of it. The numbers seem to be somewhat—I don't know if intentionally or not —vague.

There's one category of people that have an obvious penile fracture, and then I have an article I've included about the ways to treat that, but it's not a good thing. And, of course, it leaves you with erectile dysfunction. And for those that, of course, have not had collagenase or Xiaflex, you'll see it's the story of a woman on top, and the penis gets bent.

The man hears a pop, and there you have a penile fracture. In the case of Xiaflex, the collagenase dissolves the scar tissue to the point it's basically a surgical, it's a chemical surgery. So if it dissolves too much, it makes it weak and you get a penile fracture.

And I was surprised in the studies of this that it's actually more common for the penis to be fractured in the missionary position.[2] So I always thought it was mostly in the case of woman on top, but it turns out in the missionary position if the man is withdrawing and when he's halfway out at mid-shaft, if the woman tilts her pelvis a certain way, basically folds the penis middle-shaft while it's erect and that results in fracture. I think most men have experienced both types of trauma since part of the reason you have sex is to lose your mind and people are losing their mind until suddenly something goes wrong. And that mechanism or that being the more common mechanism in penile fracture surprised me.

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[2] Gelbard et al., "Clinical Efficacy, Safety and Tolerability of Collagenase Clostridium Histolyticum for the Treatment of Peyronie Disease in 2 Large Double-Blind, Randomized, Placebo Controlled Phase 3 Studies."

Anyway, so if you look through the papers, which I'm showing you now, and I'll have links to all this in the email that goes out, there's a fudge factor. There's a percentage of men that know their penis was fractured. They hear a pop, there's pain, there's significant swelling, and they're left with an ED. And then that's usually a surgical fix. But there's also the men who hear a pop, but there's not as much swelling. And that category, if you read the literature, it's hard to determine exactly how many of those you have, but if you add the two groups together, it's about 2%.

So in the group that actually has a fracture that you know about, the number was all over the place. It was a very low percentage in the official studies. But then in one of the studies I'm providing you here, there is actually... It goes up to much more than the 0.4% that's reported for the known fracture. It turns in... It's over 5%. So you get this huge difference depending on who's doing the study. But let's go with a lower number. If you add the two together, it's about 2%, which doesn't sound like much, but that's 1 in 50.

These are the papers that provide all those numbers, and I'll put the references to them in your chat box right now.[3] [4] [5]

The point I'm trying to make, though, is that we are still left with an FDA-approved collagenase for Peyronie's disease that's been, for the most part, pulled from the market worldwide. The only explanation the company gives is for "financial reasons."

I think it's worth talking about that with your patients.

The other thing is, if you look at the amount and the numbers in that chapter I just gave you, I'm summarizing what I've talked about in that chapter. If you pay the full price for a collagenase injection, it's about seven grand, and it's recommended that you have a series of four. So, you're out $21,000 give or take if you're paying for it for a series of Xiaflex. But, if you did a series of three P-Shots® to accomplish the same thing as you know, it'd be more like six grand—total. Between four and six grand, depending on where you live. But even at our lowest suggested retail price, you're right at about 4 grand versus 21 grand.

Now, it's not that big a deal if, I suppose if your insurance is paying for it. Still, I think it's worth pointing out to your patients that not only did Ronald Virag do a study showing that PRP was more effective with Xiaflex for Peyronie's disease,[6] but also the side effect was a better (erection with a P-Shot® versus a penile fracture and impotence with Xiaflex).

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[3] Gelbard et al.

[4] Furtado et al., "Collagenase *Clostridium Histolyticum* for Peyronie's Disease."

[5] Hughes, Natale, and Hellstrom, "The Management of Penile Fracture."

[6] Virag et al., "Evaluation of the Benefit of Using a Combination of Autologous Platelet Rich-Plasma and Hyaluronic Acid for the Treatment of Peyronie's Disease."

Then the question is, ***why does anyone reach for Xiaflex's first line over our P-Shot® for Peyronie's disease? I cannot find one good answer to why that should happen.***

The Negative Effect of TMJ Pain on Sexual Function (the Conversation You Need to Have That You May Not Have Ever Had)

Your first reaction to reading the title of this article may be a chuckle in that, yeah, if you can't open your mouth wide, it might interfere with your sexual function, fellatio, and kissing.[7]

And it turns out that, yes, ***women who perform sex for money have a higher incidence of TMJ problems,*** and I guess that would make it an occupational hazard.

But there's been very little talk about this: TMJ problem being a possible reason for sexual dysfunction. And these authors don't offer a lot of solutions. As you know, treating TMJ is pretty tough. Involves the dentist. It could be some of us are injecting botulinum toxin or PRP into the TMJ.[8]

But to acknowledge that it could be a problem, and more research needs to be done, and it's worth bringing it up, I think it can be embarrassing just talking about sex in general, as we know, is hard for most of your patients to do. Part of the beauty of our group is that most of the doctors in our group like treating sexual problems because we have an answer, and we're not afraid to talk about it.

One of the things that you can look for (this is in the botulinum toxin course that I teach) is that in a woman, unless she's Asian, if her master muscle, if her jawline is wider than her cheekbones, then she probably has bruxism. Not always, but probably has bruxism, and probably has the beginnings at least of TMJ, and probably has a mouth guard she's wearing that she hates.

And if you offer her injections of botulinum toxin to treat that, she'll love you for it when she gets better.

And, now we have a paper showing that it may help her with her sexual function.[9] So bringing that up, seeing it, you can see it from across the room usually.

And you just ask the woman, she's on your exam table, "Do you grind your teeth at night? Does it hurt to open your mouth? Is it affecting your sexuality? Here, I can fix that with some botulinum toxin, or at least a good chance I can help it."

And that's the purpose of giving you this paper.

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[7] Leonid, "Exploring the Relationship between Temporomandibular Disorders and Sexual Function."

[8] Khademi Mansour et al., "Re."

[9] Leonid, "Exploring the Relationship between Temporomandibular Disorders and Sexual Function."

Remember, I call this Journal Club with Pearls & Marketing. It consists of three things: the research I think might help you, clinical pearls, and how to use them to find people who need you.

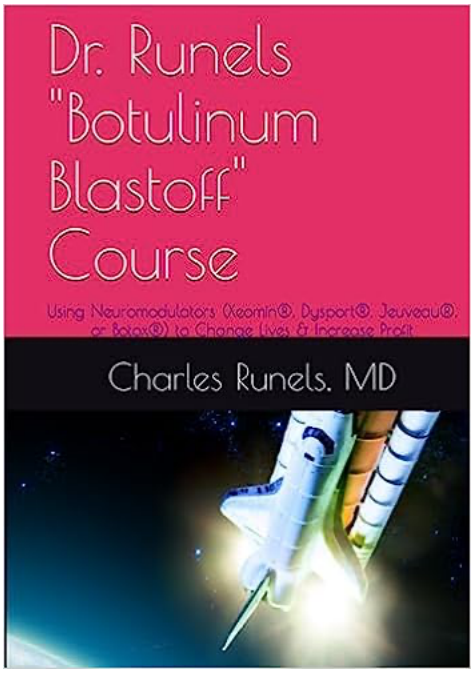
You could take a link to this paper and put it in an email or on social media and say, "Hey, if you have trouble opening your mouth, it's not a laughing matter; it could be affecting your marriage bed. And I have a way to help it."

I'll give you the quick answer to how to inject it with toxin: You just find the midpoint for both anterior-posterior, cephalad, and caudad, and you inject 15 units of botulinum toxin right in the middle of the masseter muscle. But my course has videos and more detailed explanations.

Survey of Doctors Treating ED with Regenerative Therapies

Yeah, this one is a review article in which they just surveyed doctors who are treating erectile dysfunction with regenerative therapies.[10] They found that 80% were using shockwave therapy, and about 60% were doing PRP of some sort. A smaller percentage,14%, were injecting stem cells.

The efficacy comparisons were about the same, except the stem cell people thought theirs might be working the best. That's a nice review article.



I don't know if this one is as useful to share with your people, but it might be. It's worth reading through. So there you go—that's a recent article that should confirm for us that we're on the right track.

The Painfully Slow Adoption of PRP by Rheumatologists

I still think it's tragic how the autoimmune attenuation by platelet-rich plasma is not talked about enough.

It's dramatic. I know I've seen some amazing photographs from you guys where you've treated something else like eczema or, of course, the lichen sclerosus, and they're supposed to be an autoimmune component to Peyronie's disease.

But even with the eczema and the scleroderma, if you go to the literature, it's talked about with all these other problems, like just rheumatoid arthritis. And, of course, we have studies looking at it for alopecia

[10] Al Hashimi et al., "The Role of Different Modalities of Regenerative Therapies in the Treatment of Erectile Dysfunction."

areata. It's a strong, useful, and well-documented property of platelet-rich plasma. And I think it supports what we're doing.

It came out on the last day of the year, New Year's Eve, so it's a fairly recent study worth reviewing.[11] It gives a strong scientific base for the things we talk about and good moral and intellectual support for the idea that, yeah, we're actually... We have a scientific basis. This isn't a magic shot; it's just magic what these cytokines and growth factors can do. But we have a good scientific basis for treating these problems. Alopecia areata, Peyronie's disease, lichen sclerosus, scleroderma. I haven't had as many scleroderma patients, but those ladies suffer tremendously from dyspareunia. And so far, the few I've treated and heard about being treated have done well. So that's low-hanging fruit for someone to do a study. And there you go. Let me put this one in your box, too.

I have eight minutes, so I will cover the book and the question.

A Way to Tap My Marketing Brain

The question I had, and then I'll get to the book, was someone very prominent plastic surgeon for whom I have tremendous respect in New York City asked if I could give her personal attention regarding marketing. And it's so tempting that... And I have done that in the past, and hopefully, it's been helpful; some who I have helped have done extremely well, and others have done moderately, so, depending on how you want to measure it. But because my clock is ticking, I'll be 65 in April; I'm selfishly trying to download as much as I can out of my own brain while it's working.

My dad died recently in the past year from the end stages of Alzheimer's, and who knows? Hopefully, I didn't get the gene. My mom's still clicking and bright at 85. Hopefully, I got her genetics when it comes to the longevity of my brain. Some of my favorite authors were still writing and did their best work in their eighties, so hopefully, it'll last. But who knows, our life is a puff of smoke, as the Good Book says.

And so I'm focusing for now, at least. I'm not taking any new private clients when it comes to helping with marketing. But I downloaded some stuff from this course, and I'll put the link to it. Let's see if I can pull it up for you. There you go. That's an outline of the system or sort of a... I guess that's a piece of the poster outlining the system. It's a transcript, videos, and supplemental materials for a course that I taught online that lasted for about eight weeks. It's always money back if it does not bring you back much more than it costs. And if you get through that course, you will know a lot of stuff. I will be shocked, and let's just put it this way: I would be surprised if you don't add an extra zero to the money that's coming in and some extra soul satisfaction for people being inspired by your marketing stuff will quit being ads, and it'll turn into educational, inspiring stuff of various forms that people read and miss when you quit making it.

Let me cover the book, and then I'll take your questions, or I'll open the mic if you have something you

[11] Yessirkepov et al., "Use of Platelet-Rich Plasma in Rheumatic Diseases."

The 80-Year-Old Book That Will Help You Think

I just recently discovered this book; I can't believe I didn't know about it.[12]

He was a priest, but don't let that scare you off. Depending on what bible you read or don't read, that might attract you or frighten you. It's called *The Intellectual Life*.

Let me pull it, make it where you can see it. Hold on a second. It was written in the 194... But it could be maybe the most inspirational, practical guide I've read to how to just enjoy... You wouldn't be on this call if you weren't someone who enjoys learning, and finding practical ways to use what you're learning. So how do you limit what you're going to read or not read? How do you work it into your life?

And I think you'll be relieved to know that he thinks not two minutes, but if you can carve out two hours a day, he says every day, but I still think six days a week is better. I've done seven days a week and burns you out.

But if you can carve out two hours a day, he thinks you can change the world and dive. One of the gurus I have read said just 30 minutes a day but focused on one subject matter and at the end of a year or two, you're a world expert. This author thinks two hours.

But how do you turn that into productive time?

How do you stay motivated? And frankly, how do you turn it into a form of prayer?

I don't want to get too metaphysical on you, but if your studies become a form of prayer where you're actually communing with whatever you call your higher power as part of your exploration of this planet and its laws, you can imagine the possibility of staying motivated as well as the possibility of seeing what others might not have seen yet becomes maybe more possible.

And I've never heard anyone describe it like this man does.

He specifically says, "It's not just about writing spiritual," he acknowledges science, and even though he's a spiritual guy, he acknowledges how the physical sciences tie in with it all and can be part of the same thing—another form of prayer.

That's the best book I've read this week. Normally, I read a book, and then I'm done with it, but this one is one I'm probably going to want to keep rereading once a year. It goes on that list.

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

When I see one that's this old, I like to go to eBay and find something as close as I can to the original. I found, especially with some of the spiritual stuff, that they'll edit a lot of it, even some children's books. They don't tell you they took that page out or they changed something that wasn't politically kosher. And I think sometimes there's something to be learned by seeing what the original format of the book

[12] Sertillanges, *The Intellectual Life*.

was, how it was laid out, and feeling that original hardback. And so I bought it on eBay. This one was not expensive. It wasn't like getting the first copy of *For Whom the Bell Tolls*, but you can pick it up and use it on eBay, or if you want a new paperback version, Amazon has you covered.

An Easy Way to Make Any Procedure Hurt Like Crazy (a Question)

Member:

Can you hear me?

Charles Runels:

There you are. Yep, I can. Thanks for participating. Tell us what's on your mind.

Member:

Yeah, so not every O-Shot® has been a resounding success, but most have gotten good results, and I've never had what I would call a complication until now. I recently started adding Clitoxin®. And I'd done a few Clitoxin® procedures as standalone, just the Clitoxin®.

One that I really want you to shout out is a woman who had breast cancer a number of years ago, and her libido has basically zero ever since. I couldn't use hormones on her, of course. I tried the O-Shot®, which helped her urinary incontinence a lot but did nothing for her sex.

And then finally, I just Hail Mary, "Let's give you... I'm not even going to charge you. I'm just going to give you a Clitoxin® shot and see what happens."

And lo and behold, it actually brought back her sexual response and her libido!

Charles Runels:

Beautiful! Beautiful!

Member:

Yeah, I thought was wonderful.

Anyway, about a month or so now, I guess it was a little before Thanksgiving, I had a woman come in who wanted to do the Clitoxin® and the O shot together. So it was the first time I'd done it as a combination. And I prepared the PRP as I usually do, with four mls to inject into a vagina near the urethra and one in the clitoris. But of course, once I activated that one mL, I mixed it with 0.5 of...

Usually, I use saline. In this case, we'd run out, and I actually used sterile water. I don't know if that matters or not, but that's what I ended up using to dilute the 50 units of botulinum toxin. So, a total of 2.5 mLs were injected into the clitoris.

I did what I normally do. I put the BLT on; then I did the clitoral block. So everything seemed like it was all ready to go; I put the ice on, got ready, and started injecting. I got about 1.5 mLs in, and suddenly, I

hit a lot of resistance. I couldn't even push the plunger. So I repositioned it and pulled it out. First, I tried to reposition it, then I actually pulled out and re-injected. I still couldn't do anything.

So I'm like, "I don't know what happened. Maybe I clogged the needle."

So I removed the... I think it was a 31, 30, 32 gauge whatever needle at that point. And I replaced it with a 25. Injected again, still hit a lot of resistance.

Finally I pulled that one off and I realized that there was a... I guess it was actually a fibrin clot in the neck of the syringe where it meets the hub. And I never come across this before. So then I cleared that out, put the needle back on and the injection, and then did the vaginal injection. And everything seemed to be going fine.

I said, "Okay, I'll step out, let you get dressed, and I'll come back and make sure you're good to go before you leave."

A couple of minutes later, my assistant came and got me and said, "This lady's having a lot of pain; you want to just check on her."

So I do. And she's having significant pain in the vulva area and, in particular, to touch the clitoris. Now, mind you, the clitoris was well numbed before I Injected, and the lidocaine should not have worn off at this point.

I'm thinking, "Maybe I just traumatized it. I did put more than one needle hole in it, so maybe."

So I said, "Let's just put some ice on it." She did it for a few minutes, and then I came back and checked on her again.

She's like, "No, it hurts worse than ever. This is really, really bad."

And I'm starting to think, "Gosh, did I create a hematoma by putting too many needle holes in and it's pressing on the pudendal nerve? Did I push a clot into there, and am I causing necrosis?"

I'm starting to panic a little bit at this point.

Finally, after about 15 minutes, she started to feel better. A little bit after that, she was down to feeling a little bit sore and not really having any pain.

So, she did fully recover, but I've never come across that before. And I just wondered if you had any thoughts. Did maybe I do something wrong? Should I have done something differently? Are there any lessons to be learned that we can take away so that it never happens again?

Charles Runels:

Thank you for sharing that. Before I answer it, so have you had feedback since then, since the procedure? Any feedback about how she's doing?

Member:

I've actually reached out to her a couple of times, and she's never called back, so I have not spoken to her since then. I tried calling her about three times, three or four times and she never responded.

Charles Runels:

Okay. I'll talk about a couple of things. As far as the clot goes... Before I answer, let me see if someone else wants to raise their hand and contribute. I see my wife on the call. I may unmute her to see what she has to say, but I'll give you my opinion first.

When you have some people, for some reason, maybe once, maybe 1 out of 200, their blood will just clot much faster than others. And I'm not saying that's related to the pain that she had, but the fact that you've done this a lot and there was no mention of any delays, you took the needle off and you swapped over, but the resistance happened before any significant delay. So it sounds like she was a fast fibrin matrix maker for some reason, a fast clotter. I've had people where... And you're using the same activation that you normally do, but then I've had people that I draw blood again and then it would clot so fast you couldn't only get the procedure done using the usual protocols. So I don't know if that's related.

The only thing I heard that might've made it different is that I know when you do **botulinum toxin in the face, there's a pretty noticeable difference in pain if you use saline that is preserved versus even regular saline. And I would imagine sterile water would be even less comfortable.**

So it wouldn't cause any permanent damage, but it would make the pain different. And I still use Clitoxin®; I treat it as if I were doing the face and use preserved saline, which, as you know, has a little benzoyl alcohol in it, but so minute.

So I don't know, I think that's a stretch. I don't really know that that's why she had more pain. It's the only thing I heard you say that would account for more pain if you were injecting the face, but it wouldn't cause any damage. It wouldn't cause any increased risk at all to the procedure. I don't know if it changes how fast things might clot when you add in the botulinum toxin. I think the pH would probably be the same. So I don't know if there's a difference with the saline versus the water and the clotting mechanism.

That's all that I really have to say about it as far as what might've caused her to hurt more and none of that would've caused any increased risk from the procedure. You'd still be injecting something that has basically a zero chance of causing tissue damage. The other thing I suppose. There has been with some of the...

One of the kits that are used recently swapped their anticoagulant, but one of the kits was causing significant pain. Can you tell me which kits you were using?

Member:

I was using the Integrity kit.

Charles Runels:

Yeah, that's not on my hit list.

So I don't know if Integrity has made any kind of swaps in their supplier or not. But as you know, it's possible for a company to swap their source. If that's a new batch, you might talk with them about if that's a new batch or not, a new lot number, or if they have a different source. Because that's all that's in there, so you have PRP, which is never known to cause any permanent damage except in half a dozen cases injected in weird places around the eye. But as far as the other millions of procedures that are done every year, millions, I don't know anything safer. You can't find where tissue's been damaged. So that leaves the anticoagulant and the diluent. And that's my thoughts on both.

Member:

Do you think that using a larger syringe, three mL syringe narrowing down into a 30-gauge needle, the hydrodynamics would change in a way that it could promote clotting?

Charles Runels:

Yeah, possibly. Yeah, possibly. As you know, pressure and vacuum can activate platelets, and hence clotting when you have a difficult phlebotomy is one of the many things that can activate it. What I do, I didn't ask you about the size of a clitoris, but if it's a smaller clitoris, I'll stick with the one cc. In other words, I'll take the botulinum toxin. Instead of adding more volume, I'll just dilute the 50 units with a cc of PRP so you wind up with the same volume. I don't know what the final best way to do it is going to be. The original reason for increasing the volume is if the botulinum toxin works, it's working [inaudible 00:35:38] through, we think, through the same mechanism that's thought to happen with migraines, with axonal transport to the ganglion, and then the ganglion connects to the inferior hypogastric plexus up to the midbrain and changes parasympathetic activity to increase libido and orgasmic function.

So in order to facilitate that, the idea was let's increase the volume so it travels farther by hydrodissection into the clitoris. But we don't know that the extra volume is necessary, and we think we can manage to get to the trigeminal ganglion by just injecting the procerus. If you read the migraine literature without a lot of volume, it's like 0.2 cc. Depending on what you're injecting, it's less than a half a cc for sure, usually. And so I would feel free to go down on that volume, especially with a smaller clitoris and just use your usual one cc syringe.

Member:

All right.

Charles Runels:

We'll all be curious about how she does. So far, even in the ones where they had the suspect anticoagulant, they came back around and had good recovery and outcomes. The only other thing I would add is that if a woman... I know my wife, Alex, had a woman who had clitorodynia. If they have pain, it could be that the Clitoxin® could make the pain worse.

And that makes sense if you think about the mechanism that's happening. But just for anorgasmia or decreased libido in our research, and so far, what I'm hearing from the group is it's working very well. Let me see if Alex... I see that she's on the call. If you have something, Alex, click your button. Otherwise, we'll call it a night. She clicked the button. Let me unmute. Are you there? Let me unmute her. Go for it, Alex.

Alexandra Runnels:

Am I unmuted? Can you hear me?

Charles Runels:

Yep. Yes, very well.

Alexandra Runnels:

I'm not going to say a whole lot. I just want... My 2 cents worth is that I very much think that the sterile water is the dilutant, is the problem as far as the pain goes because of the difference in osmolarity compared to saline. So the water's hypotonic and creates... By injecting it into the tissue, it creates a sudden osmotic gradient in the tissue, which causes severe pain. And I've done that in the same situation before when I didn't have... I was out of bacteriostatic saline and used sterile water in the face for botulinum toxin in the face, and the patients acted like I injected fire into their faces. And it was not just one person, it was many. And as somebody who has a clitoris, my face is not as sensitive as my clitoris. So if you put that into my clitoris, I would probably scream too. So I think that's probably the source of the pain.

Charles Runels:

That's reassuring because it also means that although that mechanism might cause pain, it would be unlikely to cause any permanent damage.

Alexandra Runnels:

Yes, I don't think there's any permanent damage done at all. It's just temporary pain.

Charles Runels:

Yep. Thank you.

Member:

Yeah, I think next time, if I'm out of the bacteriostatic, I'll just tell I'm, "Sorry, we're going to have to reschedule you."

Charles Runels:

Thank you for sharing. You just heard Alex tried it in the face and you'll save someone else from relearning that lesson. So thank you. Tell everybody what you texted me about the fractured penis. I thought that was smart.

Member:

Oh yeah, it was just a thought. You mentioned at the very beginning how many more men fracture their penis in missionary sex compared to that cowgirl woman in the top position. I think it's just data... Is that selection bias where basically because so many more sex acts are missionary positions, of course, you're going to have more fractures in that way.

Charles Runels:

Yeah, could be true.

Member:

That might not be the case if we're talking about the rate. Yes, the rate may be higher in the woman on top, but the actual absolute numbers are going to be higher from missionaries just because the number of acts is higher.

Charles Runels:

I bet you're right.

Member:

Just a guess.

Charles Runels:

It makes sense. I didn't even think of that. It worries me more because you don't have as much control with women on top, but there is still some movement that can be painful in missionary, but I bet you're right. That makes sense. All right, thank you, guys, for being on the call, and thank you for the great question and feedback; Y'all have a good night. Bye-bye.

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

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Tags

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