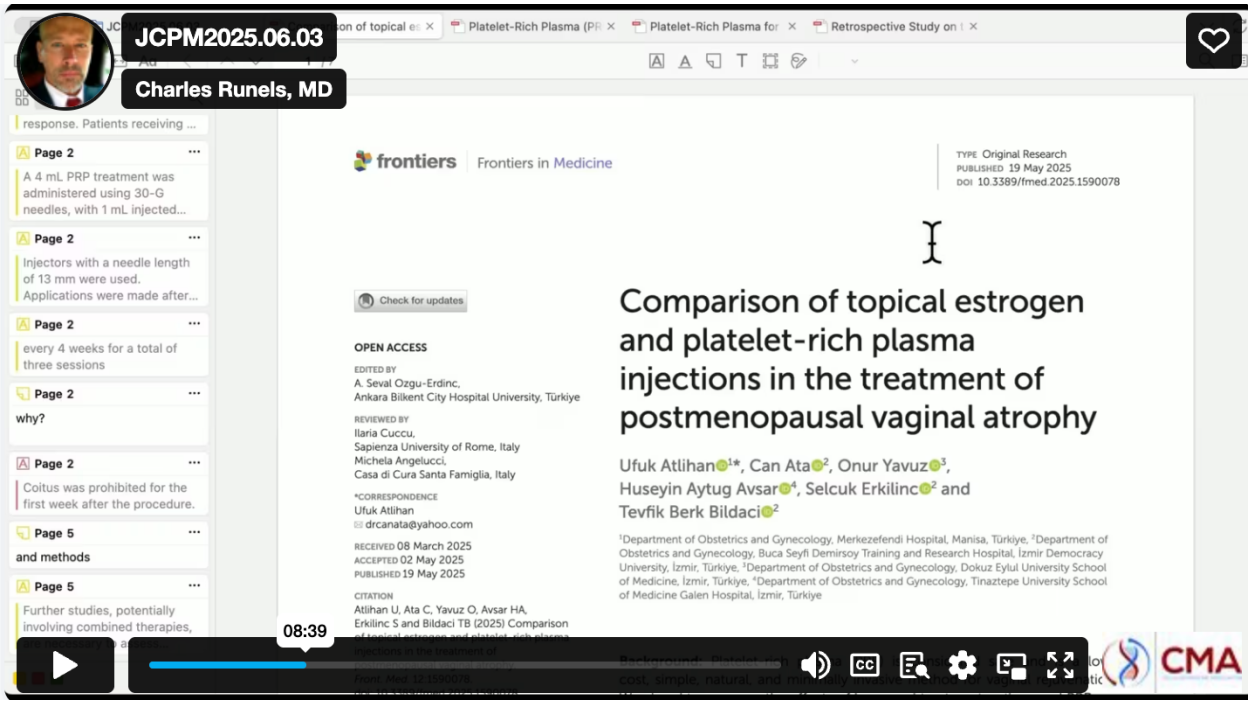
# JCPM2025.06.03

The following is an edited transcript of the *Journal Club with Pearls & Marketing* (JCPM) of June 3, 2025, with Charles Runels, MD.

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




## Topics Covered

- **What works better for dyspareunia from dryness: our O-Shot® procedure or estrogen cream?**
- **More Research Using PRP to Recover Viable Eggs**
- **Why PRP May be Working Better than Expected for Dyspareunia**
- **Does treating Lichen Planus with PRP Work Better than Corticosteroids?**
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**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 our journal club.

When we first started 15 years ago, almost 16 years, can you believe it? 16 years of thinking about platelet-rich plasma and cellular therapies, and everything from amnion and stem cells, seeing things come and go, and the FDA changing opinions three different times. Throughout those 16 years, some of you have been with us the whole time and have helped hundreds of thousands of patients collectively, I'm sure, over 1,000,000 O-Shot®s by now. But in the beginning, the research was scant, relatively speaking. We had right at about 5,000 papers total in PubMed about platelet-rich plasma. And all of us were new, so we called a journal club with pearls and marketing, and we talked about what we were seeing. It was amazing.

When I first did the O-Shot®, I practically didn't even know what lichen sclerosus was. And then next thing you know, I'm financing the study, and we're showing that it helps. So, the expansion of our knowledge and our ideas has been steps ahead of the research. But of course, the research is backed up so far, everything we've done and then some. But now we have so many papers coming out every week, I can't even get to them all. So, I'm having to choose.

And when I say papers, I'm focusing on cellular therapies, especially in relation to sexual medicine and aesthetics, with some inclusion of infertility and other sidelines like pain and orthopedics, for those of you who are practicing family medicine or gynecology and infertility. That's what I look for.

But in the beginning, there was less research to talk about and there was more... All of us were new, so there was more discussion about the relative nuances in doing the procedures. And now that we have, some of you have been doing the O-Shot® for 15, 16 years, you don't really need to go over so much where to put the needle, but those who got it wrong dropped out. Some people were just unteachable, and they tried things that didn't work or tried to use our name and do it their own way. And we've modified the procedure along the way, but we've got the 16-year history/protocol that we know works if you know how to pick the right patients.

And so, it became necessary, I think, to split our conference into two parts because the new people have questions that most of us have thought about before over a decade. So that's why I have the separate webinar on Mondays now, where we answer more questions for protocols regarding the

procedure and marketing questions, and less about the current literature. So if you've been doing things for a while, that's not as needed for you unless something weird comes up and you want to talk about it with the group. But the journal club, we're going to keep going as well. So now we're having two webinars a week, and we'll move this one to the evening, so we have more time to leisurely talk about what's happening.

So let me swap over.

## What works better for dyspareunia from dryness: our O-Shot® procedure or estrogen cream?

Probably three or four years ago, in menopause, someone used Regen kits, which I still use. I think they're wonderful. It's a single spin, but they work great for the O-Shot®. I have others, as you guys know, but that's what was used in that study in menopause. And they just took women who had dyspareunia with a history of breast cancer and could not be on estrogens and showed that they improved their dyspareunia by using an injection of platelet-rich plasma into the vaginal wall.[1]

But the study that needed to be done just came out of Turkey.[2] And although I don't agree with all their methods, they still helped us out. They took 66 patients, and about half of them, 36 of them, just got estrogen, topical vaginal estrogen, and 30 of them got PRP, and it was 30 who were not responding to the estrogen, the topical estrogen. So these were people who had vaginal atrophy with dyspareunia, and they measured three different scales, one of them being the female sexual function index.[3] And their conclusion was that the ***PRP was as effective and actually slightly better than the estrogen, the topical estrogen.***



As far as I can tell from reading research for more than a decade, they're the first to compare the two. And they showed that it worked at least as well. You can see it's not over the top. Female sexual function index scoring in the 12th week with estradiol, it was only slightly better, but it was better and statistically it was better.

But even if you want to say they were the same, well, great. Why wouldn't you want to use a platelet-rich plasma that is not going to increase your risk of breast cancer and could have the side effect of helping urinary incontinence?

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

[2] Atlihan et al., "Comparison of Topical Estrogen and Platelet-Rich Plasma Injections in the Treatment of Postmenopausal Vaginal Atrophy."

[3] *Female Sexual Function Index (FSFI) | Free Software Calculator – O-Shot® (Orchid Shot® ).*

So I love the study.

There were a couple of weird things about it. I can't figure out why you would want people not to have sex after you've injected platelet-rich plasma. I think when I see that, I think this is someone who's not used platelet-rich plasma in other areas or is not experienced with it.

You don't tell people when you put it in the face, "I don't want you to eat or smile or move your face."

And you have people using tourniquets when they inject the penis, but you don't put a tourniquet around the neck when you inject the face.

In other words, they're not used to seeing the material flow in a place where you can see it flow, like the face, where there's only a few millimeters in some cases between the skull and the depth of the tissue, say, over the forehead, around the eye. It's easy to see what the fluid is doing because there's not much tissue there. Compared to, say, injecting the vaginal wall, where you need a flashlight to see where you're even putting the needle.

So I'm not sure where that comes from. They didn't do the procedure the way we do it. I don't think they did it as effectively as we do. They did a double spin, and they wound up with four CCs and then used some weird needle and injected in all four quadrants of the vagina. And I can't argue with putting it in other places, I don't think you hurt anything, but the periurethral glands (Skene's glands) are anterior. We've been getting great results just injecting the distal to the bladder near the introitus and the anterior vaginal wall, one injection.

When you use PRP in the face, you can see how it spreads. But you'll often see people threading the needle and doing multiple injections, not contemplating the fact that you can inject it. If you're in the right tissue plane, it hydro dissects everywhere it needs to go, and you don't have to do so much with your needle.

So you can see, I think, the inexperience of those who have not used PRP in other areas, but I love... I would buy all these people dinner tonight if I could because they've given us a study that shows that injecting the vaginal wall, even in a way that I think is inferior to the way we do it, you're able to treat the symptoms of vulvovaginal atrophy at least as good, probably better than using estrogen.

And then if you combine that with a study of women with breast cancer, with that study, you're thinking, "Okay, they chose not to have vaginal estrogen. So you tried to use something that would work as well."

But this takes it a step further and says, actually, ***the vaginal estrogen is an inferior way to treat them, even if they haven't had breast cancer***. So this is a study to definitely share with your patients.

I've put it in the download, it's open-source, so it's no problem with downloading it. And you can stick it in a file or you can link to it, the link where it lives online. I'm sure you know this, but if you give the reference, if you're giving credit to where it's due, then the rules of open-source is you could put it anywhere. You could upload it to a Dropbox and put a link to it in an email. So I'll give you a simple little

email that you could send out at the end of after we move further along. But that's my favorite paper of the week.

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And as some of you know, I missed last week. I've only missed about four, three or four in the past, I don't know, six or seven years. But my youngest son got married in New York, and I was there, and I just said, "This time I need to miss the journal club." He married a lovely, talented lady, Clara Diaz from Argentina, and she's a singer who goes with him to the New School there in New York City. He's a drummer and she's a singer. So I think that's a pretty good yin and yang match, and they're so lovely together. Anyway, that's why I wasn't here last week.

## More Research Using PRP to Recover Viable Eggs

I'm not going to plow into this meta-analysis because most of us are not infertility doctors, but now there are three to four papers coming out per week about using platelet-rich plasma to help recover viable eggs in postmenopausal women.[4] And I'm watching it, though, even though I'm not an infertility physician, because they're looking at some of the nuances that I think may apply to other things that we do.

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For example, there was a study I didn't bring up this time that showed that if you treated the ovaries twice, it didn't improve the results over just treating them once. And I'm not sure exactly how that applies, but I used to wonder, for example, when we treat the scalp, when you treat for hair, do you really need to treat three times, once every six weeks? Or would you have gotten the same results had you just treated once and then waited the 18 weeks? And someone finally did that study, and there is a cumulative effect, but someone did this study for ovaries and found that there isn't.

## Why PRP May be Working Better than Expected for Dyspareunia

We're getting crazy results for dyspareunia. And even though it makes sense that it would help, say, when you have a trigger point that's bothering someone in the pelvic floor or when you're treating lichen sclerosus, where we know PRP attenuates the autoimmune response and helps the lichen sclerosus, for some reason, our O-Shot® helps people fall in the category of dyspareunia of unknown etiology. You can't reproduce it by pushing a trigger point in the pelvic floor. There's no known rash, there's nothing on ultrasound. And that group, I think, is bigger than most people want to admit.

It's been about eight years now, but there was an editorial in the Green Journal where the editor said, speaking to gynecologists, "We should really own up to the fact that a lot of the people with

[4] Moustakli et al., "Platelet-Rich Plasma (PRP) in Reproductive Medicine."

dyspareunia, even though we have elaborate algorithm for coming to a specific diagnosis, many of them go undiagnosed."

So other than just dyspareunia.

So, looking at this paper showing that PRP, in general, can help with pain, I think it is a wonderful carryover to help understand why we might be helping with dyspareunia.[5]

Other things that come to mind are, for example, we know platelet-rich plasma has been studied many times to examine wound care in vitro and in vivo, MRSA, and all sorts of resistant infected wounds.[6] [7] [8]

So, you can say, "Well, maybe you're treating an undiagnosed infection."

There was a study out, and many of us have treated people with chronic recurrent UTIs with just a regular O-Shot® with great effect.[9]

So maybe it's an infection, maybe because it's downregulating some sort of autoimmune response.[10] [11] [12]

Maybe it's just causing healing of something that has been slow to heal with muscle, as we'll get to in a moment. But for whatever reason, it seems to help dyspareunia of uncertain etiology. This is a nice paper that shows that, in general, PRP is good for non-cancer pain.

I put it in the download section. You can share it with your patients, whether you're treating orthopedic problems or, for example, TMJ syndrome.[13]

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[5] Wang et al., "Platelet-Rich Plasma for Treating Chronic Non-Cancer Pain."

[6] Pourkarim et al., "Comparison Effects of Platelet-Rich Plasma on Healing of Infected and Non-Infected Excision Wounds by the Modulation of the Expression of Inflammatory Mediators."

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

[8] *Platelet-Rich Plasma as an Additional Therapeutic Option for Infected Wounds with Multi-Drug Resistant Bacteria: In Vitro Antibacterial Activity Study - art%3A10.1007%2Fs00068-018-0957-0*.

[9] Ke et al., "Therapeutic Potential of Intravesical Injections of Platelet-Rich Plasma in the Treatment of Lower Urinary Tract Disorders Due to Regenerative Deficiency."

[10] Vazquez et al., "Alopecia Areata Treated with Advanced Platelet-Rich Fibrin Using Micronization."

[11] Vazquez et al., "Alopecia Areata Treated with Advanced Platelet-Rich Fibrin Using Micronization."

[12] Seffer and Nemeth, "Recovery from Bell Palsy after Transplantation of Peripheral Blood Mononuclear Cells and Platelet-Rich Plasma."

[13] Tsai et al., "Effectiveness of Platelet-Rich Plasma for Treating Temporomandibular Joint Disorders."

Well, it makes sense that, and we have covered papers here frequently about injecting PRP as well as botulinum toxin in and around the TMJ joint for that pain. We covered a study about two months ago about TMJ pain affecting sexuality. It should be part of your questionnaire if you're treating TMJ: "Is it affecting your sexual function?"[14]

So you have reason to believe it might help pain and some other than what it does for the joint. And so that's a good one to share with your people if you treat pain.

## Does treating Lichen Planus with PRP Work Better than Corticosteroids?

This one I brought out because, and this one's in your handouts too, we've had multiple papers. I've yet to see a paper that does not support platelet-rich plasma for lichen sclerosus. And by the way, it's spelled with a "u", not an "i".[15]

I'm not sure why they did that, but the people who research lichen sclerosus will laugh at you if you use an I. Even though Mark Twain said he didn't give a damn about a man who just knows one way to spell a word, you really should spell lichen sclerosus with a U instead of an I.

Even though some papers have shown benefit when treating lichen planus with PRP,[16] this review, in which they reviewed the papers, showed that it's not so certain and questionable whether it's helpful. Some of the papers show that corticosteroids work just as well. So, I don't know what to do with that one. But I wanted to give you something counter. It's not all positive.

Correction: Only one paper showed no benefit with lichen sclerosus (not lichen planus) and in that paper, they used saline as a placebo. The placebo arm had a greater than 50% response rate.[17] Over 50% of the placebo patients improved on biopsy, which to me just shows that the saline was not really a placebo when it was used.

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

[15] Niemczyk et al., "Use of Platelet-Rich Plasma (PRP) and Injectable Platelet-Rich Fibrin (i-PRF) in Oral Lichen Planus Treatment."

[16] ElGhareeb et al., "Intralesional Injection of Platelet-Rich Plasma versus Steroid in the Treatment of Oral Lichen Planus."

[17] Goldstein et al., "A Randomized Double-Blind Placebo Controlled Trial of Autologous Platelet Rich Plasma Intradermal Injections for the Treatment of Vulvar Lichen Sclerosus."

Multiple studies in the dermatology literature have used hydrodissection with saline to treat scarring, leishmaniasis, and other conditions.[18] [19] [20]

So except for that one-off paper, all the papers for lichen sclerosus have been positive, but not for lichen planus.

## Treating Melasma with the Vampire Facial® Procedure

This one, looking at treating melasma with microneedling,[21] reminds me of another paper where they looked at microneedling with PRP versus microneedling with TCA for acne scars. The TCA worked better for ice pick scars than microneedling with PRP. So, our Vampire Facial® with PRP does not work as well, at least in that study, for ice-pick acne scars, as does microneedling with TCA.[22]

And I like a lower concentration TCA. I used to do the Obagi Blue Peel, and I never had a bad outcome, but I saw people who did from other doctors. So I use a 5% TCA that I get from Vi Derm, they have a peel that I think is safe.

So This one shows they're about the same, give or take.

We've covered half a dozen papers that show microneedling with PRP helps melasma, but ***you must, of course, tell them to stay out of the sun***. It's a horrible problem, and people love it when you treat it. For some reason, a lot of our people who are doing the Vampire Facial® are not aware that you can treat it with PRP, but you can. I think this is close enough that I would go with the PRP, but both worked.

## Review Article of Treatment Options for Stress Incontinence Includes our O-Shot® Procedure

And this one is just a systematic review of the treatment for stress incontinence.[23]

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[18] "Clinical Benefit of Intra-Articular Saline as a Comparator in Clinical Trials of Knee Osteoarthritis Treatments_ A Systematic Review and Meta-Analysis of Randomized Trials | Elsevier Enhanced Reader."

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

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

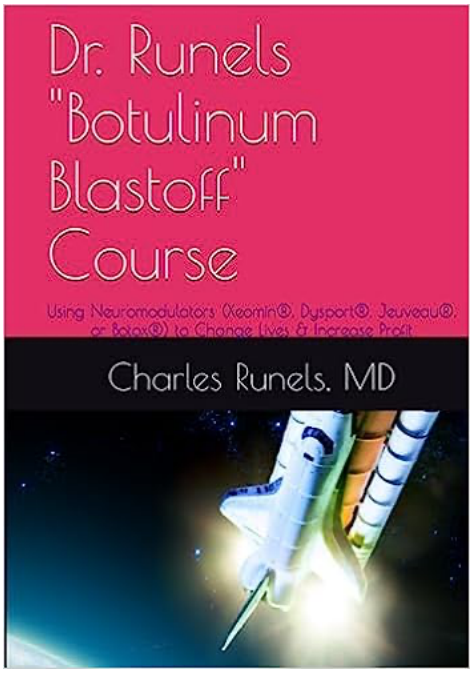
[21] Pazyar et al., "Evaluation of the Efficiency of Microneedling with PRP Versus Microneedling with Tranexamic Acid in the Treatment of Melisma."

[22] El-Domyati et al., "Microneedling Combined with Platelet-rich Plasma or Trichloroacetic Acid Peeling for Management of Acne Scarring."

[23] Petca et al., "Modern Conservative Management Strategies for Female Stress Urinary Incontinence."

I put it in here because we're starting to show up as one of those treatment possibilities, which I think is wonderful. And if you look at what's happening, it really seems to be working better than you would expect if the mechanism of effect were only from increased blood flow, or bulking.

So what I've come to think, and this study, here's a low-hanging fruit study to be done, but what I've come to think is that we may be helping the muscle function of the urinary sphincter. We're getting to a muscle study in a moment, but there's a longitudinal layer, a circumferential layer, another circumferential layer, and the space between the layers of muscle of the urinary sphincter and the musculature of the vaginal wall are separated when you get proximal to the bladder, but they actually touch when you get near the introitus.[24]




So our technique, if you look at it, I was more lucky than smart. I was thinking injecting close to the periurethral glands to help with ejaculatory orgasm. And my second patient told me it had helped her incontinence. And I think I was lucky enough not to know what most gynecologists for incontinence were injecting, closer to the ureterovesical junction with bulking agents. And now we know our O-Shot® doesn't work so well for incontinence when you inject more proximal to the bladder.

Anyway, this is another study supporting what we're doing, that our O-Shot® is helpful for incontinence, as part of our systematic review that they do.

But it has to be done the right way or you're not going to get good results.

And if you're looking for low-hanging fruit, measure the musculature with ultrasound before and 12 weeks after an O-Shot® and correlate that with your incontinence. Someone will eventually do that study.

## A Call for Protocol

This one is just a general one, and it's in your handouts, too. It talks about how there's a need for protocols in the study of what we're doing, PRP therapies and cellular-based therapies, mesenchymal cells, amnion, and such. How should these studies be conducted?[25]

So between the lines, part of this is that what we've predicted. That first you prove that, or you show, you never prove anything, but you stack up research showing that an idea might be helpful. And then

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

[25] Winkler et al., *Evidence-Based Guidelines on Orthobiologics*.

Once that happens, you're just at the starting line because then the infinite number of variabilities make it so that you have thousands of studies to do to figure out the best way.

How deep should the needle be? What else do you mix with the PRP? Do you cool the platelets? Do you wash them with saline? Do you activate or not? And if so, with what? And how much and how do you prepare it? Double spin, single spin white cells are not white cells. And so many variables that the studies will go on long after I'm at some place other than the planet Earth.

So this is another document giving ideas about how we could conduct our studies in the future.

Of course, they all say we should have a standard protocol that evolves as science evolves. And so we're ahead of them on that. We're doing that, and depending on which procedure we have, we have anywhere from 16 years of experience with our O-Shot® and Vampire Procedures, to two years of experience with our Clitoxin® procedure: collectively millions of patients because of our group size.

But this is something to look at if you're going to be doing any research, and it's a nice way to grade our papers as we go through them, too.

## Vampire Facelift® Methods Improve Periorbital Aging

This one is, I admit, I usually spend hundreds of dollars downloading non-open-source articles every week, but sometimes I'll protest because I'm okay with spending $50 to download something. When they get over 70 or 80 bucks to download one article, I just protest it.

So this one, I'm going to give you the link in the chat box, but it's just what we're doing.[26] Another person showed that if you inject around the eye, the dark color, the crepe-papering improve. The bags, not so much, which is what we see.

So your general rule of thumb, if it's a texture problem, or a loss of volume, or an increased pigment, you can make it better.

Usually we're treating every six weeks for a series of three, and I recommend you microneedle it and inject subdermally.

I saw a brilliant Indian woman in New Delhi show me her technique of injecting, and she's putting two and a half CCs under each eye. You can see a description of that on our membership site on the Vampire Facial®; just put in the search bar, "periorbital color" or "dark color" or "dark circles" under the eyes and put in Sylvia Silvestri. She gives a beautiful explanation about how to do it, better than what's in this recent article.

[26] Xin-Li et al., "Safety and Efficacy of Platelet-Rich Plasma in the Treatment of Periorbital Skin Photoaging."

But you could take this article, it's not open-source, but you could take a link to it and send it out to your people and say, "Hey, here's more research showing that our Vampire Facial® for under the eyes helps make the eye look younger."

Now, if they have extra tissue, they need a blepharoplasty. I don't even try to treat that. This study showed that that was not so helpful, but the rest of it, the color and the texture, helped. So I just put a link to it.

## What You Can Learn from Superman

Now, why does that work, sending an email about this? If yesterday, if you sent an email: "Hey, come to our office. 10% off if you'll let us microneedle your eyes," that's an ad. And your bargain shoppers look for ads. But the people who just want quality medicine from a smart person look for a letter.


And if you compare an email that says, "10% off for the next week for microneedling. Here's a before and after picture of someone untreated, and it's going to make your eyes look younger," you'll get some people to come in, but it's an ad. Now, if you send a letter out tomorrow that says, "Hey, there was this article that just came out where researchers showed that if you inject the eye in the way that we do it with our Vampire Facial®, it helps lighten the color, if you have dark color. It helps smooth the tissue. Not so good for the bags, you probably need a blepharoplasty. But this just came out, I read it, I thought you'd be interested in it, and we know how to do it even better than what's described in this article."

So now you've written a letter about recent research. And imagine receiving that from your doctor versus an email that's basically begging you to come see them, to the point that I'll give you a discount if you just come see me. Superman does not give discounts. He doesn't say, "10% off if you let me save you today." He lets people know what he's able to do.

You know he exists. He's flying around in the sky wearing pantyhose and a cape, but he doesn't beg you to let him help you. So that's your version of a pantyhose and a cape. People don't know what you're able to do. It's our responsibility to teach them. But teaching is more effective than begging.

So there you go. If you're doing microneedling or the facial, you have a beautiful article to entice people to come see you. I put the link to it in the chat box.

## HA alone vs. HA plus PRP for OA of the Knee (MRI documents difference)

This one, I've been wanting as well, another, I think, landmark study. We've had multiple studies that show that injecting the knee with PRP helps with osteoarthritis. Corticosteroids often help with pain in the short-term, in the first month or so, but by the time you get six months out and longer, PRP is better for the pain and better for preservation of the joint.

I haven't seen a good study. I don't even remember seeing a study that compared HA alone with PRP plus HA with MRI. And the combination, as you would expect, works better.

What are we doing when we do the Vampire Facelift®? We're using an HA, and then we're layering PRP on top of it, or sometimes I'm sure it's going into it. And if you look at the wound care research, what's happening is the HA acting as a scaffolding that serves as a place for the stem cells that are recruited by the PRP to attach and grow healthy tissue. And no reason to be surprised that it might help in the same way in the knee. And this study indeed showed that.



So if you're doing knee injections, this is a strong study, an MRI, it's done the right way, and you can bank on it. And it was open-source.

So you could send a link to this to your people and say, "Hey, this is what I do, and here's new research showing that me using this combination of PRP plus the Synvisc or Hyalgan, whatever you're using, is better than what people are doing with either cortisone or alone. So come see me."

If you're not doing these, Karen Rea teaches joint injections; her name is in our directories.

## Online FSFI Calculator (FREE)

Okay, and the last one, and then we'll see what questions you guys have. Oh, this is not a paper. It was a reminder to me that if you remember this paper about the topical estrogen working less effectively for vulva vaginal atrophy than our O-Shot®, actually an inferior version of our O-Shot®, one of the things they measured is the female sexual function index (FSFI).

I just got tired of calculating that test about six months ago or so. It's aggravating to calculate it, but I think it's the best test. I've used the female sexual distress scale; it's much easier to grade. Neither one of them really takes long to administer, but the female sexual function index gives you better domains.

Are they having problems with lubrication? From pain? From arousal? From orgasm? And what's their overall satisfaction? It gives you a smarter, more granular look at what's going on with your person.

But it's a complicated, time-consuming... It's not calculus, but it's a time-consuming grading process where you have to grade each question a little differently, and then you add it up, and it's just aggravation.

So I had someone write some software. And I'll give you the link to it right now. Let me swap what you're able to look at. It's been a while since I talked about it, but I really think you should do the female

sexual function index on your patients if you're treating sexual problems, because you don't really have a good objective way to measure.

You can't measure it in an EKG, and so having a... It's why it's in all the studies when they're doing tests on sex, they do the female sexual function index.

Here's the link to the online FSFI calculator<=

They can also see what the various prescription drugs do versus what our Clitoxin® does. Our Clitoxin® with the O-Shot® blows these out of the water, with references.

So you can send your person there, and they can do it in the office on an iPad, which is a good way. Or if you want them to do it on their iPhone, you could just text them the link and have them take that test.

It wasn't cheap to have this written, but it was, I think, needed. I couldn't find another place online that I liked. There was one other one that would calculate it, but it required you to do all sorts of things. This doesn't ask anything of your patient except just to take the test. And it doesn't keep track of their name, so if they want to just do it for fun, they can.

But I just have my patients do it on their phone and then text me a picture of the score.

Okay, I think that's it. Let's see if there are any questions. If not, we'll call it a night or make comments about anything.

Let's see. Okay, so in summary: I would say you have two or three papers here that... Oh, wait, wait, wait, wait, wait, wait. I can't not do the... There was one other paper that I think I forgot to cover. I'll cover it next time. It had to with muscle injury.[27] I'll get it next time.

Anyway, so thanks for being on the call. And you have two papers you could use to promote your practice.

The one about topical estrogens not working as well as our O-Shot® for vulva vaginal atrophy. That would be every woman that's over 40, 45 years old would want that.

Why not?

And the same thing... I don't like to push too hard about making good better because ethically, I think we're policed to talk more in terms of making sick well versus well to be better.

[27] Munteanu et al., "Retrospective Study on the Efficacy of Platelet-Rich Plasma Treatment in the Recovery of Quadriceps Muscle Strength After Anterior Cruciate Ligament Reconstruction in Non-Professional Athletes."

For example, you can't give testosterone to a man who's not having problems just to give him stronger muscles. You'll lose your license. But so far, we've been okay. It's the powers that be have implied that it's okay to make good sex better.

Still, if you notice, mostly I talk about problems, sexual dysfunction. I seldom talk about making good sex better. I just talk about treating broken sex with women, dyspareunia, anorgasmia, lack of libido, those problems.

But the truth is, you're going to have people come to see you that have good sex, and they want you to make it better because they realize that even though they may not have vulva vaginal atrophy, if you have something that makes the tissue healthier in an 80-year-old woman, and many of us have 80-year-old women who are very sexually active, after our O-Shot®, you will have those patients if you start doing the O-Shot® regularly. But you also have the 30-year-old, 35-year-old woman who maybe she's not having pain, but she wants things to keep working well. And maybe it's not like it was when she was 25, and she'll come to see you too.

So that's a good one to teach your people what you're able to do. Or the other would be the micro needling under the eyes. And then the last, of course, is the HA combined with PRP in the knee, just a simple little two-line email or a social media post with a link to those papers, and you should get some new patients. Okay, hope that was helpful. Have a good night. Thank you for being on the call. See you next Tuesday night.

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## Here's an Email You Could Send

1. Copy and paste the following message into a new Word document.
2. Then edit it so that it sounds like you.
3. Add a story or a personal observation if you have time.
4. Then, fill in the information with your phone number, etc., and send it to your patients.

Hello (first name),

I thought you might find this research interesting, which shows that our O-Shot® procedure works better than topical estrogen for the treatment of pain with sexual relations (dyspareunia).

This would be especially helpful and encouraging to women who have concerns about breast cancer.

If you think this may help you or someone you love, please contact us.

Best regards,

Your name
Your phone
Your email

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## Tags

Charles Runels, MD, Journal Club, PRP procedure, FDA-approved kit, Vampire Facelift®, O-Shot®, Orchid Shot®, Priapus Shot®, P-Shot®, Priapus Toxin®, Vampire Breast Lift®, Vampire Wing Lift®, Clitoxin®, Cellular Medicine Association, marketing tips, protecting patients, sperm count, testicles, advertising, vampirefacelift.com, BrandShield, opt-in emails, email marketing, hands-on workshop, live model training, FSFI calculator, 5-Notes Expert System, membership login help, ONTRAPORT, affiliate marketing, online training, botulinum toxin course

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