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The following is an edited transcript of the Journal Club with Pearls & Marketing (JCPM) of October 13, 2026, with Charles Runels, MD.

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Transcript

Welcome: Some Very Impactful Studies

Charles Runels, MD: We have some, I think, very impactful studies to talk about. One of them was pointed out to me this morning by my brilliant wife: what they call an umbrella review of botulinum toxin for refractory erectile dysfunction, which of course directly impacts our Priapus Toxin® procedure. So we'll save that one for last.

I think it deserves the deepest dive, and I have something to show you in that regard what I generated today to help out. These others are quick, and despite all of it, I think we can get through them within our 30-minute timeframe.

PRP Versus Cortisone for Orthopedic Pain, Again

For this first one, I'm not even going to dive into the science; I'm showing it as more evidence because this happens every week and I don't talk about them. Almost every week, there's at least one study that shows this when you treat some sort of orthopedic complaint: elbow, knee, osteoarthritis, tendonitis,

plantar fasciitis, all these different locations. There's a huge stack of articles, and this is another one that came out this week showing that if you use cortisone, you have better pain relief the first month or so, and then there's crossover. Usually somewhere between four to six months out, you start to have better pain relief for the group that got platelet-rich plasma, and imaging studies show better joint preservation.[1]

So that's a repeat of an old refrain, but just a reminder that those studies are still being done, and if you're doing something like that in your office, you're still on strong ground if you're going straight to PRP for most orthopedic indications.

A Critical Review of Regenerative Therapies for ED

Your Enemies Make You Stronger

Okay, the next one is sort of a hit piece. Remember, your enemies make you stronger. You want a smart person to criticize you (if you do not have an enemy, go make one), so that he/she points out where you need to think more, work harder, or do more. And this is one of those articles where they reviewed, they humped it all together (put intended) about regenerative therapy. So they include shockwave therapy with our PRP and other things.[2]

And you can guess what their position is: yep, it is something that there's evidence for, but they just can't bring themselves to say everyone should be doing it. I think they're waiting. I mean, if you're writing for a high-impact journal where you're setting the policies, it's the chicken-and-egg question. There's got to be some blowback if you say, "Okay, this is something everybody should do," but insurance isn't covering it yet. Now, that's my personal opinion. That's nowhere in this paper, but that's how it feels to me when I read these papers.

Regenerative Versus Making What's There Work Harder

And the thing that maybe should be emphasized the most is: just look at the name ("Regenerative Therapy for Erectile Dysfunction: Paradigm Shift or Premature Promise?"). They are putting together the things that actually might reverse some of the pathophysiology, because the others don't. The PDE5 inhibitors don't. Of course, a penile implant doesn't. Even Trimix and PDE5Is; those things are just making what's there work harder. They're not triggering a regenerative effect.

And you could argue that botulinum toxin could actually be in this regenerative group, because going back to the '50s, you can find studies showing neurogenesis and neovascularization.

Their Pros and Cons

And so when you get to their pretty picture here, they have a nice pro-and-con thing. And yeah, it's heterogeneous protocols, PRPs all over the map. These are all real: variable patient selection, limited validation, uncertain durability. Well, six months to a year is still a whole lot longer than the 24 to 48 hours from a Cialis.

And the thing is, we don't have the budget. When you think about it, AbbVie pulls in $61 billion a year, and we're dealing with blood. There's no patent on that. So "not ready for routine use": if you're 66

years old like me and you're going to wait for that to happen, my penis will be in the dirt by then. It's going to be another 40 years. And your patients don't really want to wait for that to happen, if you have something as safe as these therapies (most of them are) and you're saying, "We have to wait."

So it's okay to take their opinion into account when setting global policies, but that doesn't mean a physician and a patient can't choose to do something more, even with an off-label drug. We're going to get to that idea next. But I think it's great we have smart people thinking about our procedures, even if they are not yet convinced.

Publication Bias: Yes, We're Biased

Let's look at their biggest bomb to blow up what we're doing: publication bias and study limitations. Okay. Yep. We've got risk of bias; I admit that. I'm biased about a lot of things. I hate drive-through windows. I'm biased against going north of I-10. It's frozen tundra to me (that's my bias), unless I'm just going to visit for a short time.

And I think I'm biased against these authors, because I think it bothers them that we're prospering, and they're probably locked into insurance pay. So that's okay. But I think that if you want to look at the science of it, yeah, okay, we're biased. That's a personality thing.

No Discrete Finish Line

Durability: we're more durable than a Viagra pill. Limited objective validation: okay, we need some more data. But the data so far has been supportive. There's no discrete finish line. The way you show something is by formulating a hypothesis that's testable, then doing repeated studies that try to shoot it down. And there is no "Okay, this is the one that proves it." It's just that the evidence keeps piling up, and it has been piling up.

And yeah, they're mostly using scores, variable patient selection. That's true with any study. And if you look, there's nothing here that says, "You may go blind," right? But that's what you get with Viagra or Cialis. You may have a stroke with those drugs too. That's nowhere here with our P-Shot® . That's what you get with Viagra or Cialis. And the flip side with our P-Shot® is you may actually help slow down or reverse some of the pathophysiology. That's the positive thing that you don't get with the PDE5 inhibitor.

We Are Not Going to Wait

So I think it's a bias thing, but it's great. I liked looking at it, because if this is the best you've got, this is your strongest bullet, then great, I feel reassured.

Yes, I will discuss all of this with my patient. And if they choose not to wait till the studies are done, because their marriage is on the rocks and he can't keep the woman he loves most happy in the bedroom, and he's worried that she's going to run off with the next Amazon delivery person, we are not going to wait because someone thinks we're biased.

Okay? And we'll get more into how you do that and take care of your license while you're taking care of your patient. But it's becoming more and more difficult. This one's almost irrelevant, because we've

been hearing this for 15 years. But the next one about botulinum toxin we have to pay more attention to.

A Letter on Cash Pay and Ethics

Find Out If Your Patient Is Truly Happy

So let's go to this one. This is really the heart of it: the cash pay, the fact that we're getting money. And so, I really like this article because it's a letter back to those who are worried about us making money.[3] Remember, ***people always want their lawyer to be rich and their doctor to be poor***. It's okay. That's the way it's going to be. Just understand it and deal with it. Even your colleagues don't want you to make too much money.

But let's look at this. This is a very, very brightly written letter, so I'm just going to read at least some of it. Elective procedures are common, and they're being done in the millions annually. You can say that now about our P-Shot®. You just do the math; it's really easy. It's been done millions of times. Cash pay can provide income, and when they reach for it for uncertain efficacy, that could be a problem.

This whole debate, this whole conflict of ethics that is being talked about as part of the current conversation, is why ***you must find out if your patient is happy, like truly happy, with what you did. And if they're not, either repeat it or do something of equal value or refund their money, whatever makes them happy.*** You don't have to do that if insurance pays for it, but I think you have to hold yourself to that standard, and ***that's the shield to this bullet.***

Shared Decision-Making

Then they start getting to the science, and this is where I like it. So decision-making combines the patient's values with expertise to support informed, autonomous decisions.

Okay? So we know that.

You talk about it with them, and what it boils down to is we just provide the evidence, the guidance, and say, "Okay, if you realize that your penis will also be dirt by the time they do all these double-blind, placebo-controlled studies, and you agree that this is what you want to do, insurance doesn't pay for it, so would you mind paying me to do it for you?"

And so thank you for this letter. It says, ***"Financial sustainability and ethical practice are not mutually exclusive." Just keep it aligned***.

That's all it is. Just have a framework for cash-pay procedures. So that's it. That's the war that's been waging, and I want you to see the bullets.

The Tail Wagging the Dog

And you can say, "Oh, I don't want to play in this arena."

It's okay. "I'll just go back to: if insurance doesn't pay for it, I won't do it."

To me, ***that is the classic metaphor for the tail wagging the dog, when you have a stack of research supporting something that's safe, and you're waiting for insurance to approve it.***

Insurance doesn't pay for my running shoes, but I know from many studies, starting 30 years ago with Kenneth Cooper in Dallas, that my miles per day will do more to prevent heart attack or stroke than any drug on the market, including diabetes and blood pressure drugs. Blue Cross doesn't pay for my running shoes, but I still buy them.

PRP in the Testicle

Okay, I'm going a little fast, because I'm going to try to do 30 minutes. I went over last time. This one I bring up again to show you this is going to be a thing. I've done it. It's not that painful. And I love this one because this study shows that they ***actually observed an increase in testicular size***.[4]

We don't have this yet, to where we're seeing this become a cosmetic procedure, but restoring volume of the testicle in a man who's not trying to get his wife pregnant, but just wants things to look more like they were when he was 20, could become a thing, and I think it's going to be. You could already argue it if you're trying to have a baby and your sperm count is low.

I've seen a dozen studies like this now: some form of PRP injected into the testicle. Again, it's not that big a deal. I did it on myself a couple of times, just to see and think about the methodology, before I ever saw a study like this, and it's not a big deal.

But leave it to the Italians. I love the Italians: the doctors, the people, Leonardo. I mean, they're just brilliant, smart, brave people who almost ruled the world twice. So I don't know what the gene pool is over there, but I like reading their research, and this is a good one. I'll give you all these links before I hang up the phone.

Over-the-Counter PDE5 Inhibitors in the UK

Viagra, the Internet, and Jail

Okay, almost done, and then we'll get to the legal thing. This one, I love this study. Let me tell you about the progression here, because I'm old enough to remember the early 2000s, when the internet was new. Did you know when Bill Clinton was elected president, there were only about 35,000 websites total on the internet? There was no spam filter. There was no YouTube.

And I remember walking down the street to my neighbor, who had just installed something on his computer called "Windows," and I thought, "What the heck is that? Why don't you just write your own software in DOS?"

It seemed like a lazy man's thing to me. And so obviously I missed that boat.

But then there was this crossover where you had PDE5 inhibitors, you had Viagra, and you had the internet, and some doctors did make quite a bit of money letting people order that by phone and/or a form online, writing a prescription, and mailing it to the patient. And there was actually some big warehouse somewhere close to me, I'm told, that was shut down. If you go online, you'll find at least

one doctor that went to jail for that two decades ago.[1] And I remember watching the news and seeing two or three people in my area go to jail for doing things like that.

And someone approached me. They were going to pay me something with six zeros, so it was a million-plus, just to do that in the early days. And I said, "No, I don't want to go to jail." I mean, this doctor went to jail. And so I didn't do it.

Viagra by Text Message, and Over the Counter in the UK

I checked the other day: $29, You can get a text-message visit on AMAZON. But if you're a Prime member, you get five more visits for free. So, for around $30 to $40, you can get a total of six doctor visits via text message if you're an Amazon Prime member. And you can do that and get your Viagra.

This is taking it one step further, because in the UK (I didn't realize this), it's over the counter. So they did a study to look and see: well, is this okay? Are people getting hurt or seeing the doctor less? And they concluded that it's okay: just make PDE5 inhibitors over the counter.[5]

And I imagine that'll be the next thing. Here in the States, I don't know, but I can see that coming.

Then we will have gone from a prison sentence for prescribing it over the phone to buying it over the counter without even speaking with a doctor. Imagine how Dr. Valentin must feel now.

When Advil Went Over the Counter

Some of you are the same vintage; you'll remember when Advil went from prescription to over-the-counter. I was a medical student when that happened, maybe an intern; I don't know. But I remember doing a rotation with a godfather nephrologist. He made sure everybody he met knew the following: I watched him draw out on a blackboard back how the combination of Tylenol and Advil over time, taking enough of it, would just… you're going to be on dialysis.

He treated people who did that with chronic headaches, and the two together were killing off their kidneys a piece at a time. And he thought that was the most tragic thing, when something that could kill your kidneys, like Advil, became over the counter.

And if you do the math on it, 20 extra-strength Tylenol is a lethal dose for a young female of, you know, 110 pounds. And I would know that because that's often a suicide gesture. Having spent 12 years in the ER: a suicide gesture can sometimes be, "I'll just take some Tylenol for attention, but it won't really kill me. But I'm depressed, and people will notice."

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[1] **Mario Alvarez Valentin and online Viagra prescribing**
On January 11, 2002, Dr. Mario Alvarez-Valentin was sentenced to 26 months in prison after pleading guilty to wire fraud connected with unlawful Internet sales of Viagra. Licensed only in Puerto Rico, he authorized more than 4,000 Viagra prescriptions from April 2000 through January 2001.
Source 1 — Federal account in 2003 congressional hearing, printed page 37

And then if the ER doctor forgets to check a few things, then the patient gets put on the floor of the hospital (not the ICU) with suicide precautions, nobody knows about the Tylenol, and the patient's liver dies. So both of those drugs can be a problem, but the two together…

Is This Okay?

A long way of saying: is this okay? I don't know. For a drug that makes you go blind, to make it where you don't need a doctor to get it, or you can get it for $29 on Amazon, I don't know. But I think that it's already here, apparently, in the UK, and this study is sort of a prophetic message that it probably will be coming this way. So you won't even need the $29 Amazon visit. You just order your magazine and your new book and order a bottle of Viagra off of Amazon without even sending a text message.

PRP and PRF for Herpes Zoster Pain

An Early O-Shot® Patient With Genital Herpes

Okay, this one. Why did I put this in here? Wait a minute. Oh, yeah, yeah. I put this in here because very soon (I think it was my second or third patient), I had a woman who saw me, and I did an O-Shot® on her. She had a lover whose job required him to leave the country for months at a time. So she would come off of her prophylactic acyclovir, whatever she was taking for her genital herpes, and when he would come back into town, she would take it. Well, after the O-Shot®, she said her recurrence rate went down dramatically off of that medication, the prophylactic medicine.

The Study: PRP Plus PRF Versus PRF Alone

And I haven't seen this out like this. I've not seen it for herpes zoster, but in this study they showed… Two things about this study. One, they showed that PRF. They didn't do a PRP-alone arm. They did PRP with PRF or PRF alone, to see if it would decrease the pain, chronic pain of thoracie, herpes zoster.[6] And the ***PRP with the PRF worked better than PRF alone*** (we are left to wonder if PRP alone would work better than PRF alone).

That, to me, sort of hints of maybe a little bias, because maybe they were wanting to show that PRF was… I don't know what they're trying to show, but there's this ***emotional*** debate about which is better, PRP or PRF, and there was no PRP arm. That'd be interesting: did PRP alone beat PRF alone? And that could be the study they didn't want to do.

But the bottom line is that for herpes zoster, PRF (or better, PRF plus PRP) can attenuate the pain response. And anecdotally (someone should do the study), we have some signs that it might decrease recurrence severity. Others in our group have told me that: severity or recurrence rates in genital herpes are decreased with our O-Shot®.

The Umbrella Review: Botulinum Toxin for Refractory ED

Who Was Studied and What Happened

Okay, this is the one that I had to pay the most attention to, so thank you, Alex [my wife, Alexandra Runnels, MD, FACOG], for showing me this.[7] Then I'll show you my response to it. We've covered all these studies. They looked at the studies that have been done for botulinum toxin in the corpus cavernosum, and the studies that I have seen, and the ones they looked at, were ***for erectile dysfunction in men who had quit responding to PDE5 inhibitors***. So that was the criterion.

It's been done with Dysport, Xeomin, and Botox. They were told to stay on their PDE5 inhibitors and add this in. Some of them had long-standing diabetes. Some of them had, as you see, multiple sclerosis. Some of them had spinal cord injuries. And the results showed a positive response: around 40% responded. It wasn't everybody, but it was a statistically significant response.

And so, of course, the next question is: well, if it works that well for someone who's not responding to PDE5 inhibitors, what does it do for someone who's not even on them? And that study hasn't been done, as far as I know.

Safety, Dose, and Our Priapus Toxin® Procedure

Let's look at the safety. No serious outcomes. One case of priapism. No fibrosis, so no Peyronie's disease developed, at least for the time they followed up. And in the studies, one used 50 or 100 units, and 100 units lasted longer. It lasted a year, nine months to a year, when you jump to 100. So based on these studies, we rolled out our Priapus Toxin® procedure.

Is It Legal? Off-Label Prescribing of Botulinum Toxin

Off-Label Is a Thing

So is that legal? Can you do that? So here's what I want to show you: some of my reasoning behind that, and why I think we're in good shape.

First of all, just think about off-label prescriptions in general. You can see, in 2001, there were an estimated 150 million off-label mentions. Off-label is used most commonly in cardiac medications: 40% of antihyperlipidemics and antihypertensives. Anticonvulsants: 40% of the prescriptions. Amitriptyline: as you guys know, we use it for a lot more than depression, 81%. And I didn't put this one here, but in one study of children in the hospital, over 90% of them had at least one off-label prescription.[8,9]

Here are off-label uses of botulinum toxin in dermatology reviewed by Lewandowski et al.[10]:

1. Hidradenitis suppurativa
2. Rosacea
3. Anal fissure
4. Raynaud phenomenon

5. Androgenetic alopecia
6. Plaque psoriasis
7. Inverse psoriasis
8. Hailey–Hailey disease
9. Eccrine nevus
10. Oily skin
11. Pompholyx (dyshidrotic eczema)
12. Darier's disease
13. Hidrocystomas
14. Notalgia paresthetica
15. Linear immunoglobulin A bullous dermatosis (LABD)
16. Hypertrophic scars and keloids
17. Primary hyperhidrosis outside the axillae (palms, soles, trunk, and craniofacial region)

So off-label is a thing. You can't practice medicine really very well without writing off-label prescriptions.[11]

Here's another study that came out a few years ago that reviewed botulinum toxin in male sexual dysfunction.[12]

PRP Is Not a Drug

So here's the thing I put together. We've talked about this before, but I wanted to update it and give you something more specific. Off-label in general: remember, PRP is not an off-label drug, because PRP's not a drug. That's a procedure, and the FDA regulates drugs, food, and devices, but it doesn't regulate medical procedures. It never evaluated cholecystectomy or hysterectomy.

And so, once you have PRP in a syringe, it's a blood product, so it's not regulated by the FDA, and the procedure isn't either. The device that prepares it to go back into your body is cleared by the FDA. You don't just use any device. So that's where PRP is different from a drug.

But if you want to write an off-label prescription for any drug, whether it's in the penis or injecting Botox for keloid or for androgenic alopecia, well, it's all the same. You're using botulinum toxin off-label. So how do you do it so that you and the patient can have a conversation that's ethical and legal and scientifically sound?

What the AI Said

So I fed the chat some papers that I just showed you. I fed it what we do. I fed it the paper that I just showed you where someone's criticizing the use of it, and how I think about off-label drugs. And I said, "Give me your best estimate of where all this stands and how we can stay safe."

And it did, with all that in mind (here's the download)<-

So I'm going to show it to you, and I'll give it to you as a download, and you can decide what you want to do with it. And then, with that, I'll answer any questions, and we'll call it a day. We'll be real close to 30 minutes, but I want to make sure I get all this into your download box before I close the call.

Okay. So I'll just read what I think are the best parts of it.

"A narrowly individualized decision for a carefully selected refractory patient is a different question from a general recommendation for routine use."

So these are ethical, smart people who wrote their paper, but they're writing about general recommendations. We're trying to decide about the 66-year-old man, like me, who doesn't want to wait for the research, but can read it.

"The most defensible clinical position is to consider any use only after adequate evaluation": right, exactly what you're doing already.

"Documented patient-specific reasoning, explicit informed consent": we've given you a consent form, and the consent form should include what you're doing with the botulinum toxin, as well as the usual consent form for whatever toxin you have: Botox, Dysport. I don't think Daxxify works as well for this. But Xeomin. So that's a separate consent form, about the myasthenia gravis and the generalized things that can happen with that.

But then the other part is recognizing what we just talked about: that it's an off-label use. And so here it just reviewed what we just talked about, the different papers, and I gave it the papers about off-label prescriptions.

Clinical Care Versus Clinical Investigation

Then, here we go. "An individualized decision made for a patient's care is not automatically an FDA-regulated clinical investigation. Conversely, organized perspective design investigations to produce generalized knowledge can trigger IRB, informed consent, and possible IND requirements."

Oh, here we go.

This is what I'm trying to get to. The AMA has a policy. We haven't gotten to that yet, but the AMA is actually taking care of you on this one. They have a policy integrated into this, and I think I made sure it was referenced. This is the AMA policy for informed consent and off-label drugs, those two right there: five and seven.[13]

Your Do List

What do you do? Here's your do list. Establish a diagnosis: no big deal. You've got an exam. You always get your score; it takes five minutes. Document the failure of whatever they're doing, or their rejection of it for whatever reason. They're worried about going blind from Cialis, and now we know that over the years (or at least we have a study that shows it).[14,15]

Then document why they should be considered, why the benefit may outweigh the risk, and those studies we just showed you. There was one priapism; that was it. Confirm that the treating physician knows how to inject; that would be you.

Know Your State Medical Board

Get legal advice when you're unsure. This could be a call to your board, or it could be a visit to the medical board website to see what their views are on off-label drug use. If you call them and tell them you're going to inject Botox into the penis, that could be asking for trouble. I don't know. Maybe that's what you do. But to me, this is an off-label use of a drug, so you and your attorney decide what you want to do about that.

What I've seen in my state, which could be argued to be the strictest on the planet, is that they let you know what they're worried about. They just send out a letter. They came down pretty hard about peptides in the state of Alabama. They're still pretty strict about hormones, and only within the past year have they let nurse practitioners inject Botox or botulinum toxin, but everything they do has to be on label, so an NP in Alabama could not do Priapus Toxin® . So those sorts of nuances you would find in your state medical board.

Malpractice and Consent

For this, we've got you covered. For your malpractice, we have someone who will cover these procedures if you have a documented certificate of training from our group and provide your consent form on your letterhead (assuming you haven't done something horrible, and you wouldn't be on this call if you did). But for the people in our group, with those caveats, they will give you malpractice if your carrier balks (usually they don't; no one goes blind from BOTOX).

And then we talked about the procedure-specific informed consent, which we've given you. And then you do what you normally do. You document what you did and what you gave them, and then you follow up.

I think it's best to put the consent form on your website so patients see it when they see you talk about the science, and I do this. If you go to the Priapus Shot® website, or our website, PriapusToxin.com, there's a link to download and read the consent form, and it's scary. I listed just about everything that could go wrong with the genitalia, because how are you going to deny it if they say their orgasm stopped or they're having retrograde ejaculation because you did this? You can't disprove that, and we don't know what could happen, so I just have a very scary consent form. But I can tell you almost nothing on those forms has happened thus far.

So you state the off-label use. Well, this is being duplicative. And some of you are running without insurance, so you disclose that. That's it. And then the botulinum-specific one I already talked about: you have that separate consent form.

The Official Position

And then this is what the chat said we should say, and this is sort of our official idea about it, and I've told you my official idea. But with the AI reading everything that I just gave you, plus more, it says: "It remains investigational. Evidence is uncertain. FDA permits off-label use of approved drugs, but doesn't make every off-label use justified."

Don't just give it to everybody with ED, but a refractory patient should get "appropriate evaluation, consider established alternatives, document the rationale, obtain meaningful consent, verify the training," which would be: go do our little test online, let us send you the certificate, let us help you with insurance if we need to, and "arrange for follow-up."

And of course, anyone can sue you at any time about anything. But that's how you do it, with the added caveat, which the chat didn't say, that you ***do follow up. If they don't love it, you work it off, or you give them all their money back and try to make it so they're better off than they were (they get the money back plus something), so that you're taking care of people***. And you're careful about who you choose to treat, so that you don't have to do that often. But you're always, always, always leaving people better off than when they first came to see you.

So I think this really just takes what's already known about off-label prescription and applies it to the Priapus Toxin® and Clitoxin®. It would apply to that as well. But it doesn't apply to our O-Shot®, P-Shot®, or PRP procedures, because, of course, those are not drugs.

Questions and the Handouts

And I think with that, let me see if anybody has a question or a comment. Correct me if I've said something stupid or something you don't agree with, because I want to be educated, and most of what I've learned has been from our doctors and our patients. So it's not from a book; it's from us talking to each other. I don't see anything else.

So let me put these documents into your handout section, and then I'll close the call. Let's see, make sure there are no questions. Nope. Okay. Let me upload these to your handouts

I've actually trademarked Vampire Testicles®, but I haven't had the balls to start promoting that one yet. I'm going to wait until it's okay to do it cosmetically. We need more research on that one.

Marketing: Teach Your Patients With Webpages and Emails

Okay, that's everything. Thank you for being here. I hope that was helpful to you. Remember, the best way to find more patients in your office is to ***teach your patients what you're able to do, and the only things you have left that are not censored are webpages and emails***. So if you haven't seen it yet, we have a course, our 5-Notes Expert Marketing System. Some of you already have access to it. If you don't,

just call our office: 888-920-5311. They'll get you logged in, and it'll help you know how to convert this research into new patients in your waiting room.

Thank you. It's always an honor. Have a great week. Bye-bye.

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Tags

PRP, platelet-rich plasma, Priapus Toxin®, Clitoxin®, P-Shot®, Priapus Shot®, O-Shot®, botulinum toxin, intracavernosal botulinum toxin, umbrella review, refractory erectile dysfunction, erectile dysfunction, ED, PDE5 inhibitors, Viagra, Cialis, Trimix, Botox, Dysport, Xeomin, Daxxify, priapism, Peyronie's disease, off-label prescribing, off-label use, FDA, informed consent, consent form, AMA Code of Medical Ethics, state medical board, malpractice insurance, regenerative therapy, shockwave therapy, publication bias, cortisone, osteoarthritis, tendonitis, plantar fasciitis, joint preservation, cash pay, cash-pay procedures, ethics, shared decision-making, patient satisfaction, refund policy, Kenneth Cooper, testicular PRP, testicle volume, sperm count, Vampire Testicles, telemedicine, Amazon, over-the-counter PDE5 inhibitors, UK, Advil, Tylenol, NSAID nephropathy, acetaminophen overdose, PRF, platelet-rich fibrin, herpes zoster, postherpetic pain, genital herpes, acyclovir, patient education, email marketing, physician marketing, 5-Notes Expert Marketing System, regenerative medicine, sexual medicine, journal club, marketing pearls