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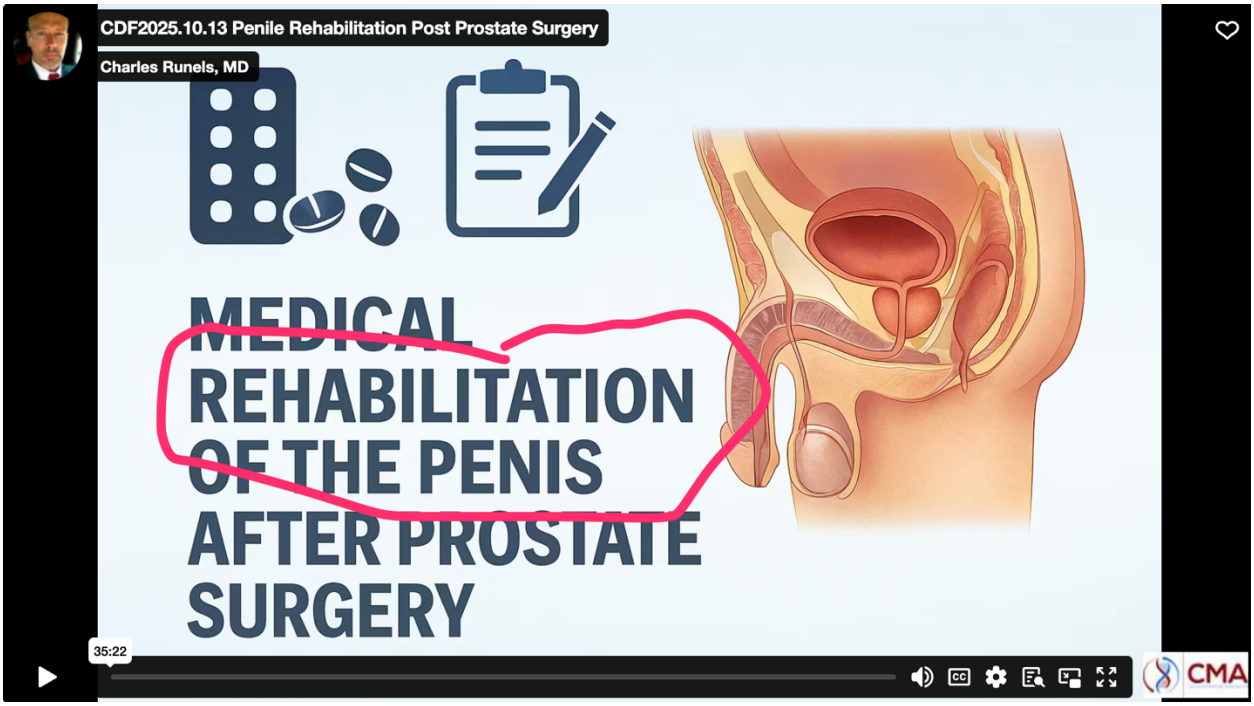
The following is an edited transcript of the *Cell Doctor Forum* with Charles Runels, MD, held on October 13, 2025.

>-> The video of this live Cell Doctor Forum can be seen here <-<



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Charles Runels, MD
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Transcript

Welcome to the Cell Doctor Forum, where we focus on the procedures and less on what came out in the literature over the past week or two. This is especially for our new providers and, when necessary, an update for those of us who have been at it for over a decade.

I had a patient this past week who is now several years out from a prostatectomy (2023). Wise man, a smart wife; I was disappointed to discover that neither had even heard the phrase "penile rehabilitation."

History

It first appeared in the medical literature around 2009, and yes, there is indeed no standard protocol, and there is still debate about whether penile rehabilitation is effective or not.

But imagine that you are a man or a woman married to a man who has had prostate surgery. Do you really want to wait for another 10 to 20 years before the research decides what is the best protocol to use to rehabilitate the penis?

Do you really want to do that, or do you want to use our best research at the moment, together with our best understanding of the physiology and the physics of erection, to try to recover the penis, penile function?

The first person I treated with the P-Shot® combined with the protocol for penile rehabilitation was a man who had been married to his wife for around 60 years and was getting ready to do a second honeymoon. And he was over two years out from his prostate surgery, so I wasn't sure it would work.

Since then, I have treated many, and more importantly, I've heard from our members. The research is continuing to stack about why our protocol might work, but we have added to it.

So, after meeting this couple and seeing that they had been to prominent universities and met with prominent urologists, and no one had ever even mentioned the concept of penile rehabilitation, I decided I needed to get back on my soapbox and reiterate the importance of it, review some of the literature that's come out and give what my opinion is the best protocol based on that recent research.

Of course, some of this is my opinion, it's my speculation, but I'll show you the research to support that speculation. I've already put some of it in the material section for you to download, but let's talk through it, and I will do my best to come in under 30 minutes.

Step 1. Talk with the Urologist

First, it's important to communicate with the urologists who did the surgery.

As you know, when your patients come to see you and offer you cash, they've already seen more than one physician who takes insurance and are usually attached and loyal to that physician. It's almost like a married person cheating on their spouse. They're nearly embarrassed that they are seeing another doctor.

So, it's essential to open the conversation by stating that you intend to communicate with their physician. If business hours allow, I usually try to make the call while they're there, just an old-school phone call.

Call Dr. Jones and say, "Hey, Dr. Jones. John's here in my office, and he respects you and likes you and wants to keep using you, but he wants to try something else to recover his erectile function, and I am calling to let you know what we're doing."

And most of the time, actually every time, at least on the phone, and as far as I know, off the phone, I've had a welcome reception to that phone call.

There's a good chance that you are dealing with one of Dr. Jones's more troubling cases. The patient wouldn't be in your office if it were an easy case.

If you're respectful and open about what you do, the physician will also respect you. What doesn't work, I don't think, is going out to find a urologist and offering to help rehabilitate penises after they have prostate surgery. If they were aware of what we do sufficiently to want to refer people to you, then they would do it themselves.

I'm not sure why, but often, after you take some of their more troubling patients and make them better, they will start referring patients to you. The same is true of gynecologists. They will sometimes, instead of learning to do our procedure, just keep referring people to you.

I know this from practice: this is how many of our providers developed a referral base: nurse practitioners and primary care doctors getting referrals from specialists to do our P-Shot® or O-Shot® procedures. It's by calling the person and letting them know what you're doing.

Okay. And then it comes down to, well, how long do you wait after surgery before starting the rehabilitation?

Even though there is some reasoning behind the idea of starting the penile rehabilitation the day or very soon after surgery, my preference is to wait until the urologist is done. Please wait until the surgeon has done all they can, and then the person searches for another answer.

This is how most present anyway, because if the urologist is doing their best, they're not likely to seek one of us to offer this procedure unless you ***are*** the urologist.

Of course, we have urologists in our group. If you're the surgeon deciding when to introduce these ideas and the best protocols.

Anyway, that's the first step.

Step 2: Daily Cialis

The second step is daily Cialis.

Let me pull up one of my papers and come back to my list.

My strategy is not to sneak up on it. In other words, I don't try one thing and then try another.

Here's someone who's had prostate surgery. They're troubled and bothered by the length of time it's taken them to recover their erectile function, or else they would not be in your office.

So, I think, it's the best way to explain it to the patient and say, "Listen, I want to make you better with the least amount of medicine and therapy as possible, but let's start by helping you achieve your best erection and then let's back things off and see the minimum amount it takes to help keep you going."

I've yet to find a person who disagrees with that strategy. Okay, so here's a review article. This one is in your handout section: Erection rehabilitation following prostatectomy strategies in future directions.[1] And they make the point, of course, that what is used to treat ED could be used to recover ED after surgery.

The other thing I don't do is get too far into the idea of whether it was a nerve-sparing surgery or not. The details of what went on in the operating room are really only known by the surgeon, no matter what label or technique was used.

And let's say it was a more aggressive nerve-damaging type of surgery, would that still keep you from wanting to try rehabilitation if it were your penis and your love life?

Of course not!

So I always offer people the chance to rehabilitate the penis, no matter what the surgery. I don't consider it my job to tease out which surgical technique was done.

And I ALWAYS give back all of their money if they are not pleased with the outcome of my treatments.

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[1] Sopko and Burnett, "Erection Rehabilitation Following Prostatectomy Current Strategies and Future Directions."

In that paper, they discuss some of the different protocols for using the PD-5 inhibitors.[2] If they tolerate it, start them on five milligrams of Cialis once a day—that's the first step.

Step 3: Penis Pump

And then you have the vacuum erection devices or the pump.[3]

Let's see. Here's another paper actually suggesting the use of our PRP or some version of our P-Shot® and, of course, shock wave therapy to help recover the blood flow, neovascularization, but neurogenesis.[4]

All the ones I'm showing you here are in the handout section and involve using the pump.[5] [6] [7] [8] [9] [10]

But let's go back. Let me back up a second and talk a bit about protocol and why these different modalities might help.

So those are my favorite papers, but this is not the night for the journal club. I want to give you the protocols.

Let me return to my protocol and explain why I think it's working. It has worked for many people in my practice and others.

Party Balloons & Penises

Imagine the penis as a balloon.

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[2] Sopko and Burnett, "Erection Rehabilitation Following Prostatectomy Current Strategies and Future Directions."

[3] Lin and Wang, "The Science of Vacuum Erectile Device in Penile Rehabilitation after Radical Prostatectomy."

[4] Ismy et al., "A Potential Treatment for Erectile Dysfunction."

[5] Ismy et al., "A Potential Treatment for Erectile Dysfunction."

[6] Javier et al., "(219) AUTOLOGOUS PLATELET-RICH PLASMA IMPROVES ENDOTHELIAL AND TADALAFIL-INDUCED RELAXATIONS IN CORPUS CAVERNOSUM FROM PATIENTS WITH ERECTILE DYSFUNCTION."

[7] Senad et al., "(268) EARLY EXPERIENCE IN PENILE REHABILIATION AFTER RADICAL PROSTATECTOMY."

[8] Lee et al., "A Novel Management for Postprostatectomy Urinary Incontinence: Platelet-Rich Plasma Urethral Sphincter Injection."

[9] Weech et al., "Anatomy, Abdomen and Pelvis, Penis Dorsal Nerve."

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

All right?

So here's a balloon (see video). It's just a water balloon, and the size of the balloon will be based on the pressure on the outside of the wall and the pressure on the inside, right?

It's vectors.

And even though it's not a simple balloon, you can model it mathematically like a balloon. And the pressure on the outside, of course, would be atmospheric pressure, and if that's greater than the pressure inside, you'll have a collapsed balloon (limp penis).

The pressure inside is determined by arterial blood flow increased by blocking venous outflow, but it also involves the balloon's tensile strength (of the wall). As you know, when you have a birthday party, you must stretch the balloon out to make it easier to blow up.

So that's one of the purposes of the penis pump. If you stretch it out with a pump, you get decreased tensile strength because you've loosened up Buck's fascia, the skin, and all the different tissues that are combining to cause resistance to expansion.

The other thing that's probably happening is intermittent hypoxia, because when you do have a short episode of hypoxia, it triggers neovascularization. I just bought an old-school, really old-school book on weight training by Sandow. He was one of the strong men who traveled around and did strongman things back before we had movie theaters.

He had this workout routine that just used these tiny little weights. Someone recently wrote a book about how he followed this. I mean, tiny, tiny two-and-a-half-pound weights, and I got very strong. Someone recently wrote a book evaluating why it works, and he tried it, and it worked.

The theory was that because you were doing 50 to 100 reps, even though the weight wasn't heavy, that number of reps caused hypoxia, and the prolonged exercise outweighed the ability to provide blood.

There was a similar study where they took older men, and they had them exercise, and then they had another group exercise with a tourniquet. So they were creating hypoxia while they were exercising and they were able to gain strength faster, even using lighter weights.[11] It was a way to help preserve the joint in older adults when they were weight training by introducing hypoxia.

So, it could be the pump. By keeping it on there for 10, 15, or 20 minutes, you have this hypoxia that triggers it. And then also, we know hypoxia is not really talked about much as the trigger, but what has been talked about.

And I don't know if I put that in your handout or not, but I will when I post this. Still, someone did transcutaneous oxygen measures on the penis just like we used to use in the wound care center when I

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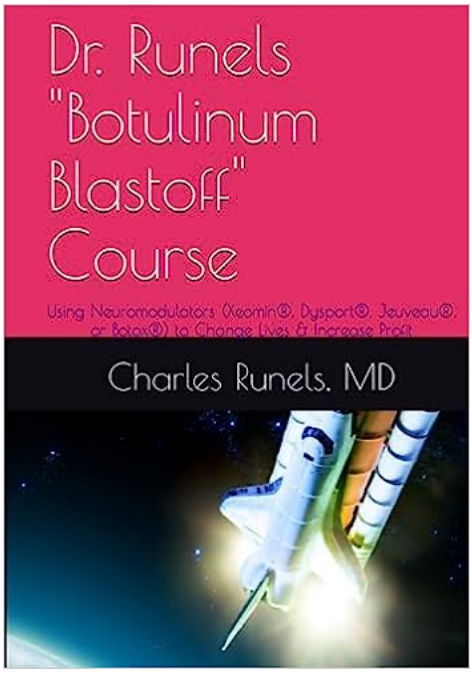
[11] Yasuda et al., "Thigh Muscle Size and Vascular Function after Blood Flow-Restricted Elastic Band Training in Older Women."

ran a hospital-based hyperbaric chamber for treating wounds of the distal extremities and people suffering with type two diabetes.[12]

So we had something that looked like an EKG machine and the electrode stuck to the skin and it would help you map out where, it helped you determine where the surgeon should cut. Because you cut too high, you lose more leg than you should have, you cut too low, then the person can't heal and make a healthy stump. So you used it.



Anyway that was put on the penis and they found when men used the vacuum pump, their transcutaneous oxygen was higher throughout the day if they used a vacuum pump in the morning. So there's a reflex increase in blood flow, and of course, one way to activate platelets is vacuum it.

You demonstrate this every time you draw blood and if you have a difficult phlebotomy, pull too hard on the syringe, you activate the thrombin cascade and you get a clot in the syringe or in the IV because you just activated platelets with vacuum.

So we're probably activating some number of platelets within the penis. We're making activated platelets on a daily basis when you use the pump. So all those things together, that making of the PRP is my speculation, but it makes sense biochemically.

And do I really want to wait if for another 40 years for somebody to prove that if I have a patient who's trying to rehabilitate their penis? I don't think so. So, I recommend the pump twice a day for 10 minutes as part of the protocol.

The other thing that I discovered with this person last week that prompted me to want to do this is that somewhere along the way someone had given him a vacuum device. And I'm embarrassed because it's my fault, someone in our group doesn't know something, then shame on me for not making sure they know it.

But they gave him a vacuum device because he had already had a P-Shot®. I heard how it was given, and I haven't found this person. Maybe they just said they were in our group because the wife is very bright, and the way she described it was in some weird location.

So my bet is someone just claimed to be in our group and didn't act. They just got some PRP, but it was not injected correctly.

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[12] Welliver et al., "A Pilot Study to Determine Penile Oxygen Saturation Before and After Vacuum Therapy in Patients with Erectile Dysfunction After Radical Prostatectomy."

The other thing is that they gave him a pump, but there's no pressure gauge. When I find someone who's got a vacuum pump, penis pump, already every time without exception, and this has happened at least 20 times.

I've had someone say, "Yeah, I've already got a pump."

And I say, "What, does it have a pressure gauge?"

And when they say, "No," I pull one off the shelf and have them use it. They are almost shocked because whatever they used without the gauge was insufficient.

In other words, when I put the pump on it, they found that a pressure of minus five to minus 10 was more pressure than they had been using. They had some weak device, probably with a bad seal, and they were just in the dark about how much pressure. So, it should be done in a measured way, a very specific way.

Of course, the other danger is that without the pressure gauge, they might over-pump and damage their penis, so you need to know. I would not tolerate my patient having a pump without a pressure gauge.

They make one called the Bathmate, which is used in the bathtub, obviously, and there's no pressure gauge on it. It's a good idea, but I don't know what it's suitable for. It's messy, and you couldn't really tell what you're doing. Nothing beats a well-fitted pump with a pressure gauge. We have a place on our membership site with a recommended place to buy one.

Step 4: Walk

Okay, so communicate with the urologist, take daily Cialis, and walk. In the studies on the shim score, a score of one to five was assigned for five questions. The lowest score would be five, the highest score would be 25.

The studies show that PD-5 inhibitors like Viagra and Cialis bump the score by about seven. In studies of our P-Shot® procedure, or some variation, the score bumps by about seven.[13] When Ronald Virag did his study on Peyronie's disease, the score bumped up by seven.[14]

Walking bumps the score by seven, and one study of tennis, which, to me, is not even (at my level) aerobic: you must be better than I am to get your heart rate up playing tennis. I'm mostly just watching it whiz by, but playing tennis three times a week, bumped it by seven, so it doesn't even have to be jogging at some high rate.

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[13] Chung, "A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction."

[14] 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."

Step 5: Priapus Shot® (P-Shot®)

So I encourage people to do everything, take the daily Cialis, go walking, and do my P-Shot®. Does it add up to 21?

Not likely, but it's going to add up to be more than any one or two of those three without the third. It just makes sense.

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

Okay, and Priapus Shot®, you guys have seen all the studies if you've been in the group for so long. We've got the placebo-controlled studies.

They weren't done exactly how we do it, but all but one showed benefit.[15] [16] [17] [18] [19] [20] [21] [22]

According to JAMA, the method matters, and we have the ONLY standardized protocol.[23]

The one that did not show benefit, they used half the dose, and they stopped the Viagra, as the same people that they started been injected with the PRP. In other words, the methodology was, in my opinion, crap.

We know it works.

Does it work all the time? Every time?

Of course not.

But does it have a high success rate, statistically significant success rate?

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[15] Chung, "A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction."

[16] Narasimman et al., "A Primer on the Restorative Therapies for Erectile Dysfunction."

[17] Chung, "A Review of Current and Emerging Therapeutic Options for Erectile Dysfunction."

[18] Priapus Shot® | P-Shot® | Official Website - Priapus Shot®."

[19] Poulios et al., "Platelet-Rich Plasma (PRP) Improves Erectile Function: A Double-Blind, Randomized, Placebo-Controlled Clinical Trial."

[20] Hinojosa-Gonzalez et al., "Regenerative Therapies for Erectile Dysfunction."

[21] Yogiswara et al., "The Potential Role of Intracavernosal Injection of Platelet-Rich Plasma for Treating Patients with Mild to Moderate Erectile Dysfunction."

[22] Towe et al., "The Use of Combination Regenerative Therapies for Erectile Dysfunction."

[23] "Errors in Text."

Yes. And it should be part of the protocol for penile rehabilitation.

Step 6: Priapus Toxin®

Now, in the Priapus Toxin®, the studies done with botulinum toxin were also double-blind and done with Dysport, Botox, and Xeomin. I don't think it's been done yet with Daxxify, but Daxxify could be used.[24] [25] [26] [27] [28] [29] [30] [31]

And Xeomin, last I checked, was the only one that looked at different dosages and duration, and 50 units wore off, but too soon. But 100 units lasted nine months. One of the urologists in our group says if that doesn't work, he gives them 200 units.

Two hundred units is less than what's used for migraines. So you're not doing a high dose at 100 units or 200, but we usually use 100 units.

The way I do it is I just mix it like I'm going to do a Priapus Shot®. Then I take the PRP and one CC of it, reconstitute the Xeomin 100 units, and divide it between the two syringes.

There's a video about it, and whoever did a P-Shot® on this man, whether they were one of us or not, I don't know, probably not one of us, but why would you not want to use toxin to give him every opportunity to get better?

Remember, all of the studies of botulinum toxin for erectile dysfunction were done in people for whom PDE5 inhibitors would not work. And they still showed a 40% success rate—not 90, but 40. But 40%, is fantastic for a group of men for whom PDE5 inhibitors do nothing.

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[24] Habashy and Köhler, "Botox for Erectile Dysfunction."

[25] Porter, *Botox*.

[26] Giuliano et al., "Effectiveness and Safety of Intracavernosal IncobotulinumtoxinA (Xeomin®) 100 U as an Add-on Therapy to Standard Pharmacological Treatment for Difficult-to-Treat Erectile Dysfunction."

[27] El-Shaer et al., "Intra-Cavernous Injection of BOTOX® (50 and 100 Units) for Treatment of Vasculogenic Erectile Dysfunction."

[28] *Research – Priapus Toxin™*.

[29] Giuliano et al., "Safety and Effectiveness of Repeated Botulinum Toxin A Intracavernosal Injections in Men with Erectile Dysfunction Unresponsive to Approved Pharmacological Treatments."

[30] Abdelrahman et al., "Safety and Efficacy of Botulinum Neurotoxin in the Treatment of Erectile Dysfunction Refractory to Phosphodiesterase Inhibitors."

[31] Giuliano et al., "Safety and Efficacy of Intracavernosal Injections of AbobotulinumtoxinA (Dysport®) as Add on Therapy to Phosphosdiesterase Type 5 Inhibitors or Prostaglandin E1 for Erectile Dysfunction—Case Studies."

They stayed on their dose of Cialis, but they weren't starting it, with no PRP, no walking regimen, no vacuum device. They just kept them on their PDE-5 inhibitors and injected botulinum toxin into the corpus cavernosum. And then you've got excellent videos about how to do this on our membership site.

Knowing that and not offering it to someone now, you're not offering everything we know how to do. I always like to offer people the best I have, and they may say they don't want it, but likely, you offer them the best you have for something that's going to bring their love life back, they're going to want it.

Now, to this day, if someone thinks I didn't help them, I offer them their money back. And I hate to tell you my success rate because I have to keep my credulity, but I have a super high success rate for people recovering from prostate surgery.

Step 7: Shockwave

If you've got a shockwave, use it. That's part of it, too. I don't think it's necessary, but there's research showing that there's synergy with our P-Shot® procedure.[32] [33] [34]

So if you have it, why would you not add it to your penile rehabilitation protocol?

Step 8: Testosterone

The testosterone is tricky because it depends on the urologist; it depends on how long it's been since the person had surgery, but if they've had a zero PSA level for some period of time, some would argue that it's okay to start the testosterone.[35] [36]

I don't make that decision, though. Their urologist should do what seems best.

Step 9: Estradiol and Prolactin

And then something that's often forgotten, but if you check prolactin and estradiol levels, you will help people. Because it's not something you'll find once a week, but you'll find it once or twice a year.

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[32] Bole and Bajic, "Editorial CommentRe."

[33] Ruffo et al., "Effectiveness and Safety of Platelet Rich Plasma (PrP) Cavernosal Injections plus External Shock Wave Treatment for Penile Erectile Dysfunction."

[34] Zhou et al., "The Efficacy of Platelet-Rich Plasma (PRP) Alone or in Combination with Low Intensity Shock Wave Therapy (Li-SWT) in Treating Erectile Dysfunction."

[35] Pastuszak et al., "Testosterone Replacement Therapy in the Setting of Prostate Cancer Treated with Radiation."

[36] Azad et al., "Combination Therapies in Locally Advanced and Metastatic Hormone-Sensitive Prostate Cancer."

And when you do, it's an easy treatment.

If you have a microadenoma of the pituitary gland, it's not likely to be a macroadenoma requiring surgery. Just put them on a little Dostinex, half a tablet or a tablet twice a week, and they go on their way, and they love you for it. Get their energy back.

Of course, unlike an estradiol level that's not zero, men and women need it for their memory, but I like the 10 to 12 times testosterone estradiol level. So, an estradiol level of around 50 to 70 is the max for a man, but I like it to be around 50, which helps him keep his memory.

And so he needs a testosterone level of 10 X to 12 X the estradiol level there, which puts them around six or 700. And I think that ratio helps a lot with their erections.

Step 10: Watch the Cycle

This cycle, I know this may be a little too esoteric, but not really, because if you've been treating people with sexual medicine for long, you've probably spent more than a week, you're going to meet what I call "widows to porn."

The woman who knows that her husband is watching pornography, and he comes to bed, he's in a refractory period. He doesn't want to have sex because he's just got through masturbating to something on his iPhone. That's very common; women usually know when it's happening.

My rule with pornography is if you're going to watch it, watch it with your spouse, so it does not take over and become a substitute for your spouse and become some dark secret that is substituting for a relationship.

I think when you do that, it loses its addictive power and can be just, it almost loses its power completely, actually. But it makes it less dangerous, and it makes it so that it's not a substitute for your spouse.

I've always been embarrassed to have any pornography around because I do not want people to think I need to pay to look at a beautiful woman's body. And I don't know, maybe I was just missing a gene somewhere, but it's never appealed to me.

But I understand it can have addictive powers over people, and when I counsel couples, I just tell the man, "Watch it with your lover around, and it will lose its power over you."

But even if you take that away, take the pornography away (we're talking about someone who's had prostate cancer, right?), he wants to have an erection, there's still this refractory period, and ***erections become stronger when the interval between ejaculations becomes longer.***

The Chinese talked about it, Thoreau talked about it in *Walden*, Sigmund Freud talked about it, and Franklin talked about it. Every football coach, every trainer of every boxer knows it. But somehow it

became commonly taught to physicians that it doesn't really matter how often you ejaculate. That's wrong.

I think you should have sex as much as you want with your sweetheart. But ejaculation should be spaced based on your cycle, your age, your health, and when it's cycled appropriately, erections get stronger.

Now, why I bring it up is because I think it happens sometimes when people get our P-Shot® procedure, they go masturbate to see if it works or not. They'll masturbate to ejaculation more than they might typically do, and now they're in a refractory period.

So, I think, the two things that make our shot less effective, our procedure, our whole penile rehabilitation program, less effective, one, is overusing the pump by pumping more pressure than 10 or 12, minus 10 or 12. And the other would be most common would be thinking every time you have an erection, you have to have an ejaculation.

So, learning how to enjoy that arousal and dip in and out of orgasm without ejaculating is a wonderful thing to learn.

Most of you have seen or downloaded my book *Anytime for As Long As You Want*. If you look around online, you can download the PDF version for free. If you buy a used version on Amazon, they usually sell for over 100 bucks, so don't do that. I'm going to revise it soon. I need to do that.

Step 11: Repeat at 12 Weeks

And then repeat at 12 weeks. Remember, it takes about eight weeks, and you have about 80% of what you're going to see from the PRP. So our P-Shot® kicks in at eight to 12 weeks, but the botulinum toxin kicks in sooner, and sometimes they even think it's better that day. So I don't know what's going on there, but I think there's an additive effect.

And so if they're better, you repeat it. Many people now are just going in and having people sign up for two. But you would not need to repeat the botulinum toxin at 12 weeks because it's good for nine to 12 months if you injected 100 units.

Okay, so that's my penile rehabilitation protocol.

I think if you want to look for science that you can pull into the sexual medicine arena, look at sports medicine, look at veterinary medicine, and look at dentistry. That's where you'll find clues: sports medicine, dentistry, and veterinary medicine.

Questions: When can a man start pumping?

Usually, I do it there in the office. They often have trouble figuring out when they get home. So for example, this couple that was there after I gave him a shot and did the whole procedure, and then I have various-sized penis pumps in my office.

Usually, I'll have them sit on the end of the bed with their testicles hanging off, give them a little KY jelly and a towel, and have them hold it while I pump it until I get a seal. And then I hand them the pump.

So now they're holding the pump in one hand and the tube in the other, and I tell them to pump to whatever's comfortable and keep the seal.

I sat there with them for 10 minutes and talked to them about the pump. So, yes, it is true that if they use it every day, their skin will start to look darker.

You tell them about it, tell them if it bothers them, and they'd rather have less darkness and a smaller penis, that doesn't work as well, they can quit using the pump. Most guys will pick a little bit darker skin, a pump, and a penis that works better.

But yes, that's a side effect and you warn them about that. Also, if they use it appropriately, they'll also have some edema, a little bit of edema when they first take the tube off, but all that goes away. I think best is after they use it daily till they achieve what they're looking for, then they can back it off to twice a week and maintain it once or twice a week.

Let's see. Okay, I don't see any other questions. I hope that's helpful, and I hope you guys will spread the word about our knowledge, and you've got a large following, so many people on this call that are just smart people. And to me, it's almost sad that we have this combination.

Every part of that protocol is helpful: vacuum device, P-Shot®, Priapus Toxin®, PD-5 inhibitors, exercise.

And the good news is that, let's say it doesn't work, many of our urologists would still rather do an implant on someone who's gone through this protocol. They have healthier tissue. I know that Joe Banno is one in our group, and he says he prefers to have everybody do a P-Shot® before a penile implant. It's a healthier tissue and more likely to get a favorable outcome.

Question: When will I do another hands-on workshop

Answer: I don't know when I will do another hands-on workshop. Thank you for asking. I've started doing them every couple of months instead of every month. I'm working on some research we hope to publish soon.

And yes, Anne, the study's been done with Dysport, Botox, and Xeomin.

And as you know, it's the same thing. You mix it, multiply, still put the same volume, and you just multiply the units times three. You know the conversion, but do the equivalent of 100 units of Botox. And these days I mostly use Xeomin, but Daxxify is a good one.

I know Alex, my wife uses a lot of Daxxify, and it could be the way we go, but we use it in the light version. So, I wouldn't mix the higher dosage like you would Botox. So far, there's been no cases of priapism, but I don't want to risk that being a thing.

So, mix it like what we know now from years of research, and now in our group we've got a lot of experience with this, and I'd be afraid to push it to that high Daxi dose.

So far we've never had priapism from a P-Shot® that I know about, never had priapism from Priapus Toxin®; but I would hold off on the high dose of the Daxxify. I use the Daxxify light dosing.

Okay, it's an honor to have so many smart people on the call. Please spread the word about our penile rehabilitation protocol. A lot of guys out there need you.

This is for a worthy cause.

Have a good night.

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

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