Journal Club with Pearls & Marketing (JCPM) 2023.11.28

Topics (Accompanying Video Available to Members of the CMA)

1. Recent research shows mechanical changes in the female sex muscles postpartum.
2. A close look at our O-Shot® and a suggested variation to use in women who have delivered vaginally.
3. The surface anatomy in relation to the superficial perineal muscle and why it matters if you do the O-Shot® procedure.
4. Heresy teachings that will lead you to less effective O-Shot® procedures, refunding money, and angry patients. (IF YOU DO THE O-SHOT, READ THIS!)
5. An amazing new tool I am using to edit videos (you will love this one for how it saves time and relaxes you when you film instructional videos).
6. References
7. Relevant links
8. A TRAP for INFRINGERS

Transcript

Charles Runels, MD:

Welcome to the Journal Club. Today, we'll look at research using mechanical engineering, talking about the pelvic muscles postpartum. The new idea behind the article, which came out very recently, is about how childbirth affects the *female sex muscles*. They're looking at something other than the pelvic floor; the female sex muscles have not been modeled mathematically/mechanically in relation to childbirth before this article.

So we'll look at that and how those mechanics might relate to our O-Shot® procedure, which would be topic number two.

Then we will look at the surface anatomy in relation to the anatomy discussed in relation to the math. As a non-surgeon and not a radiologist, being able to see with X-ray vision what's going on beneath the surface and what might be happening helped me think about how to do the O-Shot® when I first came up with the idea. But I'm discovering more and more how little I know compared to what there is to know. And how little is known compared to what we need to know.

So, we'll go into the surface anatomy that will be a review for some of the surgeons on the call. But I think it will help all of us to think about what it is we're doing and how we might improve the procedure, which will bring up some ideas that I've been *disturbed to learn that have been taught by some of our certified teachers. And we must fix this because it's going to lead to less than satisfactory results*. So I want to point that out that some things are being taught, which I think are not helpful to the group.

And then I want to show you a tool that I'm using. I had a plug-in that did the same thing to help me edit and more quickly create videos. The problem was it was like one of those shortcuts, it's only a shortcut if you hurry, a saying my Dad used to have. "We're going to take a shortcut through the forest, but it was only shorter if you walk faster."

And that's how this plug-in was; I could do tricks with it, but it was such a hassle to use it, it wasn't worth the trouble. But now there's something out that I just discovered, and it makes making your videos much easier. You'll be much less self-conscious. I'll show you that towards the end.

So, let's swap over and start with the research. I'll swap you over to my Zotero app.

Here we go.

Recent research showing the mechanical changes in the pelvic muscles postpartum

This article is open source, so I'll put it in the chat box so you can quickly get to it.[1]

But first, let's talk about it. All right, so it's called a biomechanical perspective on the perineal injuries during childbirth. And you'll see, they actually have some calculus in here, so don't worry we're not going to, I used to know what a lot of this means, but much of it is Greek to me now, I admit it. But you can still get the principle of the thing without doing the calculus.

So, a couple of things to point out about just concepts that I think are important. First of all, this idea that, well, let's just go through it, they talk about perineal trauma. And despite being widely discussed, childbirth trauma remains unpredictable. And mostly what's been talked about has been the levator ani muscle, not what they call oasis, or obstetric and anal sphincter injuries. And what they call the perineal trauma.

Now, if you look, and this brings up something we talked about and I've been plowing into the muscles. And we had an actual model of this, we were handling in one of the previous calls a couple of weeks ago.

But if you look, you have the pelvic floor, but you also have these muscles that are not part of the pelvic floor that they call the perineal muscles. But if you look at what they do, they are largely responsible for the sexual response. And that would be the bulbospongiosus, ischialcavernosus, those muscles. And the pelvic floor and these perineal muscles, or I like calling them the sex muscles, all connect to the perineal body.

Oh, by the way, this one is, correct me if I'm wrong, is mislabeled the bulbospongiosus and the ischialcavernosus muscles should be swapped in that diagram. Ischialcavernosus runs along the pubic rami over the corpus cavernosum and bulbospongiosus runs over the bulb. So, whatever, they got their names swapped, but it's still a beautiful article.

All right, so now a couple of points.

Before I go further with this mechanical analysis, I want to swap over to another picture of the surface anatomy (see the video).

I found this beautiful diagram that just opened up the universe to me. So this is out of one of the surgical textbooks.[2]

[1] Moura et al., "A Biomechanical Perspective on Perineal Injuries during Childbirth."
[2] Baggish and Karram, *Atlas of Pelvic Anatomy and Gynecologic Surgery*.

But, looking to see, we're looking at diagrams, and then you look at the woman, and we're all made differently, and there's folds of flesh. You're thinking, "Well, I thought I understood it in the cartoon in the book. But then when you look at the person..."

So, I like these little cutaway views of the surface anatomy.

A mental view of the sex muscles during sex

Now think about this: if there's sex going on, because we're talking about sex and incontinence, not just. If there's sex going on and there's a penis in this vagina, there's a bone on the front side of it that holds the tissue firm, but there's not a bone on the posterior part of this, of the vagina. But you have this superficial transverse perineal muscle which is going across there. And that, if you look at superficial anatomy, we are going right beneath the vagina. And then you have the external anal sphincter, puborectalis, iliococcygeus, and pubococcygeus. So making up levator ani, and they're all right there. That would be pelvic floor.

But once you get up here, now we're not pelvic floor anymore. And that's why I'm recommending that if you're using an Emsella machine, you (for part of the session) have the woman lean forward some so that these muscles, the perineal muscles, or the sex muscles, are flusher with the magnet.

Back to the mechanical engineering of sex muscle after childbirth

Now, let's go back. After seeing the superficial anatomy, eventually, it's fun to know things, but what we want to do is miracles.

Let's just face it: we're in medicine because we want to do miracles. If we just wanted to make money, we'd sell real estate.

So, the knowledge becomes valuable when it becomes usable the next time you're sitting in front of a woman who has a problem or just wants to stay healthy, and you want to do a miracle. So, let's get this picture in your mind (surface anatomy and the cut-away of the perineal body and surrounding muscle), especially the non-surgeons. And now, let's go back to the research we were talking about.

A Perineal Structure or a Sex Muscle?

Okay, so this paragraph right here is key because, if you read the research about the female pelvic muscles, it's all about the pelvic floor. And these authors are about to make the point, "Well, we need to think of other muscles [other than the pelvic floor} there that are just as important."

The perineum, which is an approximately diamond-shaped region situated below the levator anai muscle, encompasses several important structures: the

> *ischiocavernosus, bulbospongiosus, deep and superficial transverse perineal muscles.*[3]

So they just made the point that I suggested, these are important muscles (the female sex muscles) that are not part of the pelvic floor.

Let's read from the paper again…

> *"Central to this anatomic regions of the perineal body, is a crucial connective tissue that serves as an attachment site for both the pelvic floor muscles and the surrounding* perineal structures. *"*[4]

Oh, okay, we can keep calling them perineal *structures*, but they're not *structures*, they're *muscles*. There are structures other than muscles there, too, but these are muscles, which is why, they just said they're muscles, right (a few lines previous in the paper? The "perineal structures" are the "sex muscles": Ischiocavernosus muscle, bulbospongiosus muscle, deep and superficial transverse perineal muscles.

But, if we want, we can call them "perineal structures" ; we get to have our own personal dictionary, but I think a better description, a more accurate description, is they're "sex muscles."[5]

Okay. I won't read this whole thing to you, but I want to plow through this paragraph, actually, word-for-word, because that's key to the whole article.

> *…the bulbospongiosus anchors posteriorly to the perineal body and extends anteriorly, attaching the surface of the bulb to the perineal membrane.*

Remember, one of the questions I ponder, other than how the universe started, is *why* is the pelvic floor a muscle? Why not just make it tough fascia and tendon if the purpose is to hold the viscera in place (like a floor)? Muscles are made to contract and relax. But there's no joint there.

So what's moving and why when these muscles contract?

In the male, this ischial cavernosus and bulbospongiosus contribute to both erection (or tumescence of the penis) and to emptying of the penis with ejaculation.

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[3] Moura et al., "A Biomechanical Perspective on Perineal Injuries during Childbirth."
[4] Moura et al.
[5] Even though Faraday was a physicist and mathematician, he said that the student should always strive to write what you are learning in very exact ***words***; ponder that: a mathematician who was fanatical about ***expressing everything, even what the numbers mean, with words***. and you should all know exactly what your words mean. Richard Feinman said that you do not really understand a topic, or the math, in science unless you can explain it in non-scientific words. He claimed to be able to use the words of a child to explain Einstein's theories of relativity. He also made the point that naming something with a science word or even writing the math that describes something, does not mean that you understand it or have even explained it—you just named it or described it. Often, ***we can fake understanding by giving it a Latin name to the phenomenon we do not understand.***

We can think of significant analogies there with what might be in the female functionality of the same muscles and why our O-Shot® going into the body of the clitoris might be doing something similar to what happens when we do the P-Shot® (which I did quite a bit before I ever did the same thing to a clitoris).

Anyway, back to the subject of these sex muscles…

Up until now, medical modeling of the mechanical forces with childbirth only considered the pelvic floor. There was no mathematical model of the stressors, the vectors of the sex muscles, or the perineal muscles (if you want to keep using that term) during childbirth.

So, what they mathematically modelled was that the vectors postpartum significantly change when you add the sex muscles to the calculations, as you would expect. Some of you are mechanical engineers, so if you want to read the math, go for it. But what it boils down to, I think, from a clinician standpoint is the following:

I have a whole collection of articles about how PRP can help strengthen and repair muscle. This is just one of them.[6] I'll open it up for you. We discussed it a few weeks ago, but this one talks about ultrasound-guided injections of PRP for muscle injury in professional athletes.[7] And you guys know one of my pet peeves is the following question: why do professional athletes continue to get better care for their muscles than the person who delivered either you or your children?

An NFL athlete's thigh muscle gets more thought regarding recovery than your mama's transverse perineal muscle. We are trying to change that.

But what they conclude, and this is one of a collection, is that the PRP actually does help regenerate healthy muscle, remodel scar tissue, and increase functionality.

If you had a magic wand that can improve strength and repair damaged muscle but you had to touch the wand to the exact spot of the muscle damage for it to be effective, where would you touch the female sex muscles postpartum? If we know we have a tool (PRP) that works as a magic wand in NFL athletes to make that happen (at least in some cases), and we want to help women, "Well, where do we put the magic-wand-needle?"

Heresy teachings that, I promise, will lead you to *less* effective O-Shot® procedures, refunding money, and angry patents.

Here, I'll stop, before finishing reviewing this paper, for one more sideline to address what's very disturbing to me. We are trying to know more to be able to accomplish more. By knowing more, we can do things that looked miraculous only 200 years ago, like turning on a light bulb and flying to the moon. And we want to do the same thing in medicine by knowing more; we want to do things that would've

[6] Bubnov, Yevseenko, and Semeniv, "Ultrasound Guided Injections of Platelets Rich Plasma for Muscle Injury in Professional Athletes. Comparative Study."
[7] Bubnov, Yevseenko, and Semeniv.

looked miraculous to William Osler or even to doctors down the street from you, seeing patients right now in their office, who may not know what you know.

And the opposite of that, would be to consider the vagina in the same way as the football coach who may be brilliant, but his degree is in of how to win football games, but he's showing a 10th-grade boy how to put a condom on a banana in sex ed class; *in that case, the vagina is conceptualized as something that a baby passes through, a penis is put into, and it's a simple tube, it's a muscular tunnel*. But we're considering the functional anatomy, biochemistry, mechanical engineering, electrical activity of the nerves, the sympathetic and parasympathetic nervous system, blood flow, cell biology and electrophysiology of all the intimate structures that are unseen regarding that "tube".

That is our goal, at least. But then I found out this week we have a few teachers for the CMA that seem to have regressed, at least in how they have modified their teaching the O-Shot® procedure: to inject *all* of the PRP in the lateral vaginal wall, which would be exactly where (if I just wanted to make sure I did the least effective O-Shot®) I would put all of the PRP—at 3:00 and 9:00 with the woman supine. This would be the best way to avoid injecting near the Skene's glands, the urethra, the urinary sphincter, the perineal body, and the clitoris; hence, the best way to give the least effective procedure possible.

Now, if you want to add extra PRP to the lateral vaginal wall, I can't argue; there's muscularity there. And if you're near the introitus, you may be injecting the bulbospongiosus, perhaps even hydro dissect to inject the corpus spongiosum; therefore, contributing to the female sex muscle health and strength and to the pressure that might be applied either to the penis or even some of enhance the vectors of the female sex muscles anteriorly towards the anterior vaginal wall (where much of the pleasure happens during sex). But it would still be the least effective place to put the PRP.

I'm not saying don't put *extra* PRP wherever it seems to be appropriate. And we're about to talk about some of those places in relation to the female sex muscles in the pelvic floor. But *if you go all the way back to 70 years ago, and you read Dr. Grafenberg's work,[8] and moving forward, and we can prove that in the bedroom, the most pleasurable sensation to the woman is the anterior vaginal wall with pressure against the urethra.* We now know that pressure there also stimulates the root of the clitoris, where the body and the two corpus cavernosa and two corpus spongiosum star out like a five-prong star, that's also right there on the other side of the urethra so you are most likely to improve urinary continence (which injection into the lateral wall would not help). So pressure on the anterior vaginal wall is pushing against urethra and root of the clitoris and PRP there would improve function there; PRP in the lateral wall or even off center[9] (at 11 and 1'OClock) would not do.

So, my initial reasoning for putting PRP there, is that's where the most pleasure is. And it's also where you need the most bulk if you're trying to prevent urinary incontinence. So, I'm really appalled to discover that some CMA professors are teaching O-Shot® procedures where the anterior vaginal wall is not even addressed.

As another example of the right way to think, one of our gynecologists, Dr. Kathleen Posey, MD, FACOG, did an O-Shot® that did not work so well for a particular woman suffering from stress incontinence. But understanding the anatomy, when the woman came back at eight weeks, Dr. Posey inserted a little in

[8] GRÄFENBERG, Ernest, "The Role of Urethra in Female Orgasm."
[9] Here, I am defining "center" as ***exactly beneath the urethra*** which may not be exactly at geographical 12 O'clock with the woman supine and parallel to the bed. To do the O-Shot® properly, you MUST carefully consider where the urethra is for that particular woman.

and out catheter into the patient's urethra and found that the urethra was off center. Then, understanding the exact location of the woman's anatomically-variant urethra, Dr. Posey did another O-Shot®, making certain that it was directly between the urethra and the anterior vaginal wall, and the woman then enjoyed relief of her stress urinary incontinence.

As another example, I'm convinced that if you understand, really understand what I am saying, and you are connected to your lover (even if you are a woman and are loving yourself), you can do things with the anterior vaginal wall that result in an orgasm that produces pleasure beyond what most know, and leaves evidence for the housekeeper of your room in Vegas of a pool of fluid composed of almost every body fluid; in other words, you will see what Grafenberg described[10] observing; orgasms that result in crying, urinating, ejaculating, and sweating. If your bed's not soaked with all those four body fluids, if you or your lover do not feel like you could write your own post-coital scripture, at least occasionally, then maybe you are not thinking enough about the anatomy, or emotionally connected enough to the woman owning the vagina—and you may not understand what an O-Shot® actually does and how to perform it.

Put another way, if you try to facilitate or experience an orgasm like that and do not address the anterior vaginal wall, as Dr. Grafenberg described and multiple papers and lovers over 70 years after him, then you will not see orgasms like that; and, if you do not consider the anterior vaginal wall, directly beneath the urethra when you do the O-Shot® procedure—many of your procedures will fail, maybe most of them.

Most of the people on this call either have a vagina or make love with a person who owns a vagina. Next time you are in the bedroom***, try to demonstrate an orgasm of any degree at all without touching the clitoris or the urethra, or the anterior vaginal wall; try to reveal an orgasm that connects to a woman's soul with only stimulation of the lateral and posterior vaginal walls. You know of the difficulties of that proposition without even going to the bedroom; so why would you offer an O-Shot® where PRP is only injected into the lateral vaginal walls?***

Hopefully, all that rambling makes the point that if you want to squirt PRP in the left ear lobe, fine, you'll make the left ear lobe look more beautiful. And if you put PRP at 3:00 and 9:00 (with the woman supine) into the vaginal wall, you might improve something. But if you want to help with incontinence and you want to help with sexual response in the most dramatic way, I think most of that PRP needs to go in the anterior vaginal wall, as we described it and as we have now done for over a decade.

And if you're on this call and your teacher taught you something different, please go look at the videos on the membership website[11] ; and please think about the anatomy carefully in ever woman—her particular anatomy—before doing this procedure.

After one of his disciples asked him a question once, Christ said something, like, "Were you guys not listening to what I have been saying for the past 3 years?"

[10] Dr. Grafenberg described, in his scientific writing, observing *multiple* women demonstrating ejaculatory orgasm, but only by stimulating the anterior vaginal wall. Even though he reportedly fled Germany to the United States because he was a Jewish physician, one could postulate there were other reasons that numbered the same as the sum of the women who provided that demonstration.

[11] If you lost your password, go here to recover it in 5 minutes: https:cellularmedicineassociation.org/password

I think if he could look around now, he would say something like, “I never said anything like that! You’ve changed what I said so much I do not ever recognize it!”

So, considering that, who am I really? If people will take the words of a teacher who changed history 2,000 years ago and taught pure love into reasons for hate and destruction, then why would I expect people to not take the words and ideas of a little internist in Alabama and ignore them and make up something else? Really, it is to be expected, and maybe it is even good when it comes to my procedures since I am sure I am wrong about something about which I am unaware.

But…

If you are going to do the O-Shot® procedure and not inject the anterior vaginal wall (directly beneath the urethra), please drop out of our group, give your procedure a different name, and do not use the name O-Shot® to promote whatever it is you are doing or teaching.

It's almost embarrassing that someone teaching our procedure would conceptualize the vagina (at least as demonstrated by the way they altered the procedure) in the same way an 11th-grade football coach would describe it to a 10th-grader in high school.

So now, that's me ranting because I want to protect the reputation of our procedure, and I've had more than one person tell me this week that they were taught a way of doing the O-Shot®, where the anterior vaginal wall was completely ignored. *Please, if someone taught you that, say six Hail Mary’s, and abstain from sex until you go and rewatch the videos on the membership website[12], because you are in danger of damnation by the vagina gods.*

A close look at our O-Shot® and a suggested variation to use in women who have delivered vaginally

Okay, after ranting about ineffective modifications of the procedure, let's look at how we might legitimately modify our O-Shot® procedure (especially for those of you who are still doing obstetrics; or if you just take care of women who ever delivered a baby vaginally).

In the introduction of the paper we are considering today regarding the sex muscles and childbirth, they say, "Studies indicate that the incidences of perineal trauma can be over 90% in women who deliver vaginally."[13]

They also go on to say that many of these injuries are not obvious: you can't really meditate on that a lot in the delivery room when you have two lives at stake. And those injuries are often not diagnosed even months later, because the function of the pelvis is complicated, nebulous, and diagnosis may even involve MRI.

So what am I leading up to?

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[12] If you have trouble logging into the website, you can also call our headquarters at 1-888-920-5311 from 9-5 New York time Monday-Friday and 9-noon on Friday.
[13] Moura et al., “A Biomechanical Perspective on Perineal Injuries during Childbirth.”

Here's one possible clinical implication: I only know of two people in our group doing the following, but I see no reason why it could not be widely adopted (if you assume the superficial transverse muscle of your mother deserves application of the same science afforded the thigh muscle of Tom Brady): inject the perineal body with PRP post-partum after a vaginal delivery (either in the delivery room, or even years later).

In summary of the research, biomechanically, *the critical regions that have been identified include the perineal body near the urogenital hiatus*.

Remember that hiatus, where everything passes through the pelvic floor? So it's not the pelvic floor. ***Near the urogenital hiatus the superior region of the perineal body, which is sometimes overlooked and the area connecting the anal sphincter to the perineal body and transverse muscles***.

Some of us need to do studies where we look at injecting the perineal body, which would be easy to identify superficially, injecting the perineal body with an additional two to three CCs in women who have delivered vaginally (and still doing the rest of the O-Shot® procedure with four cc in the anterior vaginal wall and one cc in the body of the clitoris).

I know some of you guys are doing surgery in the area. My wife says she always puts PRP in the perineal body after she does a surgical repair of that area. But, maybe with less trauma and less injury, it could be that damage there could be repaired without surgery by adding that extra two or three CCs to the perineal body post-partum, which is also connected to those sex muscles we've been talking about. And hopefully lead to improvement in function of those muscles, and to a decrease in dyspareunia in those who have it in that area.

Another vision of the female sex muscles during sex

Now, let's go back to the function part of it. Let me flip back to this. Well, we can do it with this picture.

So here, the woman is prone (see the video). And so you can see that, if she were having sex, she would be on top, right? And the penis would be here. And ***the only vector holding the penis anteriorly to keep it from falling posteriorly (in relation to the woman's anterior vaginal wall) are these muscles—because there is no bone posteriorly as there is anteriorly***

So you can see that by strengthening, by putting PRP in the perineal body, possibly, I'm postulating, I'm asking for you guys to think about looking at this, trying it clinically with a couple, two or three extra CCs, and then eventually, I think we do a study with this. But you're not going to hurt anything with it. You're doing the same thing that they do with elite athletes. And it would hydro dissect, in theory, into transverse perineal, and the bulbospongiosus, and transverse perineal, all of which contribute to holding the penis in the more anterior position for more pleasure with sex.

Okay, I think that's probably enough rambling. Let me see if anybody has comments about that. And then I think that covers everything I wanted to do today with the research. I'm going to put all these references in the chat box real quick. And then, after whatever things you want to say, we're going to swap over to my new trick with making videos. So hold on just a second. I'm just going to slide these references over into the chat box. That's an open source article that I just gave you. And the textbook, I bought from Amazon. Here we go.

A video trick that helps you get over your self-consciousness and quickly produce tight and beautiful vidoes

As you guys know, I'm a big believer in videos. And I think that they do the best to explain. They give credibility, because you're mostly talking to your patients. And your patients like to hear you explain things.

Even if you use someone else's video, if a picture's worth a thousand words, I actually saw the stats on it, a video is worth many, many thousands of words. Of course, because you have so many pictures, there's just no way to duplicate the amount that's communicated in a video with writing. Can't do it. And ***the people in our group that are doing the most procedures, almost without exception, have videos on their website that they produced.***

So in the process of doing my workshops, I try to, which I've done every month, except for three or four, for the past 12 years, I've tried to incorporate teaching people how to communicate with video, in such a way it enhances your reputation and doesn't require you to be sparkly. We have people in our group who are, who have TV shows and are naturally, they could make a living just being looked at. And with their personality. I'm not one of those people, but I enjoy teaching people how to be well, as most doctors do.

So with only that qualification, knowing about the person's problem, and being willing to teach it, how do you do a video that engages?

And the biggest hang-up I see with people is they'll start and stop, and start and stop, and they're afraid they're going to say the wrong thing. And then they start over. And they never get finished with it. And they get frustrated, understandably, because it never feels comfortable.

And they quit even trying to make videos.

And so, there's software that you can use to edit videos, of course, but that's time-consuming. And you just want to get back to seeing patients. And I found software that did that, as I mentioned at the beginning of the call. But then that takes time, because then you still have to download it, and then you have to upload your video (that you made with your iPhone) to that new software, and then you have to fiddle with it.

I don't have time for that.

So I have basically, as you know by watching my videos, just been happy with something that's much less than perfect. You might even say, often embarrassingly not perfect, but communicative and successfully showing the information that I intended to show. That's about all I claim to do. And I probably only do that much 80% of the time.

But without videos, I really don't think our procedures would be much talked about. And I know that many of our people would be doing less than half of the amount of procedures they're doing now.

Hopefully, you're convinced you should at least reconsider doing videos.

So here's the new trick I have found. First of all, I'm showing you Vimeo because *I have found Google and YouTube to becoming maddeningly restrictive*, when it comes to the information I'm allowed to use. And before it even became Elon Musk fighting for freedom of speech by buying Twitter, and it became

cool to talk about freedom of speech and what it means, for political reasons**, over a decade ago, I lost a whole YouTube channel with over 140 videos because YouTube (GOOGLE) censored me.**

To do the math on that, that's a lot of time making videos and some of them had hundreds of thousands of views when that was new and uncommon; and it's how I promoted my practice when I first went cash. And some before that, just to education my patients.

And then, I woke up one day and the whole channel, all of the videos, were gone.

Gone, to never be recovered.

And it was for things that are just, were maddeningly aggravating. For example, you get three strikes and you lose your whole channel. One of my strikes was, I was demonstrating how to mix Genotropin® for the benefit of my patients, who were involved in a Phase IV clinical trial of Genotropin®. Sitting in my office with a doctor's jacket on, the office, having a legal pharmacy in it. But yet, Google, which owns YouTube, flagged it as encouraging illegal drug use. That was one of my strikes. Maddening.

If you know me, if you know me for 10 minutes, I deplore limiting what I'm able to say.

And if you have something to say I don't even agree with, I don't want to limit it, because then whoever's in charge of limiting can start limiting what we need to hear, as we all have seen both in history, recent and dissonant (there could never have been a Holocaust had Germany had a free and open press at the time).[14] So I think freedom of speech, there's a reason it's important and soldiers die for it. And I can't hardly walk across the room if I feel like I'm being squelched.

So I gave up, pretty much, on YouTube, except for the most benign stuff. And I hardly have anything that doesn't talk about sex or medicine, so I make very little content that is benign, so I don't use it that much. I used to have videos on there of cute things about my kids and stuff like that, a lot mixed in with the medical stuff, and they'll let you show boobs and talk about certain things. But ***when you start to talk about medical things, they understandably, I think, are afraid of being sued and you risk loosing all of your content.***

And surprisingly, you can talk pornographically, but when you start to talk medically, once again, I think, well, what do I know about what Google thinks? But I'll tell you what their policy is, which is that when you start to talk about medical stuff, it becomes almost impossible except in superficial and mostly ineffective ways. But, videos are hugely important, so what to do?

So, Vimeo,[15], they've never banned anything I've put up. And they seem to be now, they're monetized. It costs you a little bit per month. It's not a lot. But it's catered more towards businesses. And they don't seem to mind if I talk about sex or the details of medicine. So that's what I use, Vimeo.

Now, here's what I just discovered, and then we'll shut down this webinar. Let me just take one of the videos I've done and haven't edited this way. I've only discovered this recently.

Let's take, well, here's one that I put out that's pretty short about the sex muscles in relation to an Emsella Device.

Now, here's what I want to show you right here. "Edit and trim."

[14] Andrews, *How Do You Kill 11 Million People?*
[15] "Best Software for Interactive Video Experiences."

Now, before, this was just typical stuff that you would see. See where it says; I don't know if you're seeing that pop-up, new text-based editing. They didn't have that before. That used to be something I could only do with a separate piece of software that was expensive and time-consuming.

But now, I can just click that new button. Now watch what happens. You're going to love this. And if you haven't made videos before, hang in there because I'm going to tell you how to use this tool.

So, in just a few minutes, it's going to transcribe that whole video using the new AI stuff. And then all I have to do is, and it won't get the transcription right, perfectly, but it's close enough to know what it was I was saying, and it highlights pauses.

So now what I can do is, go in and take the words that don't sound right, or where I told an off-color joke, or got to have trouble reeling it in. So this way I don't have to reel it in. But before I send it out, I can go just find where I said something, highlight it like you're editing a Word Document and click delete.

So right now, let's take this. I'll play it for you and then I'll edit it so you'll see what I'm talking about.

I'm not going to play the whole thing. I'll play part of it.

Recording Replay:

Strengthening the pelvic floor improves both sexual function and urinary incontinence in women. But there are-

Charles Runels, MD:

All right, now, I'm going to stop it right there, "... and the, but there are," that doesn't make any sense, right? So let's pull out the, "and the" part.

Delete.

And here's the beauty of it. It's going to delete that part of the video, too.

So I have a 1.6 second pause, getting started, take that out. So we've had pause over and over again and then I start a whole new sentence. I don't need that. So let's pull that part out. And it's going to pull out exactly the same part in the video.

"We've seen research come out showing that strengthening the pelvic..."

So let's pull out the come out part.

Boom!

I would leave some of this in. Don't try to make yourself (unless that's who you are) Some of you are functioning as TV personalities—so clean it up until it's perfect. But you're still a doctor, and if you clean it up too much, it makes it seem unreal.

The hidden time saver function of the app

But here's where the big time-saver in this comes in. You're shooting a video and you get to part where you're just stuck. You don't even have to freaking turn the camera off.

You can stop, pick up your book, find out what you wanted to say next, say it wrong, say it again, say it three times, *you've never turned off the camera*.

And now you can go in and just find the place where the pause was, find the five minutes where you said something stupid, and just highlight it, pull it out, and you're done.

Now, watch when I click save. It's going to take a little while, but it's not long. Just within, you'll see it's optimum rendering. So it's getting rendered. ***And it takes five minutes or so. And then it'll play perfectly, pulling out the same parts of the video that matched where I was saying the thing I didn't like.***

So that's the big trick. It's on Vimeo. And again, the way you find it is after you upload your video to Vimeo, then you just hit that trim button, then hit the new tool where you transcribe it, pull out the part you don't like, and then you're ready to embed it or link to it in a video, or link to it in an email.

See, I'll probably edit that part out when I put this out.

All right, thank you, guys. Let's see if there's any comments, or questions, or corrections?

I don't see anything, so I think we will call it a day. I hope that was worth your time here today. Bye-bye.

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Trap for Infringers

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