

I hear some version of this almost every clinic day:

“Doc, am I too old for this stuff?”

Or, from the other side, “Should I start regenerative medicine now while I am still young?”

Age does matter, but not in the simple way you might think. Regenerative medicine is not a single treatment and it is not a magic reset button. It is a set of tools that work with biology that changes over the decades. The sweet spot for one person might be a poor choice for another, even if they share the same age on paper.

This is a practical guide, written the way I talk to my own patients, about who is and is not a good candidate for regenerative medicine at different ages, what the real trade offs look like, and how to think about cost, insurance, and safety without getting lost in hype.

What exactly is a regenerative medicine doctor?

The simplest way to think about it: a regenerative medicine doctor is a physician who tries to help the body repair, replace, or restore damaged tissues instead of simply masking symptoms or cutting tissue out.

That might sound broad, and it is. In practice, most regenerative medicine doctors come from another core specialty. The ones you are most likely to encounter:

- Orthopedic surgeons or sports medicine physicians using platelet rich plasma (PRP), bone marrow concentrate, or other cell based therapies for joints, ligaments, and tendons.
- Physiatrists (physical medicine and rehabilitation doctors) working on spine and musculoskeletal problems with image guided injections.
- Dermatologists and plastic surgeons using regenerative approaches for wound healing, scars, or hair loss.
- Hematologists and oncologists involved in stem cell transplants.
- Internists and family physicians who have added regenerative tools for metabolic or age related conditions, sometimes in concierge or longevity clinics.

There is no single, universally accepted board certification in “regenerative medicine” yet. That is part of what makes the field confusing. When you ask, “What is a regenerative medicine doctor?” you are really asking about the training and ethics of the individual in front of you.

The questions I recommend patients ask are simple: What is your base specialty? How many of these procedures have you performed? Where did you train in this specific technique? A good doctor will answer directly.

The four basic types of regeneration in medicine

Biologists describe “regeneration” in several ways. In clinical practice, we mostly work with four functional types of regeneration:

1. Cellular regeneration

Replacement of damaged or dead cells with new ones. Stem cell transplants for blood cancers, or using bone marrow derived cells to support joint healing, fall into this category.

2. Tissue regeneration

Repairing a damaged structure, such as cartilage in a knee, a tendon, or skin after a burn. PRP injections for tendonitis or chronic plantar fasciitis aim for this.

3. Organ support and functional regeneration

Trying to restore function in organs like the heart or liver after injury. This is an active research area and, outside of transplants and certain trials, remains limited in routine clinical practice.

4. System level or “whole body” regeneration

Approaches that target stem cell niches, immune system reset, or senescent (biologically old) cells across the body. This is where a lot of longevity marketing lives, but the strongest evidence is still in narrow indications, such as immune system reset in certain blood disorders.

Knowing these categories keeps expectations grounded. Most of what is offered commercially right now relates to musculoskeletal tissue regeneration, not whole body age reversal.

How age actually affects regenerative capacity

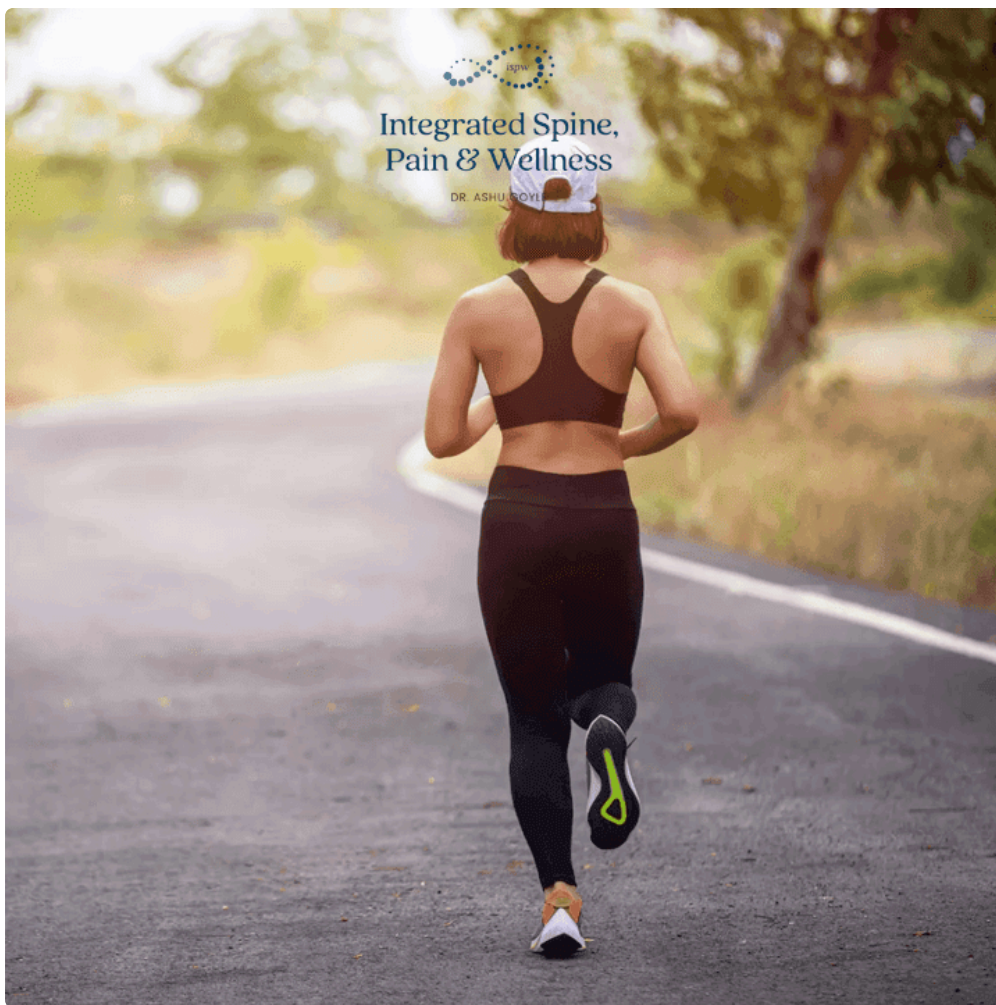
Biology does not read your birth certificate, but it does care about time. Stem cell numbers and function generally decline with age. Blood flow worsens, inflammation increases, and you accumulate structural wear and tear.

That said, I have seen 70 year olds heal faster than 45 year olds because they sleep well, control their diabetes, keep their weight reasonable, and move their bodies daily. And I have seen biologically old 30 year olds with uncontrolled smoking, obesity, and unaddressed autoimmune disease heal very slowly.

Age affects three major aspects of regenerative medicine:

First, the quality of your own cells and growth factors. PRP from a 25 year old marathon runner is not the same as PRP from a 78 year old with chronic disease. Second, the condition of the “soil” where you are trying to grow tissue: blood flow, alignment, joint space, nerve supply, and chronic inflammation. Third, your recovery capacity: sleep, nutrition, muscle strength, and overall resilience.

So are you too old or too young? Usually the better question is: is this tissue still salvageable, and are you willing to support the healing process?



Regenerative medicine in your 20s and 30s

Younger adults often ask, “Am I wasting time with physical therapy if I can just get PRP or stem cells?” In this age group, I look hard at three things: actual structural damage, lifestyle, and expectations.

For sports and orthopedic issues, 20s and 30s are often an excellent window for regenerative options like PRP or bone marrow concentrate, provided there is a clear target: a focal cartilage defect, chronic tendon pain that has failed conservative care, or a partial ligament tear. The body’s underlying regenerative capacity is generally strong, and we are layering additional support on top of that.

On the flip side, I routinely advise young patients against systemic stem cell “boosters” marketed for longevity or general performance. The evidence there is thin, the costs are high, and the long term risks are not fully characterized. If you are 28, sleep 5 hours a night, eat poorly, drink heavily, and barely move, a stem cell infusion will not fix your real problem.



For hair restoration, skin quality, and early joint changes, [Regenerative Medicine Doctor Scottsdale](#) carefully selected PRP treatments can make sense in this age group, but only after realistic discussion. If early arthritis runs in your family, using regenerative tools alongside strength training and weight management can delay or reduce the need for future surgery. That is where I see the most value in younger adults.

In terms of pain, most regenerative procedures are more uncomfortable than a typical vaccine, but usually less than major surgery. With good local anesthesia, patients in their 20s and 30s usually tolerate them well. They are often back to work within days, although sports and heavy lifting may need to pause for weeks.

Regenerative medicine in your 40s and 50s

This is often the “crunch time” decade for joints, spine, and metabolic health. Many patients here ask: “Who is a good candidate for regenerative medicine?” The honest answer is more nuanced, but there are consistent patterns.

Good candidates in this age range usually share a few traits. They have specific, image confirmed problems such as moderate knee osteoarthritis, a partial rotator cuff tear, chronic tennis elbow, or a contained disc bulge with matching symptoms. They have tried structured conservative care: physical therapy, activity modification, sometimes targeted injections. They are motivated to work on strength, mobility, and weight. They understand that regenerative medicine is not a one shot cure, but part of a broader plan.

Less ideal candidates are those with very advanced “bone on bone” arthritis where joint space is nearly gone, or with severe structural collapse in the spine. We can sometimes reduce pain or delay surgery, but tissue regeneration becomes much harder when the architecture is largely destroyed.

In the 40s and 50s, PRP and bone marrow based therapies for joints, tendons, and ligaments can still be quite effective. The success rate of regenerative medicine in published orthopedic studies varies widely, from roughly 50

to 80 percent reporting meaningful symptom improvement, depending on the condition, product, and protocol. It is not binary: "success" usually means better pain and function, not an MRI that looks like you never aged.

This age group also asks more often about systemic or intravenous stem cell treatments for general "anti aging." Here we enter a gray zone. Some clinics, especially outside the United States, offer IV infusions of allogeneic (donor) stem cells claiming global benefits. Evidence for long term safety and efficacy in relatively healthy middle aged adults is still limited. Anyone in this age range considering that route should view it as experimental and make the decision with full awareness of both uncertainty and cost.

Regenerative medicine in your 60s, 70s, and beyond

Older adults are the ones most often told they are "too old" for regenerative medicine. That is rarely the full story.

It is true that the quality and quantity of your own stem cells decline with age. PRP from someone in their late 70s tends to have a different growth factor profile than from a 35 year old. Degenerative changes are more widespread. Diabetes, vascular disease, and other chronic issues also stack the deck against robust tissue regeneration.

However, I have seen well planned regenerative procedures produce meaningful improvements even in patients in their 70s. Examples include reducing knee pain enough to walk a few miles again, calming chronic low back pain that had resisted other injections, or improving shoulder function enough to avoid or postpone surgery.

The key is matching the tool to the context. A 75 year old with moderate knee arthritis, decent alignment, good muscle strength, and well controlled blood pressure is a very different candidate from a 75 year old with severe varus deformity, bone on bone arthritis, obesity, and uncontrolled diabetes.

Older adults should also have a different risk conversation. If your main goal is a few more years of higher function before an eventual joint replacement, the bar for "worth it" might be lower than for a 30 year old who wants to return to competitive sports. At the same time, we need to carefully weigh infection risk, bleeding risk from blood thinners, and recovery demands.

Many patients also ask if regenerative procedures are more painful in advanced age. The injections themselves are similar in sensation, but recovery may feel slower. Good local anesthesia, sometimes mild sedation for selected procedures, and very clear post procedure guidance go a long way to keeping discomfort manageable.

A quick self check: are you a likely candidate?

Here is a short checklist I suggest patients go through before they travel, spend large sums, or commit to any regenerative protocol.

- You have a specific diagnosis that explains your symptoms, ideally supported by imaging or nerve studies.
- You have already tried appropriate conservative treatments, including structured physical therapy, not just a few exercises from the internet.
- Your doctor can explain how the proposed treatment targets your actual problem, not just "it helps everything."
- You are prepared to follow a real rehabilitation plan, not simply get an injection and resume old habits.
- You understand the expected odds of improvement, not a guarantee.

If you cannot honestly check most of those boxes, it is often wiser to slow down and clarify the basics before chasing "advanced" options.

How much do regenerative medicine doctors make, and why that matters to you

Patients sometimes ask, almost apologetically, “Is this just a money maker for doctors?” It is a fair question.

Regenerative medicine is not a distinct salary category in national surveys. Income depends on underlying specialty, geography, and practice model. Among US physicians, procedural specialists such as orthopedic surgeons, neurosurgeons, and some interventional cardiologists tend to be among the highest paid doctor specialties, with average annual incomes often in the 600,000 to 800,000 dollar range or more in some surveys. Primary care fields like pediatrics and family medicine are typically among the lowest paying doctor specialties, with averages more in the 220,000 to 280,000 dollar range, though there is wide variability.

Many regenerative medicine procedures are cash based, especially where insurance does not reimburse PRP or certain cell based therapies. That can create real conflict of interest pressure. A physician who derives a large share of income from these treatments must be vigilant about bias, or better yet, build systems where multiple clinicians review candidacy and indications.

From your side, the practical takeaway is simple: be more skeptical of a clinic where every person seems to “need” the same expensive solution, and where no one is told they are not a good candidate.



What does regenerative medicine cost, and will insurance pay?

Costs vary widely, but there are some rough ranges for common outpatient musculoskeletal procedures in the United States:

PRP injections for a single joint often range from about 500 to 2,500 dollars per session depending on the system used, the practice, and the region. Bone marrow derived cell procedures can run from 3,000 up to 8,000 dollars or more per area. More elaborate “whole body” or intravenous stem cell packages offered in some private clinics or overseas can reach 10,000 to 30,000 dollars or higher.

What is the average cost of regenerative medicine? There is no single number, but for a typical orthopedic problem like knee osteoarthritis treated with PRP, patients in many US cities are quoted somewhere in the 1,000 to 3,000 dollar range per treatment cycle.

The question “Will insurance pay for regenerative medicine?” is trickier. Many insurers still classify PRP and several biologic therapies as experimental for most indications. They frequently do not cover it, although there are a few exceptions in narrow circumstances or specific plans. Traditional stem cell transplants for blood cancers and related conditions are of course covered, but that is a different context than elective joint injections.

“Does insurance cover Kinetix?” is a question that comes up because of branded protocols marketed under that or similar names. Coverage is usually determined by the underlying procedure code and diagnosis, not the marketing name. Some components might be billed under standard injection or surgical codes, but the biologic product itself is often out of pocket. The only reliable way to know is to ask your insurer and the clinic for specific codes and pre authorization, rather than relying on general promises.

If a clinic tells you “this is covered” but cannot provide clear billing codes or documentation, treat that as a warning sign.

Where did Joe Rogan get his stem cell treatment, and should you follow?

Joe Rogan has spoken publicly about receiving stem cell treatments in Panama, most commonly associated in media reports with a clinic called the Stem Cell Institute in Panama City. Many other high profile athletes and celebrities have traveled to Latin America or other regions for similar therapies.

Which raises the common question: what country is best for stem cell treatment?

There is no single best country. Different regions take different regulatory approaches. The United States and much of Europe have stricter rules on minimally manipulated cells, which limits some of the more aggressive protocols but offers stronger oversight. Countries like Mexico and Panama allow clinics to offer allogeneic mesenchymal stem cell infusions and other treatments that are not approved in the US.

Traveling abroad can give access to treatments that are unavailable or heavily restricted at home, but it also raises concerns. Quality control can vary. Long term outcomes are less systematically tracked. If a complication occurs, continuity of care becomes harder once you return home. There are excellent clinicians in many countries, and there are also poorly regulated operations riding the wave of marketing.

If you are considering treatment overseas, prioritize clinics involved in published research, transparent about cell sourcing and processing, and willing to coordinate with your local physicians. Do not choose a destination solely because a celebrity mentioned it on a podcast.

How painful are regenerative medicine procedures?

Most patients are less concerned about the biology and more about the needle.

“Is regenerative medicine painful?” depends on the specific procedure. A straightforward PRP injection into a knee, performed with good local anesthesia, often feels like a series of sharp stings and pressure. Discomfort usually

peaks in the first 24 to 72 hours due to the inflammatory healing response, then settles. Many patients describe it as similar to a bad sprain or deep bruise.

Bone marrow aspiration from the pelvis, which is needed [Regenerative Medicine Doctor Scottsdale](#) for some stem cell based treatments, is more uncomfortable, but can be done with local anesthesia, sometimes combined with oral or IV sedation. Patients often describe a strong pressure or ache rather than sharp pain. With careful technique, most tolerate it well, but it is not a spa treatment.

Procedures in the spine or small joints can be more delicate. Fluoroscopic or ultrasound guidance helps place the material accurately and minimizes unnecessary tissue trauma. Good pre procedure counseling, realistic pain expectations, and a clear medication plan for the first few days make a big difference.

If a clinic glosses over pain entirely, or suggests “you will not feel a thing” without mentioning their anesthesia plan, ask more questions.

What is the biggest problem with regenerative medicine?

From a clinician’s viewpoint, the single biggest problem with regenerative medicine right now is not the basic science. It is the gap between marketing and evidence.

We have a rapidly growing, but still uneven, research base. Some indications, like PRP for mild to moderate knee osteoarthritis or chronic tennis elbow, have reasonably solid data for symptom improvement in many patients. Others, such as systemic stem cell infusions for healthy aging or cognitive enhancement, are still primarily theoretical or based on small, early trials.

Yet the public facing story often treats all regenerative approaches as equivalent “stem cell therapy,” implying near certain regeneration of whatever ails you. That mismatch breeds both unrealistic hope and understandable skepticism.

Other disadvantages of regenerative medicine that I discuss with patients:

Results are variable and not guaranteed, even in good candidates. Many treatments are expensive and not covered by insurance. Quality control across clinics is inconsistent. Long term safety data for some new protocols, especially systemic ones, are incomplete. And there is a psychological risk of delaying appropriate conventional treatment because of hope that “one more injection” will fix a structurally unsalvageable problem.

A grounded clinic spends as much time talking about what these therapies cannot do as what they might.

Does fasting for 72 hours regenerate cells?

The idea that a 72 hour fast can “reset” or regenerate the immune system has circulated widely, often traced back to studies from Valter Longo’s group and others. In mice, cycles of prolonged fasting followed by refeeding have been shown to reduce some immune cells and then stimulate stem cell based regeneration of new ones. Some small human studies suggest that prolonged fasting or fasting mimicking diets can lower certain markers of inflammation and affect immune cell populations.

However, translating that into “a 72 hour fast regenerates cells” as a clinical recommendation is a big leap. Most people are not mice, and most do not live in controlled lab conditions. Extended fasting can be risky for people with diabetes, eating disorders, or other health issues, and its role in medical regeneration protocols is far from standardized.

I am not opposed to time restricted eating or occasional supervised fasting in appropriate individuals. But I do not consider a 72 hour fast a substitute for well planned regenerative treatment when there is a clear structural problem like a torn tendon or arthritic joint.

If you are curious about fasting for health, do it with medical supervision, especially if you take medications or have underlying conditions.

What is the success rate of regenerative medicine?

Patients often want a single percentage. The honest answer is that success rates vary dramatically by condition, protocol, and definition of success.

For example, PRP for chronic lateral epicondylitis (tennis elbow) has shown high response rates in several trials, with many studies reporting 70 percent or more of patients experiencing significant long term pain reduction and function improvement compared to control treatments. For knee osteoarthritis, results are more mixed but still generally favorable compared to saline or hyaluronic acid injections in many studies, although the effect size tends to be more modest and depends on disease severity.

For spinal disc problems or advanced hip arthritis, the data are thinner and more heterogeneous. You might find a study reporting good outcomes in a narrow set of patients, but that does not translate to a blanket success rate applicable to everyone.

Any responsible physician should be able to discuss success data specific to your problem, with citations or at least summaries of relevant studies, not just “we see 90 percent success in our clinic” without clear definitions.

Questions to ask your doctor before saying yes

If you are seriously considering a regenerative treatment, go into the consultation with a few prepared questions.

- What is my exact diagnosis, and how well does it match conditions studied with this treatment?
- What are the realistic best case, average case, and worst case outcomes for someone like me?
- What are the alternatives, including doing nothing or opting for surgery now?
- How many of these procedures have you performed in the last year, and how do you track outcomes?
- What is the full cost, including follow up, and exactly what will and will not be billed to insurance?

The quality of the answers often tells you more than the specific treatment being proposed.

Bringing it together: age, expectations, and wise choices

So, are you too old or too young for regenerative medicine? In most cases, the answer is “neither.” The more accurate question is whether a specific regenerative approach, applied by a competent physician, fits your biology, your goals, and your tolerance for cost and uncertainty at this point in your life.

Younger adults often get the most impressive structural gains but sometimes chase unproven “longevity” fixes instead of building basic health. Middle aged adults stand at the crossroads where targeted regenerative treatments can delay or reduce the need for surgery if used wisely, but also risk spending heavily on things that will not overcome severe structural damage. Older adults may not reverse decades of wear, but can still gain meaningful function and pain relief when treatment is chosen with clear eyes and honest expectations.

Regenerative medicine is powerful, but it is not magic. It belongs in the same thoughtful conversation as surgery, medication, rehabilitation, and lifestyle change, not in its own untouchable category. The right time to consider it is

not defined by your birth date. It is defined by how well the science, your condition, and your values line up when you sit across from a doctor willing to tell you both the promise and the limits of what they can offer.

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