Peptide Perspectives™

THE MUSCLE-BUILDING STACK

Growth Hormone Peptides, Anabolic Signaling & Performance Supplements

THE MUSCLE GROWTH NETWORK

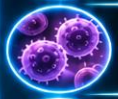
- Muscle growth is a multi-pathway process that includes hormone signaling, nutrient sensing, repair, and training.
- **Key drivers:** GH/IGF-1 signaling, mTOR activation (amino acids, especially leucine), satellite cell activity, and reduced myostatin.
- **Progressive resistance** exercise is the primary stimulus for muscle growth.
- **Higher growth hormone (GH) does not necessarily lead to bigger or stronger muscles in humans.**



Hypothalamus (GHRH) → Pituitary (GH) → IGF-1 (muscle growth & repair)



mTOR (Amino Acids)
Drives protein synthesis & muscle building



Satellite Cells
Repair and add new muscle fibers



Myostatin
A natural "brake" on muscle growth (research targets include follistatin)

SIX RESEARCH STACKS & STRATEGIES

1. CJC-1295 + IPAMORELIN

- **What it does:** CJC-1295 (GHRH) increases GH release; ipamorelin (ghrelin receptor) also stimulates GH.
- **Evidence:** Increases GH and IGF-1 in studies, but no controlled human trials show increased muscle size/strength.

COMMON COMMUNITY DOSING (UNVALIDATED)

- CJC-1295 (no DAC) 100 mcg + ipamorelin 200–300 mcg at bedtime.
- **Optional:** Some add a 2nd fasted AM or post-workout dose.
- **Cycle note:** Often 12–24 weeks, 5 days on / 2 off.

⚠ NOT A VALIDATED HUMAN MUSCLE-BUILDING PROTOCOL.

2. IGF-1 (LR3/DES) + MGF / PEG-MGF

- **What it does:** IGF-1 (e.g., LR3 or DES) activates anabolic signaling (e.g., PI3K/Akt/mTOR). MGF (a splice variant of IGF-1) is studied for local muscle repair.
- **Evidence:** Promising in preclinical research; limited and mixed human data.

COMMON COMMUNITY DOSING (UNVALIDATED)

- IGF-1 LR3 often 20–40 mcg/day to start; common 40–60 mcg/day.
- PEG-MGF often 200–400 mcg 2–3×/week.
- Non-PEG MGF often 100–200 mcg IM post-workout only.

⚠ UNVALIDATED; HYPOGLYCEMIA AND CELL-GROWTH CONCERNS.

3. CJC-1295 + IPAMORELIN + MGF

- **What it does:** A multi-pathway approach combining GH release (CJC-1295 & ipamorelin) with IGF-1 splice signaling (MGF).
- **Evidence:** Limited to preclinical and anecdotal reports; no human trials showing superior muscle-building effects.

COMMON COMMUNITY DOSING (UNVALIDATED)

- CJC-1295 100 mcg + ipamorelin 200–300 mcg nightly.
- Add PEG-MGF 200–400 mcg 2×/week or non-PEG MGF 100–200 mcg post-workout.

⚠ NO VALIDATED COMBO; SAFETY AND EFFICACY UNPROVEN.

4. TESAMORELIN + IPAMORELIN

- **What it does:** Tesamorelin (a GHRH analog) and ipamorelin both stimulate GH release through different pathways.
- **Evidence:** Increases GH and IGF-1, but no human trials show added muscle growth from the combination.

COMMUNITY / LABEL CONTEXT (UNVALIDATED FOR MUSCLE BUILDING)

- **Tesamorelin** 1.28 mg daily is the labeled EGRIFTA WR® dose for HIV lipodystrophy.
- Informal stacking discussions pair this with ipamorelin 200–300 mcg nightly.

⚠ DISEASE-SPECIFIC LABELED DOSE, NOT A MUSCLE-BUILDING APPROVAL.

5. SERMORELIN + IPAMORELIN

- **What it does:** Sermorelin (a GHRH analog) and ipamorelin can increase pulsatile GH release.
- **Evidence:** Increases GH/IGF-1 in studies, but no controlled human trials show increased muscle mass or strength.

COMMON COMMUNITY DOSING (UNVALIDATED)

- Sermorelin 200–500 mcg + ipamorelin 200–300 mcg at bedtime.
- Some add a 2nd fasted AM dose.
- Often 5 days on / 2 off.

⚠ NO VALIDATED COMBINATION DOSE FOR MUSCLE GROWTH.

6. FOLLISTATIN-344 (FST-344)

- **What it does:** Binds and inhibits myostatin and activin, which normally limit muscle growth, potentially allowing greater muscle development.
- **Evidence:** Promising in animal studies; very limited human research.

COMMON COMMUNITY DOSING (UNVALIDATED)

- Often 100–300 mcg subcutaneous **once daily.**
- Common blocks are short, e.g. 10–30 days.

⚠ EXPERIMENTAL ONLY; NO VALIDATED PERFORMANCE DOSE OR LONG-TERM SAFETY.

EVIDENCE-SUPPORTED SUPPORT DOSING (SUPPLEMENTS)

- **Creatine Monohydrate** 3–5 g daily (well-studied for strength and power)
- **Protein** Total ~1.4–2.0 g/kg/day for many exercising healthy adults (adjust to individual goals and circumstances)
- **Whey Protein** Use only to close a dietary protein shortfall (not required if protein needs are met with food)
- **HMB** 3 g/day (commonly studied; mixed evidence)
- **Essential Amino Acids (EAAs)** Helpful when dietary protein is insufficient (no universal dose).
- **Vitamin D** Use only to correct a deficiency (eg., 1,000–4,000 IU/day, based on labs and clinician guidance).

WHAT MATTERS

- **Strength** (e.g., 1RM, performance)
- **Mobility** (movement and function)
- **Muscle Function** (power, endurance)
- **Body Composition** (lean mass vs. fat mass)
- **Adverse Events** (side effects and tolerance)
- **Glucose** (metabolic response, insulin sensitivity)
- **IGF-1** (hormone levels and safety markers)

EVIDENCE TAKEAWAY

- No peptide stack is FDA-approved for bodybuilding or muscle growth.
- No validated combination dosing exists for any of the six research stacks above.
- The strongest, most practical combination for muscle building is progressive resistance training + adequate nutrition (protein) + recovery (sleep) + creatine.

COMMUNITY-REPORTED DOSING IS UNVALIDATED.
STUDIED DISEASE-SPECIFIC DOSING IS NOT A BODYBUILDING PROTOCOL.
EDUCATIONAL OVERVIEW, NOT MEDICAL ADVICE.