THE CLINICAL ASPECTS OF ORCHIDALGIA

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On qualifying and entry into practice the author was surprised to find that chronic bronchitis, with all its ramifications and complications constituted the back-bone of his working life. In the teaching wards this common condition had been a rarity. After more experience it soon became apparent that many conditions existed in the field of general practice, which were seldom, if at all, seen in the teaching hospital, and were often inadequately dealt with even in the text-book. A few conditions seem to escape reasonable description completely. Orchidalgia is one of these.

*Orchidalgia* may be defined as a neuralgic pain, radiating from the testes, and occurring as a result of prolonged and excessive sexual stimulation falling short of natural intercourse.

The exact mechanism of production of this syndrome is of course open to speculation. Two distinct factors in its production may be postulated, acting for the most part in unison but to varying degrees. These factors are:

1. Pelvic congestion, the entire genital tract becoming tumescent as a result of neural excitation. With the inhibitions imposed by both moral and social taboos, natural orgasm and subsequent detumescence does not occur. Instead a temporary disorder of the pelvic autonomic nervous system results manifesting itself in pain in the genital area.

   This, in its parallel form in the female, is widely recognized as one of the causes of disorders of vascular function of the endometrium, hypersecretion from the cervix, and a tendency to hyperalgesia in various areas supplied by the sensory components of visceral nerves.

2. Psychopathology of a conversion hysteria type acting as an insurance and guilt mechanism against obtaining tabooed pleasures.

   Of these two factors the first mechanism is undoubtedly the most prominent in the production of orchidalgia.

The literature, as previously stated, is singularly lacking in references to this condition, and those that occur are usually limited to a brief line or paragraph. Statements are often contradictory and lacking in substantiation, and confusion or lack of differentiation between true orchidalgia and gross hysteria often exists. For example, Kinsey *et al.*, (1948) in a large work, restrict themselves to a few remarks to the effect that pain in the testes or groin is not uncommonly experienced by the male who fails to reach a climax

during petting. Stekel (1940), on the other hand, gives it much more space but his interpretation is purely psychoanalytical, and his case histories are those of major psychiatric pathology. The only comprehensive work on this subject that the author has been able to find is that of Nash and Sumner (1954), and even this suffers from being purely academic in approach, no hint being given of the possible clinical implications of the syndrome. Nowhere, apparently, is to be found a description of orchidalgia in its acute form which, though rare, has succeeded in producing four night calls in this practice during the last five years. Working with 80 unmarried college students aged from 22 to 26, Nash and Sumner were able to ascertain that the incidence of orchidalgia was high (80 to 90 per cent). However, no information on the severity of the attacks is given, or whether any of the attacks necessitated a clinical consultation. They list the pain as beginning anywhere from a half hour to two hours after petting began and as persisting for a considerable time, despite orgasm or masturbation, to subside only during sleep or absorption in some non-sexual activity. The area of localization of the pain was given in the majority of cases as the testicles and, to a lesser degree, in the groin or lower stomach. In a few cases it was of sufficient intensity to cause a feeling of nausea but not vomiting. Usually, it was described in popular terms varying with the locality and social level of the subject, e.g. passion cramps, stone ache, love pains, and so on. On closer questioning, the pain was generally described as a dull ache.

In an attempt to put some of this work on a more clinical footing 50 consecutive male patients, ages 18 to 40, in the author's practice were asked the following questions:

(1) Have you ever experienced genital pain?
(2) What was its characterisation with regard to intensity, quality, radiation, duration, and manner of subsistence?
(3) Under what circumstances did it appear?
(4) Did you deem it necessary to consult a doctor?
(5) Do you know any popular name for this type of pain?
(6) Have you ever been worried about the pain and if so in what way?

The results of the investigation showed some, but by no means complete, agreement with the results obtained by Nash and Sumner. They were:

**Incidence.** Forty-one of the men admitted to having experienced genital pain during some period of their lives. However, in terms of popular language they were somewhat behind their American contemporaries; only eight recognized the syndrome in popular terminology.

**Characterization.** The pain was overwhelmingly connected with sexual stimulation. This was generally recognized by the subject but most of them had been worried as to its possible pathological
significance. It came on predominantly during or after strong sexual stimulation stopping short of natural intercourse. Two young, unmarried men admitted having had pain after frequent masturbation and one married subject who was known to have major psychiatric pathology volunteered the information that if he had intercourse more than twice in one night he usually developed genital pain.

The pain was invariably described as aching in character with a distribution and radiation similar to that found in the American investigation. The intensity was sufficient in a few cases for the self administration of simple analgesics.

Unlike in the American survey, no clear cut distinction was obtained with regard to the duration and best method of alleviation, although a night's sleep was often mentioned as doing the trick. However masturbation was mentioned as often being beneficial—far more frequently than relief from non-sexual activities.

In a number of cases, including those who admitted to pain associated with frequent masturbation, the pain persisted for more than 24 hours—in one case for 3 days. In this group of five, three had found it necessary to obtain professional advice. These reported that at the consultation the sexual connection had not been elicited or volunteered and the subject had been reassured with regard to the absence of organic pathology. On leaving the surgery, the failure of this partial reassurance had already begun. To quote one subject, "How can there be nothing wrong with me when I have a pain to prove that there is."

The results given above suggest that orchialgia is in the main a relatively minor syndrome. So minor in fact that the doctor is seldom asked to treat it. Yet, out of the small numbers under investigation, a large proportion admitted to worry over its possible pathological as opposed to physiological significance. Three had, indeed, sought professional advice, which was felt to be inadequate, falling short of the ideal purely as a result of probable insufficient knowledge on the part of the medical adviser. The high incidence of expressed concern, and the apparent production of the syndrome as a result of frequent masturbation as well as by strong inhibitory sexual foreplay, pointed to a field of clinical application within the realms of simple supportive psychotherapy. This view was strengthened when the answers to question six were analysed. Broadly speaking, the worries could be divided into two categories. The first group, the physical, was attached to the pain as the dominant factor, relating to the possible possession of a grave physical disease or abnormality. The second group, the psychological, where the pain was regarded as being more coincidental, was attached to feelings of guilt over supposed physical excesses, which in turn were in the process of procuring some irremediable illness which the
subject so richly deserved for his wickedness. Also in this group were worries affiliated to fears of lack of potency and inferiority of manhood. In view of all this credit for stability of adjustment should be given to the majority of the group under investigation—only three of them had required professional advice. Possibly the self-limiting nature, and relatively low intensity of the pain is also a factor here in the low consultation rate of the syndrome, together with the natural reluctance to present with emotional problems.

Accepting the hypothesis that one of the main clinical applications of the syndrome under discussion is in the realms of psychotherapy, it was argued that males presenting with neurotic features as a result of masturbatory and courtship problems, who had failed to respond adequately to the usual explanatory and reassuring measures, might have failed to do so because of undiagnosed orchidalgia. Two such patients admitted to orchidalgia and after explanation showed dramatic improvement.

The following are examples of "acute" orchidalgia:

Case 1. Aug. 1957. At mid-night on a Saturday night a request for a call to see a temporary resident who was described as being a young man with query appendicitis was received. The request was made by the patient's father, who said that his son had been walking about doubled up all that day. The call was to a boarding house which was found to be a hive of activity despite the late hour. On all its corridors young people were displaying the reasonably modest foreplay, so often seen at this time during the season in these establishments. On entering the sick room, a young lady rapidly disengaged herself from the patient and the extent of male stimulation was not difficult to discern through the thin bedclothes. A history was elicited of an aching pain in the groin radiating to the rt. testis. The pain had been present for approximately 12 hours, was associated with intermittent mild nausea, and had been sufficient in intensity to cause some difficulty in walking. All examinations, both local and general, proved essentially negative, apart from some tenderness in the right groin and a disinclination to stand up straight. The problem was to explain this man's symptoms in terms of inflammatory lesions which he gave no indication of having or of masses which were certainly not visible or of muscle strains to which no pointer was volunteered in the history.

At this stage the manner of introduction and the general atmosphere on entering the hotel was remembered and further questions were directed along that line. The following information was then forthcoming. The young man had met his young lady precisely 14 hours previously at the breakfast table. From that time on he had never looked back, courtship being in earnest almost from the word go. The day had been spent almost continually in foreplay, the petting always stopping short of any logical advancement as a result of a mutual agreement. The mechanism of production of the pain was explained to the patient in simple language, father reassured as to the absence of appendicular pathology, and a simple analgesic tablet left as the medical offering to the solution of the problem. Needless to say in the morning the pain had completely gone.

This case is interesting because it illustrates how a general practitioner can have the opportunity of being present, as it were, within the orbit of psychopathological mechanisms, enabling him to diagnose with reasonable certainty, even a condition for which at that time he had no official name. It may be argued, perhaps, that
for obvious reasons this case could not have been very acute. If this is conceded, it leads by a logical progression to the next case.

Case 2. Sept. 1958. A late call was received on wet afternoon to see a man of 23 who was said to be rolling around in agony from abdominal pain. Once again the address was that of a hotel, where, upon arrival, the doctor was met and escorted to the patient’s room by a most attractive and tear-ridden fiancée. The patient, while not exactly rolling in agony, was complaining loudly and seemed most uncomfortable. He described his complaint as a feeling as if he had had a kick in the privates. This had come on comparatively slowly as an ache, but had rapidly advanced to an unbearable crescendo. The distribution of the pain was very similar to that in case 1; the difference being that here it was much more intense and was maximal in the perineum as opposed to the groin. Routine medical history and examination revealed little and the clue to the diagnosis was once again in the medical aura—the picture of a rainy day on holiday with nowhere to go, and a young couple with inhibitions, yet in love. On closer questioning this was found to be, indeed, the case. Explanatory reassurance and guidance together with a dose of pethidine did all that was required.

Three more very similar cases to the ones described above have been collected in this practice. They all have in common varying degrees of severe self-limiting genital pain associated with

(a) a paucity of clinical signs and negative pathological investigations, urine invariably sterile, and
(b) strong sexual inhibitory stimuli immediately prior to the onset of the pain.

In considering the differential diagnosis of these cases the vast pathology of the acute abdomen enters the arena. Many of these conditions can be easily excluded by reasons indicated above. However, the following are perhaps worthy of more detailed discussion.

Local conditions of the genitalia and their contiguous structures. These are fairly easily excluded by the absence of any discharge, lumps, bumps and thickenings.

Acute appendicitis. Here the differential diagnosis is more difficult, especially in those cases of orchidalgia in which the pain has spread to the lower abdomen. Helpful pointers here are the minimal tenderness in proportion to the discomfort, nausea but no vomiting, absence of hyperalgesia and rigidity, negative Blumberg’s and Rovsing’s signs, and absence of positive psoas and obturator tests. Most important of all, however, is the direct correlation of onset of the pain with prolonged sexual stimulation.

Stone in the ureter. This is perhaps the most confusing differential of all. However, the absence of urinary symptoms, the self-limiting nature, and the sexual correlation of the pain are useful pointers.

To quote Balint, “If you ask questions you get answers—and hardly anything else.” The general practitioner, with his intimate contact with patients in all the phases of their physical and emotional life, can and often does get the right answers more easily than his consultant colleague. In all the patients with acute orchidalgia seen
in this practice the highly personal history of intense and prolonged inhibitory sexual stimulation so essential to the diagnosis of acute orchidalgia was elicited with very little trouble.

Summary
The syndrome of orchidalgia is defined and described. It is suggested that in its non-acute form its clinical importance is mainly psychotherapeutic. An acute form is described and its differential diagnosis from the acute abdomen is discussed.

REFERENCES

WANTED
The editor has had requests from libraries and individual members for back numbers of the Research Newsletters, the Journal and early Supplements. Many of these are now out of print and in order to satisfy these demands he would be grateful if any member having no further use for his copies would send them to the Journal Office, Prospect House, Dartmouth.

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