

# Referred Testicular pain and Chiropractic: A conservative treatment approach

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**Abstract:** The testes are a potential sight for referred pain from the lower back and pelvis. In this case a man presented with a four-year history of pain in his left testicle. The pain was alleviated by adjustment of sacrum and L5 subluxations. A complicating factor was an anatomically short leg, which was addressed with the judicious use of a shoe lift as indicated by Gonstead analysis of the patient's standing X-rays.

**Indexing Terms:** chiropractic; testicular pain; anatomical short leg; heel lift; Men's Health.

## Case History

This is the case study of a sixty-four year old man who presented with a history of chronic left testicular pain.

The patient reported that the initial onset of the pain was during a heavy lifting activity four years earlier. The pain was nearly constant but aggravated by walking and relieved by sitting for short periods, although again aggravated by prolonged sitting. The patient, who was semi-retired, spent on average four hours per day working sitting down using a computer. This prolonged sitting resulted in near unbearable pain.

The patient's general health history showed him to be epileptic and utilising *Dilantin* for the past forty-five years. He had been involved in a motor vehicle accident twenty-eight years prior and suffered a skull fracture. Due to resulting olfactory nerve damage he had lost his sense of smell. He also reported some short-term memory loss since the accident, but despite this had run a busy and successful business. He denied any neck or back pain but reported occasional frontal headaches. The patient was noted to be moderately obese and reported no involvement in any regular exercise.

*... an additional clinical benefit of analysing radiographs in the Gonstead Method is the indication for a heel lift, which in this case, together with segment-specific adjustments, resolved this patient's complaint of testicular pain'*



With the initial onset of symptoms, the patient sought a medical examination. An incidental finding with later medical examination was advanced prostate cancer. This was believed to be unrelated to the testicle pain.

The patient's prostate was treated aggressively with radiotherapy. This therapy had finished one-year prior and the procedure considered successful.

As the patient recovered from the effects of radiotherapy, his attention again returned to his testicular pain. On re-approaching the urologist about this pain he was reportedly told that the treatment of choice would be surgical removal of the testicle and replacement with a prosthesis. Rejecting this suggestion, the patient sought no further treatment until presenting to my office.

### Clinical Assessment

Standing inspection showed flattening of the left waist curve and accentuation of the right. Bilateral *genu valgus* was noted, as was bilateral increased foot flare, which was more pronounced on the right. The lumbar paravertebral muscle bulk was more pronounced on the left.

Lower back range of motion was free with the exception of pain and stiffness in the left sacro-iliac region on left lateral flexion. *Fabere* test was normal.

Temperature breaks were noted at the T2 and L5 vertebral levels using a skin temperature differential instrument (nervoscope) for this examination. Motion palpation revealed fixation at T2 relative to T3, generalised stiffness through the thoracic spine and fixation at L5/S1 and the left sacro-iliac articulation.

### Radiological Assessment

Erect full spine AP and lateral radiographs were taken.

Moderate degenerative changes were noted in the lower cervical spine with more advanced changes in the lower thoracic spine. Bridging osteophytes were noted between the T6 to T11 segments. The L5 disc showed D4 (Gonstead) degenerative changes. The lateral film shows forward head carriage and increased thoracic kyphosis.

The left femoral head appeared 16mm lower than the right with associated left convex lumbar curve. The lumbar, thoracic and cervical vertebral body rotation was posterior on the left.

Left ilium was listed as AS<sub>4</sub>IN<sub>2</sub>. The sacrum was listed as P-L<sub>11</sub>. L5 was listed as L5 PR-m.

### Chiropractic Diagnosis

I considered that the patient's left testicle pain could well be associated with the P-L sacrum. It could also, at least in part be related to the L5 subluxation.

The pelvis had misaligned in such a way as to reduce the leg length discrepancy by approximately 2mm to 14mm. I considered the possibility that a lift within the left shoe may be required to gain a lasting result. The fact that the patient's lumbar curve was convex on the side of the shorter leg and that the vertebral body rotation was posterior on this same side made the trial of a lift appropriate if symptoms were recurring.

### Treatment and Outcome

On the first visit the sacrum was adjusted P-L on the pelvic bench, with a good deep audible set. The patient returned four days later and reported no pain in the left testicle since the adjustment but had experienced some mild pain in the right side intermittently. The P-L was again adjusted. One week later the patient reported no further right testicle pain but occasional pain in the left, mostly after prolonged sitting. This level of pain was quite tolerable and nowhere near the intensity or constancy of the pain over the previous four years.

Over the next three weeks the sacrum was adjusted similarly a further two times and the L5 adjusted once. There was further alleviation of pain but still mild recurrence of symptoms.

At this point it was decided to address the leg length discrepancy. Initially a 9mm heel lift was given to the patient to wear in his left shoe. Over the next ten days the sacrum and L5 were again adjusted on separate occasions and further improvement noted. There was still some residual recurrence of symptoms.

It was decided to take two AP lumbar/pelvic radiographs, one standing barefoot and one wearing a heel lift. The lift was increased from 9 to 12mm for the film, as this was closer to a full correction.

The barefoot film showed an increase in leg length discrepancy from 16 to 18mm and a reduction in the P-L rotation from 11 to 7mm. With the addition of a 12mm heel lift the leg length discrepancy reduced to 5mm. The P-L rotation was measured at 9mm.

The patient reported complete relief of left testicle pain following a further P-R sacral adjustment and the use of the 12mm heel lift. Replacement of the heel lift with a full shoe lift was suggested as a superior option.

### Discussion

According to *Gray's Anatomy*, the nerve supply to the testis is derived from the 10<sup>th</sup> and 11<sup>th</sup> thoracic segments of the spinal cord, through renal and aortic autonomic plexuses.

Whilst marked degenerative changes were noted in the patient's lower thoracic spine on radiographic examination, there was no clinical suggestion of subluxation in this region.

*Gray's* also states that the scrotum is innervated by 'the ilio-lingual and genital branch of the genitofemoral n., the two posterior scrotal branches of the perineal nerve, and the perineal branch of the posterior femoral cutaneous n. It is to be noted that the anterior third of the scrotum is supplied mainly from the first lumbar segment of the spinal cord ..., whereas the posterior two thirds are supplied mainly from the third sacral segment.'

It may be that the patient's perceived testicle pain was more a pain in the posterior scrotum from nerve irritation at the sacro-iliac articulation. It could also be that the pain was directly referred from the subluxated sacro-iliac articulation.

*Gray's* also notes that the nerve supply of the prostate is from the pelvic plexus.

By applying chiropractic philosophy we could speculate that the patient's chronic sacro-iliac subluxation may have been an underlying contributing factor to the development or progression of prostate cancer.

### Conclusion

The patient's testicular pain was relieved essentially, by specific adjustment of a sacro-iliac subluxation. In addition, a lasting resolution of this problem has hopefully been achieved by the reduction of leg length discrepancy using a shoe lift.

As to the reported advice of the urologist, i.e. removal of the offending body part, it would seem that if pain to an area of the body were referred, then surgical removal of the tissue in the referred zone without addressing the origin of that referred pain would not correct the problem. In other words, in the unlikely event that a surgeon performed the suggested procedure, the patient could have been left with a prosthetic testicle that still ached.

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## About

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