Epididymitis: Causes, Symptoms, Diagnosis, Treatment, Fertility Effects and the Role of Unani Medicine

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Introduction: "Doctor, My Testicle Is Painful and Swollen—Is It an Infection?"

One of the common reasons men consult me for scrotal problems is pain and swelling around one testicle.

A patient may say:

"Doctor, there is pain behind my testicle and the whole area feels swollen."

Another may complain:

"I have burning while passing urine, and now my testicle is painful."

A younger man may ask:

"Could this be because of a sexually transmitted infection?"

An infertility patient may be more worried about the future:

"Doctor, I had epididymitis. Has it permanently damaged my sperm?"

And sometimes a patient with severe sudden pain assumes:

"It is probably epididymitis, so I will take some medicine and wait."

That last situation can be dangerous.

The medical condition called **epididymitis** means inflammation of the **epididymis**, the long coiled tube located behind the testicle that plays an essential role in sperm maturation, storage and transport.

Epididymitis can occur at almost any age.

It may be caused by:

- sexually transmitted infections,
- urinary bacteria,
- urinary-tract abnormalities,
- tuberculosis,
- rarely viral infections,
- medication reactions,
- trauma,
- or non-infectious inflammation.

Current European Association of Urology guidance estimates an incidence of approximately **25–65 cases per 10,000 adult males per year** and recognizes acute, chronic and recurrent forms.

Most importantly:

Epididymitis should not be treated as one disease with one medicine.

A 22-year-old man with chlamydial epididymitis needs a different approach from a 65-year-old man with urinary infection and prostate enlargement.

A man with tuberculous epididymitis needs an entirely different treatment.

And a man with sudden severe testicular torsion does not have time to wait for herbal or antibiotic treatment at all—he may need urgent surgery.

At **Saira Health Care**, my approach is therefore:

First identify whether the inflammation is infectious, non-infectious, acute or chronic, and rule out testicular torsion. Then treat the cause while protecting the man's reproductive health.

What Is the Epididymis?

The epididymis is an important part of the male reproductive system.

Each testicle has an epididymis positioned mainly along its back and upper portion.

Although it looks small externally, it is actually a highly coiled tube.

Its major functions include:

- receiving newly formed sperm from the testicle,
- allowing sperm to mature,
- helping sperm acquire motility and fertilizing capacity,
- temporarily storing sperm,
- and transporting sperm toward the vas deferens.

In standardized Unani medical terminology published by CCRUM, the epididymis is referred to as **Aghdīdūs**, described as the first part of the excretory duct associated with each testis.

Because the epididymis has such an important role in sperm transport and maturation, significant inflammation—particularly if it becomes bilateral, recurrent or chronic—can potentially affect fertility.

What Is Epididymitis?

Epididymitis is inflammation of the epididymis.

The inflammation usually produces:

- pain,
- swelling,
- tenderness,
- and increased warmth

on the affected side of the scrotum.

According to CDC terminology:

Acute epididymitis

Symptoms have generally been present for **less than six weeks**.

Chronic epididymitis

Pain or discomfort persists for **six weeks or longer**.

When inflammation spreads from the epididymis to the testicle itself, the condition is called:

Epididymo-Orchitis

rather than isolated epididymitis.

Acute Epididymitis

Acute epididymitis usually develops over:

- hours,
- or several days.

Typical inflammation is commonly:

- one-sided,
- painful,
- swollen,
- tender,
- and warm.

Current EAU guidance describes acute epididymitis as usually presenting with **unilateral pain, palpable epididymal swelling and increased local temperature**, with symptoms generally worsening over several days.

Chronic Epididymitis

Chronic epididymitis is more complicated.

A patient may experience:

- dull aching,
- recurrent tenderness,
- heaviness,
- discomfort during intercourse,
- discomfort after ejaculation,
- or persistent epididymal sensitivity

for six weeks or longer.

Sometimes infection was present initially.

In other men, no active infection can be found.

CDC specifically notes that chronic non-infectious epididymal pain has a broad differential diagnosis that includes:

- previous trauma,
- malignancy,

- autoimmune conditions,
- and idiopathic chronic pain.

Such patients may require urological assessment rather than repeated empirical antibiotic courses.

A 2026 review of chronic epididymitis and orchitis similarly emphasizes that these conditions remain complex and may involve infection, inflammation, ductal obstruction and effects on fertility.

What Is Recurrent Epididymitis?

Some men improve completely after treatment but later experience additional episodes.

This is called **recurrent epididymitis**.

When infection keeps returning, I consider underlying factors such as:

- urinary-tract abnormality,
- bladder outlet obstruction,
- prostate disease,
- recurrent UTI,
- residual STI exposure,
- inadequate partner treatment,
- incomplete antibiotic treatment,
- instrumentation,
- or less common chronic infection.

Simply prescribing the same antibiotic repeatedly without determining why inflammation keeps returning is not ideal treatment.

Major Causes of Epididymitis

The cause varies significantly according to:

- age,
- sexual exposure,
- urinary health,

- medical procedures,
- medications,
- immune status,
- and other clinical factors.

The major causes are discussed below.

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1. Sexually Transmitted Infections

Among sexually active younger men, sexually transmitted organisms are important causes.

Current CDC guidance identifies important pathogens including:

- **Chlamydia trachomatis**
- **Neisseria gonorrhoeae**
- **Mycoplasma genitalium**

while contemporary EAU guidance also discusses organisms such as *Ureaplasma* in appropriate contexts.

In sexually transmitted epididymitis, infection often begins in the:

- urethra

and travels backward through the reproductive tract toward the epididymis.

Epididymitis Can Occur Even Without Obvious Urethral Symptoms

A man may incorrectly think:

"I have no discharge, therefore I cannot have an STI."

This is not reliable.

CDC notes that urethritis accompanying sexually transmitted epididymitis may be **asymptomatic**.

Therefore, appropriate STI testing can be important even when:

- penile discharge is absent,
- or urinary symptoms are mild.

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2. Gonorrhea

Gonorrhea can cause:

- urethral discharge,
- burning during urination,
- urethritis,
- and ascending epididymal infection.

The discharge may be:

- thick,
- white,
- yellow,
- or green.

Current EAU guidance emphasizes that fluoroquinolone antibiotics should **not** be relied upon for gonorrhea because of resistance concerns; ceftriaxone-based therapy forms part of recommended treatment when gonococcal epididymitis is suspected.

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3. Chlamydia

Chlamydia is another important cause, particularly among sexually active younger men.

The infection may be surprisingly silent.

A patient may have:

- no obvious discharge,
- mild burning,
- or no urethral symptoms

before developing epididymal inflammation.

This is why proper testing matters.

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4. Urinary-Tract Bacteria

Not all epididymitis is sexually transmitted.

In older men especially, bacteria originating from the urinary tract become increasingly important.

A common organism is:

Escherichia coli – E. coli

Current EAU guidance describes non-sexually transmitted epididymitis as typically associated with **Enterobacterales such as E. coli**.

Why Do Urinary Bacteria Reach the Epididymis?

Possible underlying factors include:

- recurrent urinary infection,
- enlarged prostate,
- bladder outlet obstruction,
- neurogenic bladder,
- urinary retention,
- urinary catheterization,
- recent prostate procedures,
- and urinary-tract instrumentation.

CDC particularly notes an association between non-sexually transmitted epididymitis and bacteriuria related to bladder outlet obstruction such as **benign prostatic hyperplasia**.

Therefore, treating an older patient may require addressing both:

the infection

and

the reason the infection developed.

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5. Epididymitis After Urinary Procedures

Epididymitis can sometimes follow:

- urinary catheterization,
- prostate biopsy,
- urinary surgery,
- vasectomy,
- cystoscopy,
- or other instrumentation.

Bacteria may gain access to the urinary or reproductive tract.

This history is therefore important during diagnosis.

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6. Bacteria Associated With Anal Sexual Exposure

Men engaging in insertive anal intercourse may be exposed to gastrointestinal bacteria in addition to conventional STI organisms.

Current CDC and EAU treatment recommendations specifically account for the possibility of both:

- sexually transmitted pathogens,
- and enteric bacteria

in this setting.

This is why antibiotic selection should be based on the likely organism rather than using the same antibiotic for everybody.

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7. Tuberculous Epididymitis

This deserves special attention, particularly in regions where tuberculosis remains common.

Tuberculosis can involve the epididymis and usually presents more chronically.

CDC describes **Mycobacterium tuberculosis** as the most common granulomatous cause of chronic infectious epididymitis.

Current EAU guidance recommends considering tuberculous epididymitis particularly in:

- men with immunodeficiency,
- individuals from high-TB-prevalence regions,
- patients with relevant TB exposure,
- or men with persistent chronic epididymal disease.

A draining scrotal sinus may sometimes develop.

How Is Genital Tuberculosis Investigated?

When TB is genuinely suspected, testing can include:

- early-morning urine specimens,

- acid-fast bacillus culture,
- nucleic-acid testing for *Mycobacterium tuberculosis*,
- and selected tissue or fluid investigations.

EAU guidance recommends three sequential early-morning urine specimens when tuberculous epididymitis is suspected.

This is entirely different from routine bacterial epididymitis.

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8. Mumps and Viral Disease

Mumps more classically causes:

orchitis

rather than isolated epididymitis.

However, viral inflammation can involve male genital structures.

Current EAU guidance advises considering mumps when there is:

- bilateral scrotal involvement,
- viral symptoms,
- and salivary-gland enlargement.

Bilateral painful testicular swelling with mumps therefore deserves proper evaluation.

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9. Non-Infectious Epididymitis

Not every inflamed epididymis contains bacteria.

Possible non-infectious mechanisms include:

- chemical inflammation,
- sterile urinary reflux,
- trauma,
- medication reactions,
- autoimmune disease,
- and chronic idiopathic inflammation.

These patients require a different approach from bacterial disease.

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10. Reflux of Urine

Occasionally, urine may reflux backward through the reproductive ducts.

If the urine is infected, it may carry bacteria.

If sterile urine refluxes into the system, chemical irritation may theoretically produce inflammation.

This is sometimes referred to as **chemical epididymitis**.

Therefore, giving antibiotics to every patient simply because the epididymis is tender is not always appropriate.

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11. Amiodarone-Induced Epididymitis

A particularly interesting non-infectious cause is the heart-rhythm medication:

Amiodarone

Drug-related epididymitis from amiodarone has been recognized for many years.

Importantly, a **2026 case report** again documented amiodarone-associated epididymitis and described complete resolution following discontinuation after other causes were considered.

Patients should **never stop amiodarone themselves**, because it may be treating a serious heart-rhythm disorder.

Instead, a suspected medication reaction should be discussed with the cardiologist or prescribing physician.

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12. Trauma

A significant blow or injury to the groin can produce:

- local inflammation,
- swelling,
- pain,
- or secondary complications.

However, significant trauma also raises concern for:

- testicular rupture,

- hematoma,
- torsion,
- or vascular injury.

Therefore, persistent pain after substantial injury should not simply be labelled epididymitis without evaluation.

Symptoms of Epididymitis

Symptoms vary according to the cause and severity.

Common features include:

- one-sided scrotal pain,
- tenderness behind the testicle,
- swelling,
- warmth,
- redness or discoloration,
- feeling of heaviness,
- pain in the groin,
- lower abdominal or pelvic discomfort,
- burning during urination,
- urinary frequency,
- urinary urgency,
- penile discharge,
- pain during ejaculation,
- discomfort during intercourse,
- blood in semen,
- fever,
- and chills.

Mayo Clinic notes that pain is commonly unilateral and often develops more gradually than testicular torsion.

Can Epididymitis Cause a Lump?

Yes.

A swollen inflamed epididymis can sometimes feel like a:

- lump,
- thickened area,
- or tender swelling

behind the testicle.

However:

Every scrotal lump should not automatically be attributed to epididymitis.

A persistent hard or painless mass requires further evaluation.

Can Epididymitis Cause Blood in Semen?

Yes.

Hematospermia, meaning blood in semen, can occasionally occur.

This may look alarming but is often caused by inflammation within the reproductive tract.

However, persistent or recurrent blood in semen deserves proper assessment, particularly in older men or when other symptoms are present.

Can Epididymitis Cause Fever?

Yes, especially with significant infection.

However:

- severe fever,
- systemic illness,
- rapidly worsening swelling,
- or severe uncontrolled pain

may indicate a more serious complication.

Such patients may require hospitalization.

CDC advises considering hospital referral when severe pain or fever raises concern for conditions such as:

- torsion,
- testicular infarction,
- abscess,
- or necrotizing infection.

The Most Important Differential Diagnosis: Testicular Torsion

Whenever a man develops acute testicular pain, one of the most important questions is:

Could this be testicular torsion?

Testicular torsion occurs when the spermatic cord twists and compromises blood supply to the testicle.

This is:

a surgical emergency.

CDC states that torsion should be considered in every acute epididymitis-type presentation, particularly with severe sudden unilateral pain.

Epididymitis vs Testicular Torsion

Typical epididymitis tends to:

- develop more gradually,
- involve epididymal tenderness,
- and may be accompanied by urinary or infectious symptoms.

Torsion more often causes:

- sudden severe pain,
- nausea,
- vomiting,
- marked tenderness,
- and sometimes an abnormally elevated testicle.

But patients should not attempt to make this distinction themselves.

There can be overlap.

A Normal Ultrasound Does Not Always Solve Everything

Doppler ultrasound is useful when torsion is suspected.

However, CDC emphasizes two important points:

1. ultrasound is mainly valuable for excluding torsion or another diagnosis when the clinical picture is uncertain;
2. a negative ultrasound does **not** automatically rule out epididymitis.

Clinical judgment remains essential.

Other Conditions That Can Resemble Epididymitis

Differential diagnosis includes:

- testicular torsion,
- orchitis,
- epididymal cyst,
- spermatocele,
- hydrocele,
- varicocele,
- inguinal hernia,
- testicular cancer,
- scrotal abscess,
- trauma,
- chronic pelvic pain,
- and referred pain.

Persistent symptoms after appropriate treatment therefore need reassessment rather than automatically receiving more antibiotics.

How I Diagnose Epididymitis

Diagnosis should answer three questions:

1. Is this truly epididymitis?

2. What is causing it?

3. Is there an urgent competing diagnosis such as torsion?

Step 1: Detailed History

I ask about:

- how suddenly the pain began,
- whether pain is one-sided or bilateral,
- urinary burning,
- frequency or urgency,
- urethral discharge,
- sexual exposure,
- recent STI,
- fever,
- previous UTI,
- prostate problems,
- catheterization,
- urinary surgery,
- trauma,
- TB exposure,
- medication use,
- infertility,
- and previous episodes.

This often directs the investigation.

Step 2: Physical Examination

Examination may assess:

- epididymal swelling,
- testicular tenderness,
- testicular position,

- scrotal redness,
- hydrocele,
- spermatic cord tenderness,
- inguinal lymph nodes,
- and other abnormalities.

The aim is not simply to prove inflammation.

The physician must also look for clues suggesting:

- torsion,
- tumor,
- hernia,
- or abscess.

Step 3: Urine Testing

Current EAU guidance strongly recommends obtaining:

- a midstream urine specimen for bacterial culture,
- and first-void urine for sexually transmitted pathogen testing when appropriate.

Urine culture is particularly useful when urinary bacteria such as E. coli are suspected because it can guide antibiotic choice and susceptibility.

Step 4: Chlamydia and Gonorrhea NAAT Testing

CDC recommends testing suspected acute epididymitis cases for:

- **C. trachomatis**
- and **N. gonorrhoeae**

using nucleic-acid amplification tests—NAATs.

First-void urine is generally the preferred specimen in men.

NAAT is much more appropriate than simply guessing that a younger patient “probably has an STI.”

STI Testing Is Not a Moral Judgment

I believe this is important to say clearly.

An STI test is:

a medical investigation.

It should not be interpreted as:

- accusing someone of infidelity,
- judging someone's character,
- or shaming the patient.

Correct diagnosis protects:

- the patient,
- the partner,
- fertility,
- and future reproductive health.

Step 5: Other STI Screening

CDC currently advises that men with acute epididymitis should also be tested for:

- **HIV**
- and **syphilis**

when sexually transmitted epididymitis is part of the clinical picture.

Step 6: Ultrasound

Scrotal ultrasound may be particularly useful when:

- torsion cannot be confidently excluded,
- the diagnosis is uncertain,
- a mass is present,
- an abscess is suspected,
- or another scrotal disease may be present.

EAU guidance notes that ultrasound can show acute inflammatory changes and can also help exclude other pathology.

Step 7: Blood Tests

Depending on severity, blood tests may include:

- complete blood count,
- inflammatory markers,
- kidney function,
- blood glucose,
- and other investigations.

These are not required in exactly the same way for every patient.

Step 8: Tuberculosis Testing When Indicated

I consider TB evaluation when there is:

- chronic epididymal enlargement,
- a scrotal sinus,
- persistent symptoms despite ordinary antibiotics,
- significant TB exposure,
- immunosuppression,
- or another compatible clinical picture.

This is particularly important in countries where tuberculosis remains an important health problem.

Modern Treatment of Acute Epididymitis

The treatment depends on the suspected cause.

The most important principle is:

If acute epididymitis is caused by bacteria, correct antibiotics are the primary treatment.

Herbal medicines should not replace appropriate antimicrobial therapy for active bacterial infection.

Antibiotic Treatment

The antibiotic regimen is selected according to whether the likely cause is:

- gonorrhea/chlamydia,
- both STI and intestinal organisms,
- urinary Enterobacterales,
- or another identified pathogen.

Current CDC guidance uses a **ceftriaxone-plus-doxycycline strategy** when gonorrhea and chlamydia are likely, with different combinations when enteric organisms are also suspected.

The updated **EAU 2025 guideline** similarly recommends antimicrobial therapy based on the likely pathogen and local resistance patterns; it uses ceftriaxone plus doxycycline for likely gonorrhoeal/chlamydial disease and culture-appropriate agents for enteric infection.

I deliberately do not recommend that patients select these medicines themselves.

Antibiotic choice depends on:

- sexual history,
- laboratory tests,
- bacterial resistance,
- allergies,
- kidney function,
- drug interactions,
- and local guidelines.

Why Self-Medicating With Antibiotics Is a Problem

A patient may take:

- ciprofloxacin,
- doxycycline,
- azithromycin,
- cefixime,
- or another antibiotic

because someone else with scrotal pain took it.

This can result in:

- incorrect treatment,
- antibiotic resistance,
- partial symptom suppression,
- missed gonorrhea,
- missed TB,
- delayed torsion diagnosis,
- and delayed diagnosis of another serious condition.

Antibiotics should be selected according to the clinical picture.

Finish the Full Antibiotic Course

If bacterial epididymitis has been diagnosed and antibiotics prescribed:

Take the treatment exactly as directed.

Do not stop simply because pain improves after two or three days.

Mayo Clinic notes that patients often begin feeling better after several days of appropriate antibiotic therapy, while swelling and discomfort may take several weeks to fully resolve.

Supportive Treatment

In addition to cause-specific treatment, supportive measures are often helpful.

Current CDC and EAU guidance recommends measures such as:

- rest,
- scrotal elevation,
- local cooling,
- and appropriate anti-inflammatory pain relief.

Scrotal Support

Supportive underwear can reduce movement of the inflamed testicle and epididymis.

This may decrease:

- pulling,

- heaviness,
- and discomfort.

Cold Packs

Cold packs can sometimes reduce:

- swelling,
- inflammation,
- and pain.

They should be:

- wrapped in cloth,
- applied for short periods,
- and not placed directly on bare skin for prolonged periods.

Anti-Inflammatory Pain Medicines

NSAIDs can reduce:

- pain,
- swelling,
- and inflammation

when appropriate.

However, not everyone can safely take them.

Particular caution may be required with:

- stomach ulcers,
- kidney disease,
- anticoagulants,
- certain heart conditions,
- or allergies.

Avoid Heavy Lifting During Acute Recovery

Heavy lifting and strenuous physical activity can make scrotal discomfort worse during the acute inflammatory phase.

Mayo Clinic recommends rest and avoiding heavy lifting during recovery.

Sexual Activity During STI-Associated Epididymitis

If gonorrhea or chlamydia is suspected or confirmed:

sexual activity should be avoided until the patient and partner have both been treated and symptoms have resolved.

CDC specifically recommends this approach to reduce reinfection and transmission.

Partner Treatment Is Part of the Patient's Treatment

This is extremely important.

If only the man takes antibiotics while an infected partner remains untreated, reinfection can occur.

CDC advises evaluation and treatment of recent sexual partners in sexually transmitted epididymitis.

This should be handled:

- confidentially,
- professionally,
- and without blame.

When Should Symptoms Improve?

Improvement often begins within a few days after appropriate treatment.

However:

Swelling may take several weeks to disappear completely.

This does not necessarily mean treatment has failed.

Mayo Clinic notes that pain and swelling may persist for weeks after the infection has been treated.

What If There Is No Improvement in 72 Hours?

This requires reassessment.

CDC recommends reevaluating the diagnosis and therapy when symptoms fail to improve within approximately **72 hours** after starting treatment.

Possible explanations include:

- resistant bacteria,
- incorrect antibiotic choice,
- abscess,
- tumor,
- infarction,
- TB,
- fungal disease,
- torsion,
- or an incorrect original diagnosis.

Do not simply continue the same treatment indefinitely.

When Is Hospital Treatment Needed?

Most patients can be treated as outpatients.

Hospitalization may become appropriate when there is:

- very severe pain,
- high fever,
- systemic illness,
- vomiting,
- inability to take oral medication,
- abscess,
- testicular infarction concern,
- severe infection,
- or significant medical risk.

Current EAU guidance notes that severe infection may require:

- intravenous antibiotics,
- fluid therapy,
- and hospital observation.

Epididymal Abscess

In severe infection, pus can accumulate and form an abscess.

If an abscess develops, antibiotic treatment alone may not be enough.

Surgical drainage may be necessary.

Current EAU guidance notes that surgical exploration may be required to drain abscesses or remove severely damaged tissue.

Epididymectomy

Rarely, severe chronic or destructive epididymal disease may require surgical removal of part or all of the epididymis.

This is called:

Epididymectomy

Because the epididymis transports sperm, fertility consequences must be discussed, particularly if:

- both sides are involved,
- or the opposite reproductive tract is abnormal.

Treatment of Chronic Epididymitis

Chronic epididymitis requires more individualized thinking.

The first question is:

Is active infection still present?

If yes, treatment should target the organism.

If no, repeatedly prescribing antibiotics may provide little benefit.

Management may include, depending on the cause:

- anti-inflammatory treatment,
- scrotal support,
- chronic-pain management,
- pelvic or pelvic-floor assessment,
- treatment of obstruction,
- evaluation for TB,
- treatment of autoimmune disease,
- and selected surgical approaches.

A 2026 review emphasizes phenotype-based management because chronic epididymitis can represent very different biological problems in different patients.

Epididymitis and Male Fertility

This is particularly important in my practice because my focused clinical work includes:

Male Infertility

The epididymis is not simply a tube.

It is involved in:

- sperm maturation,
- sperm storage,
- acquisition of sperm motility,
- and sperm transport.

Therefore, severe epididymal disease can potentially affect fertility.

Does One Episode of Epididymitis Cause Permanent Infertility?

Usually:

No.

Many men recover without permanent fertility impairment.

Current EAU guidance reports that semen parameters can become temporarily impaired during epididymitis and may recover after successful treatment.

This is reassuring.

A man should not assume:

“I had epididymitis once, therefore I am permanently infertile.”

When Does Fertility Risk Become More Important?

I am more concerned when there is:

- bilateral epididymitis,
- severe epididymo-orchitis,
- recurrent infection,
- chronic inflammation,
- abscess,
- scarring,
- obstruction,
- tuberculosis,
- or another underlying testicular disorder.

A 2026 review of chronic epididymitis and orchitis notes that chronic inflammatory disease can potentially impair sperm transport and may require fertility-preserving management.

How Can Epididymitis Affect Sperm?

Potential mechanisms include:

- inflammatory damage,
- oxidative stress,
- impaired epididymal maturation,
- reduced sperm motility,
- altered sperm quality,
- ductal obstruction,
- and scarring.

Research on chronic epididymal inflammation has reported abnormalities in sperm motility and other semen characteristics, although the degree of impairment varies between patients.

Can Epididymitis Cause Azoospermia?

It is uncommon after an uncomplicated unilateral episode.

However, severe bilateral epididymal damage or obstruction can theoretically prevent sperm from reaching the ejaculate.

This could produce:

obstructive azoospermia.

In such a case, the testes may still produce sperm normally, but sperm cannot pass through the damaged reproductive ducts.

This requires specialist male-infertility evaluation.

When Should Semen Analysis Be Done After Epididymitis?

Not every patient needs semen analysis.

I consider it particularly when:

- the couple is experiencing infertility,
- disease was bilateral,
- epididymo-orchitis was severe,
- there were recurrent infections,
- chronic epididymal symptoms persist,
- an epididymal obstruction is suspected,
- or the patient already had an abnormal semen report.

I generally avoid judging fertility during intense acute inflammation.

A follow-up semen analysis after appropriate recovery provides more meaningful information.

Epididymitis and Sexual Function

Epididymitis primarily affects the reproductive tract.

It does **not automatically cause erectile dysfunction.**

However, during acute disease:

- pain,
- anxiety,
- fear,
- inflammation,
- and sexual avoidance

may temporarily affect sexual activity.

A man should not conclude that temporary sexual difficulty during painful infection represents permanent impotence.

Can Epididymitis Reduce Testosterone?

Simple isolated epididymitis usually does not significantly damage testosterone production because Leydig cells are located within the testes, not the epididymis.

However, when significant **orchitis** accompanies epididymitis and damages testicular tissue, endocrine function can be affected in severe cases.

This distinction matters.

Prevention of Epididymitis

Not every episode is preventable.

But several measures can reduce risk.

Safer Sexual Practice

Using condoms appropriately can reduce transmission of:

- gonorrhea,
- chlamydia,
- and other sexually transmitted infections.

STI Testing and Partner Treatment

Timely STI testing and treatment can reduce progression of infection through the genital tract.

When one partner is diagnosed, partner management is essential.

Treat Urinary-Tract Infections Properly

Especially in older men, untreated or recurrent urinary infections can contribute to epididymal infection.

Persistent:

- urinary frequency,
- difficulty urinating,
- weak urine stream,
- urinary retention,
- or recurrent UTI

deserves evaluation.

Manage Prostate and Bladder Problems

Bladder outlet obstruction from conditions such as benign prostate enlargement can contribute to recurrent genitourinary infection.

Treating the underlying urinary problem can therefore reduce recurrence risk.

Do Not Ignore Scrotal Pain

Early evaluation can help distinguish:

- epididymitis,
- torsion,
- trauma,
- or other conditions.

Waiting several days with severe scrotal pain can sometimes lead to preventable complications.

Epididymitis in the Unani System of Medicine

As a physician trained in Unani medicine, I consider inflammation within the broader framework of:

- Mizaj,
- Akhlat,
- organ function,
- nutrition,
- general vitality,
- sleep,
- environment,
- psychological health,
- and lifestyle.

The official CCRUM standard terminology describes the epididymis as:

Aghdīdūs

within Unani anatomical terminology.

Traditional Unani medicine also has a broad concept of **Warm**, meaning inflammatory swelling.

However, an important academic distinction must be made:

Modern acute bacterial epididymitis is a microbiologically defined infectious condition.

It should not be explained only as a temperamental or humoral disturbance.

When testing shows:

- gonorrhea,
- chlamydia,
- E. coli,
- tuberculosis,
- or another infection,

that organism must be treated appropriately.

Mizaj and Individualized Assessment

Mizaj—or temperament—is one of the important traditional principles of Unani medicine.

Within a Unani consultation, I may consider:

- physical constitution,
- digestive health,
- sleep,
- appetite,
- metabolic state,
- activity,
- psychological condition,
- and associated reproductive complaints.

This individualized perspective can be valuable during:

- recovery,
- chronic disease,
- recurrent disease,
- and infertility management.

However:

Mizaj assessment does not replace urine culture, NAAT testing, ultrasound or emergency torsion evaluation.

Both systems should be used for what each can appropriately contribute.

Akhlat and Inflammation

Classical Unani medicine describes the humors:

- Dam,
- Balgham,
- Safra,
- Sauda.

Traditional inflammatory conditions may be interpreted partly through abnormalities of:

- Mizaj,
- humoral balance,

- and accumulation of abnormal material.

These concepts form part of Unani medical tradition.

But they should not be presented as modern microbiology.

Chlamydia is Chlamydia.

Gonorrhea is gonorrhea.

Tuberculosis is tuberculosis.

When such infections exist, specific antimicrobial treatment remains essential.

Four Major Unani Treatment Modalities

Official Ministry of AYUSH material describes four major forms of treatment within the Unani system:

Ilaj-bit-Tadbir

Regimenal therapy

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical treatment

This is an important concept because authentic Unani medicine is not merely:

“give a herbal powder.”

It recognizes:

- diet,
- regimen,
- medicines,
- and surgery

according to the nature of the disease.

Ilaj-bil-Ghiza in Epididymitis

No particular food cures bacterial epididymitis.

However, during recovery I encourage an appropriate diet that supports:

- hydration,
- metabolic health,
- immune function,
- bowel regularity,
- and general strength.

This may include:

- balanced protein,
- fruits,
- vegetables,
- whole foods,
- adequate water,
- and appropriate calorie intake.

If the patient has:

- diabetes,
- obesity,
- metabolic disease,

these conditions should also be properly managed because poor systemic health can complicate infection.

Hydration

Adequate hydration can be useful for general urinary health unless a patient has a medical reason to restrict fluids.

However:

Drinking water does not substitute for antibiotics when bacterial epididymitis is present.

Hydration is supportive.

It is not antimicrobial treatment.

Ilaj-bit-Tadbir: Rest and Regimenal Care

Some traditional regimenal principles overlap well with modern supportive care.

During acute recovery, useful measures may include:

- adequate rest,
- avoiding strenuous activity,
- supportive clothing,
- appropriate local cooling,
- sleep optimization,
- and stress reduction.

These can complement cause-specific treatment.

What About Massage?

I do **not** advise aggressive massage over an acutely painful and swollen epididymis.

A painful scrotal swelling might represent:

- acute infection,
- abscess,
- trauma,
- or torsion.

Repeated manipulation could worsen discomfort and delay proper diagnosis.

What About Hijama?

Hijama has a role in traditional Unani regimenal medicine for selected conditions.

However:

There is no high-quality evidence that Hijama eradicates gonorrhea, chlamydia, E. coli or TB from an infected epididymis.

It should therefore not replace:

- antibiotics,
- STI treatment,
- TB treatment,
- or urgent surgery.

If used in other aspects of general Unani care, it should be selected individually and performed appropriately.

Ilaj-bid-Dawa: Unani Pharmacotherapy

Traditional Unani medicines may be considered according to:

- stage of disease,
- symptoms,
- Mizaj,
- general health,
- associated reproductive complaints,
- semen parameters,
- and the underlying cause.

In acute bacterial epididymitis, my principle is:

Unani treatment is supportive—not a substitute for the antibiotic needed to eradicate the organism.

This is particularly important because undertreated infection can lead to:

- abscess,
- chronic pain,
- recurrent disease,
- or fertility complications.

Unani Medicine in Chronic or Post-Infectious Epididymal Symptoms

The potential supportive role of Unani medicine becomes more relevant after dangerous and infectious causes have been properly treated or excluded.

For example, an individualized programme may focus on:

- residual discomfort,
- general reproductive health,
- nutrition,
- lifestyle,
- semen quality,
- general weakness after illness,
- sleep,
- and associated male infertility.

But persistent pain should still be reassessed rather than automatically labelled a humoral problem.

What Does Current Scientific Evidence Say About Unani Treatment Specifically for Epididymitis?

At present, I do not find strong high-quality randomized controlled evidence demonstrating that a particular Unani formulation alone can replace guideline-based antibiotic treatment of acute bacterial epididymitis.

Therefore, I do **not** make a claim such as:

“One Unani medicine cures every epididymitis infection.”

This would not be medically responsible.

The strongest role of Unani medicine here is within an:

integrative and individualized programme

that supports:

- general health,
- recovery,
- lifestyle,
- reproductive wellness,
- and associated fertility problems,

while appropriate modern antimicrobial or surgical therapy addresses active infection and complications.

Spermogenic Powder: Where Does It Fit?

Saira Health Care currently lists **Spermogenic Powder** as a Dr. Qasmi herbal formulation intended mainly for male reproductive-health concerns such as:

- low sperm count,
- reduced sperm motility,
- abnormal semen quality,
- and other male fertility concerns.

This means its most rational role in an epididymitis patient is not:

“antibiotic replacement.”

Its role may instead be considered later when the patient has:

- reduced semen quality,
- fertility concerns,
- or associated male reproductive weakness.

I do not advise presenting Spermogenic as a scientifically proven treatment that eradicates epididymal infection.

Jawahar-e-Khusia

Saira Health Care's current pharmacy page describes **Jawahar-e-Khusia** as a Unani preparation used traditionally for:

- male reproductive support,
- spermatogenesis,
- semen quality,
- and related male-health concerns.

Again, this is better understood as a:

reproductive-health support medicine

rather than a direct antimicrobial treatment for acute infectious epididymitis.

Ativeerya Capsule and Pouch Kit

Saira Health Care currently lists **Ativeerya Capsule and Pouch Kit** for male fertility issues including:

- low sperm count,
- asthenospermia,
- teratospermia,
- and sexual weakness.

Its ingredient profile contains multiple herbal and traditional mineral preparations.

Therefore, if considered in a patient who has recovered from epididymitis but continues to have a documented semen abnormality, it should be treated as:

fertility-support therapy

rather than infection treatment.

Sperm Plus Capsule

Saira Health Care's current pharmacy listing describes **Sperm Plus Capsule as an Ayurvedic formulation** for male vitality and reproductive support.

Therefore, despite appearing in the original material supplied for this article, it should not be described as a classical Unani medicine.

If it forms part of an integrative fertility plan, it should be labelled accurately.

Why I Separate Epididymitis Treatment From Fertility-Support Treatment

This distinction is extremely important.

Imagine two patients.

Patient A

Has:

- acute chlamydial epididymitis,
- fever,
- pain,
- urethral inflammation.

His immediate treatment priority is:

- appropriate antimicrobial therapy,
- STI management,
- pain control,
- rest,
- and partner treatment.

Patient B

Had epididymitis three months ago.

The infection has resolved.

Now semen analysis shows:

- reduced motility,
- and mild oligospermia.

His current clinical problem is different.

Here I may consider:

- fertility evaluation,
- nutritional care,
- Unani reproductive support,
- lifestyle correction,
- and follow-up semen analysis.

This is how rational integrative treatment should work.

Dr. Nizamuddin Qasmi's Special Individualized Approach at Saira Health Care

When a patient consults me with suspected epididymitis, I prefer the following structured pathway.

Step 1: Rule Out Testicular Torsion

Before discussing herbs, antibiotics or fertility:

I first ask whether this could be torsion.

Sudden severe pain requires urgent assessment.

This step can save a testicle.

Step 2: Confirm the Clinical Diagnosis

I assess:

- location of pain,
- epididymal swelling,
- onset,
- urinary symptoms,
- fever,
- discharge,
- sexual history,
- trauma,
- and associated testicular findings.

Step 3: Identify the Likely Cause

I determine whether the clinical picture suggests:

- STI,
- urinary infection,
- TB,
- non-infectious inflammation,
- medication reaction,
- or another condition.

This prevents one-size-fits-all treatment.

Step 4: Arrange Appropriate Testing

Where indicated, I advise:

- urine analysis,
- urine bacterial culture,

- NAAT for gonorrhea and chlamydia,
- other STI screening,
- ultrasound,
- blood tests,
- or TB investigations.

Step 5: Treat Infection Promptly

When bacterial epididymitis is suspected or confirmed:

appropriate antibiotics are essential.

I do not replace necessary antimicrobial treatment with traditional medicines.

Step 6: Manage Pain and Inflammation

Supportive treatment may include:

- rest,
- scrotal support,
- local cooling,
- appropriate anti-inflammatory medication,
- and avoidance of strenuous activity.

Step 7: Protect the Partner When an STI Is Involved

Treatment includes:

- partner evaluation,
- appropriate testing,
- treatment,
- and avoiding intercourse until infection is cleared.

This prevents reinfection.

Step 8: Reassess Early

If symptoms are not improving within approximately:

72 hours

I reassess the diagnosis and treatment.

This follows current CDC recommendations.

Step 9: Assess Fertility Where Appropriate

After recovery, I consider semen analysis when:

- infertility already exists,
- disease was bilateral,
- disease was severe,
- symptoms became chronic,
- or the patient is concerned about future fertility.

Step 10: Integrate Unani Care According to the Stage of Disease

During and after conventional cause-specific treatment, an individualized Unani plan may support:

- nutrition,
- recovery,
- Mizaj-based general care,
- lifestyle,
- reproductive health,
- general vitality,
- and documented semen abnormalities.

The stage of disease matters.

Step 11: Treat Persistent Fertility Problems Separately

If semen analysis later shows:

- oligospermia,

- asthenozoospermia,
- abnormal morphology,
- or another problem,

I address that diagnosis separately.

This is where fertility-focused treatment may include appropriately selected:

- Spermogenic,
- Jawahar-e-Khusia,
- or another individualized formulation

where clinically suitable.

Step 12: Refer When Advanced Urological Care Is Needed

I advise urological or hospital management when there is:

- abscess,
- severe systemic disease,
- testicular infarction concern,
- persistent mass,
- chronic severe pain,
- possible obstruction,
- or another surgical indication.

Referral is part of good treatment.

It is not a failure of Unani medicine.

Why Saira Health Care Emphasizes Male Fertility After Epididymal Disease

Saira Health Care's current service listing specifically includes:

- epididymitis,
- epididymal cyst,
- azoospermia,
- oligospermia,

- asthenospermia,
- abnormal sperm morphology,
- varicocele,
- and other male infertility conditions

within its reproductive-health services.

This overlap matters because some patients do not come to us during the acute infection.

They come months later saying:

“My infection is gone, but my semen report has deteriorated.”

That requires fertility-focused investigation rather than simply another antibiotic course.

Common Myths About Epididymitis

Myth 1: Epididymitis always means an STI.

Fact: STIs are important causes, especially in sexually active younger men, but urinary bacteria, TB, medications and non-infectious causes can also produce epididymitis.

Myth 2: Epididymitis can never be sexually transmitted.

Fact: Gonorrhea and chlamydia are well-established causes.

Myth 3: No penile discharge means no STI.

Fact: STI-associated urethritis may be asymptomatic.

Myth 4: Every epididymitis patient needs the same antibiotic.

Fact: Antibiotic selection depends on the likely pathogen and local resistance.

Myth 5: Any antibiotic will work.

Fact: Antibiotic resistance and pathogen differences make correct selection important.

Myth 6: Herbal medicine alone should treat acute bacterial epididymitis.

Fact: Active bacterial infection requires appropriate antimicrobial treatment.

Myth 7: Severe sudden testicular pain can wait until tomorrow.

Fact: It may be testicular torsion, which is a urological emergency.

Myth 8: Epididymitis always causes permanent infertility.

Fact: Many men recover fully, and semen abnormalities occurring during acute disease may improve after successful treatment.

Myth 9: Every patient with epididymitis needs semen analysis.

Fact: Semen analysis is particularly relevant when infertility, bilateral disease, severe disease or persistent problems are present.

Myth 10: Repeated antibiotics are the answer to chronic scrotal pain.

Fact: Chronic epididymal pain can be non-infectious and requires reassessment.

Myth 11: Massage can cure acute epididymitis.

Fact: Aggressive manipulation of a painful swollen scrotum is not appropriate before establishing the diagnosis.

Myth 12: Spermogenic directly kills epididymitis bacteria.

Fact: Spermogenic is marketed by Saira Health Care primarily for male reproductive and semen-quality support, not as a validated antibiotic.

Frequently Asked Questions

What is epididymitis?

It is inflammation of the epididymis, the coiled sperm-carrying structure behind the testicle.

Is epididymitis dangerous?

Most cases respond well to appropriate treatment.

However, untreated or severe disease can occasionally lead to:

- abscess,
- chronic pain,
- obstruction,
- epididymo-orchitis,
- or fertility complications.

Can epididymitis be cured?

Most acute bacterial cases can be effectively treated with correct antibiotics and supportive care.

The outlook for chronic epididymitis depends more heavily on the underlying cause.

Is epididymitis an STI?

It can be.

Gonorrhea and chlamydia are common sexually transmitted causes, but many cases are not sexually transmitted.

Can E. coli cause epididymitis?

Yes.

E. coli and other Enterobacterales are particularly important in non-sexually transmitted epididymitis.

Can UTI cause epididymitis?

Yes.

Urinary bacteria can travel into the male reproductive tract.

This is particularly relevant with:

- prostate enlargement,
- urinary retention,

- catheterization,
- or urinary instrumentation.

Can TB cause epididymitis?

Yes.

Tuberculous epididymitis is particularly important in chronic disease and high-risk patients.

Can epididymitis cause infertility?

It can in some severe or chronic cases.

However, one properly treated unilateral episode does not automatically result in permanent infertility.

Can sperm motility decrease after epididymitis?

Yes.

Inflammation can temporarily affect semen quality.

Current EAU guidance reports that impaired semen parameters during acute epididymitis may recover after successful treatment.

Can epididymitis cause azoospermia?

Severe bilateral epididymal obstruction can theoretically prevent sperm from reaching the semen.

This is uncommon after ordinary uncomplicated unilateral disease.

Can epididymitis cause erectile dysfunction?

Not directly in most cases.

Pain and anxiety may temporarily affect sexual activity, but erectile dysfunction should be evaluated separately if it persists.

Can epididymitis cause low testosterone?

Simple epididymitis usually does not.

Severe epididymo-orchitis involving significant testicular tissue may have more potential to affect testicular function.

How long does epididymitis take to improve?

Patients with bacterial disease often begin improving within a few days after appropriate antibiotics.

However, swelling and discomfort may take several weeks to fully resolve.

What if I am not better after three days?

You should be reassessed.

CDC recommends reevaluation when symptoms fail to improve within approximately 72 hours.

Can Unani medicine help epididymitis?

Unani medicine can contribute through:

- individualized general assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- nutritional support,
- recovery support,
- lifestyle management,
- and male-fertility care.

However:

Acute bacterial epididymitis should receive appropriate antimicrobial treatment.

Unani therapy should be complementary rather than a substitute for eradicating an active bacterial infection.

Is Spermogenic useful in epididymitis?

Its most appropriate role is as a male reproductive-health and semen-support formulation in selected patients, particularly when a semen abnormality remains after the acute infection has resolved.

It should not be regarded as a replacement for antibiotics.

Is Jawahar-e-Khusia useful?

Jawahar-e-Khusia is a traditional Unani male reproductive-health preparation currently listed by Saira Health Care Pharmacy.

Its use should be individualized and focused on reproductive-health support rather than portrayed as a stand-alone antimicrobial cure.

Is Sperm Plus a Unani medicine?

The current Saira Health Care pharmacy page describes Sperm Plus as an **Ayurvedic formulation**, so it should be labelled accurately rather than calling it a classical Unani medicine.

When Should You Seek Emergency Care?

Seek urgent emergency assessment if you develop:

- sudden severe testicular pain,
- rapid swelling,
- severe pain with nausea or vomiting,
- a suddenly high-positioned testicle,
- severe trauma,
- high fever with systemic illness,
- or rapidly worsening scrotal symptoms.

These symptoms may represent:

- torsion,
- abscess,
- infarction,

- or another serious acute scrotal condition.

CDC specifically identifies sudden severe unilateral pain as a situation requiring immediate assessment for testicular torsion.

When Should You See a Urologist?

Urological evaluation is particularly appropriate when:

- diagnosis remains uncertain,
- symptoms are severe,
- pain becomes chronic,
- recurrent epididymitis occurs,
- a mass remains after antibiotics,
- abscess is suspected,
- TB is suspected,
- infertility is present,
- obstruction is suspected,
- or symptoms fail to respond as expected.

Dr. Nizamuddin Qasmi and Saira Health Care

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with focused clinical practice in:

Sexual Disorders & Infertility

My professional education and training include:

- **BUMS – Hamdard University, Delhi**
- **MD**
- **CGO**
- **Certificate in Infertility – MGBIMS, Delhi**
- **Certificate in Urology – London, UK**
- **Masters in Male Infertility – MasterHealthPro (HealthPro)**
- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**

Saira Health Care's public professional profile describes my focused clinical work in sexual disorders and infertility, with particular involvement in male fertility conditions such as:

- azoospermia,
- oligospermia,
- asthenospermia,
- abnormal sperm morphology,
- varicocele,
- epididymal disorders,
- and hormonal abnormalities.

The Saira Health Care service directory also specifically lists **Epididymitis** among its male infertility and reproductive-health disease areas.

Why My Infertility Training Matters in Epididymitis

A patient with epididymitis does not always need an infertility specialist.

However, fertility expertise becomes particularly relevant when:

- disease is bilateral,
- episodes recur,
- chronic inflammation develops,
- semen parameters deteriorate,
- sperm transport is obstructed,
- or the couple already has infertility.

My additional training in:

- infertility,
- urology,
- male infertility,
- and integrated sexual and reproductive health

helps me evaluate not only:

“Is the infection better?”

but also:

“Has reproductive function been protected?”

This second question is very important to men planning a family.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At Saira Health Care, I believe one of our most important responsibilities is:

correcting misinformation.

A patient with scrotal pain may be told:

“It is sexual weakness.”

Another may be told:

“It is definitely an STI.”

Another may be given antibiotics without any investigation.

Another may be given only herbs even though he has acute bacterial infection.

Another may continue antibiotics for several months even though his infection has resolved and he now has chronic non-infectious pain.

None of these approaches is appropriately individualized.

Saira Health Care describes its treatment philosophy as patient-centered and focused on sexual disorders and infertility while combining traditional Unani knowledge with contemporary diagnostic information and individualized care.

The Saira Health Care Integrative Philosophy

I believe modern medicine and Unani medicine can work together when the strengths and limitations of both are respected.

If a man has gonococcal epididymitis

He needs appropriate guideline-based antibiotics and partner management.

If he has E. coli epididymitis associated with prostate enlargement

He needs appropriate antimicrobial treatment and assessment of his urinary tract.

If he has tuberculous epididymitis

He requires appropriate anti-tuberculous therapy.

If he has testicular torsion

He needs emergency urological treatment.

If an abscess develops

He may require drainage.

If the acute infection has resolved but reproductive health is impaired

This is where fertility-focused treatment, nutrition and appropriately selected Unani supportive care become increasingly relevant.

If chronic pain remains without active infection

He needs chronic-pain and urological reassessment rather than automatic repeated antibiotics.

That is the type of integrative care I consider medically responsible.

Latest Scientific Perspective: 2025–2026

Current evidence has strengthened several important principles.

Updated EAU Urological Infection Guidance

The **2025 EAU guideline** updated its acute epididymitis evidence and continues to emphasize:

- urine bacterial culture,
- NAAT testing for sexually transmitted pathogens,
- pathogen-directed antimicrobial therapy,
- gonorrhea-appropriate treatment,
- supportive anti-inflammatory care,
- partner management,
- and surgical drainage when abscess is present.

Antibiotic Resistance Matters

The EAU emphasizes increasing resistance among Enterobacterales and recommends adjusting therapy according to:

- pathogen identification,
- susceptibility,

- and local resistance patterns.

This is another reason not to self-prescribe antibiotics.

Acute Epididymitis and Semen Quality

Current EAU guidance notes that semen parameters may become impaired during epididymitis but can recover following successful treatment.

For me, this is an important message for infertility patients:

Temporary semen deterioration is not automatically permanent infertility.

Chronic Epididymitis and Fertility

A **2026 review** emphasizes that chronic epididymal and testicular inflammation can involve:

- persistent inflammation,
- obstruction,
- altered reproductive function,
- and fertility impairment,

and may require individualized medical, surgical or assisted-reproductive strategies.

Medication-Induced Epididymitis

A newly published **2026 report** again highlights amiodarone-induced epididymitis as a rare but important non-infectious cause, reinforcing the need to review medication history when ordinary infectious testing is negative.

These developments reinforce one central principle:

Epididymitis is a syndrome with multiple causes—not a diagnosis that should automatically trigger one medicine.

My Final Message to Patients

If you develop pain and swelling around the epididymis or testicle, do not panic.

But do not ignore it either.

Ask the right questions:

Did the pain start suddenly or gradually?

Could this be torsion?

Do I have fever?

Do I have burning urination?

Is there penile discharge?

Do I need gonorrhea and chlamydia testing?

Do I have a urinary infection?

Could my prostate or urinary system be contributing?

Do I have a history of tuberculosis?

Could one of my medicines be causing inflammation?

Has ultrasound ruled out another scrotal disease?

Is the problem acute or chronic?

Has the infection actually cleared?

If I am planning children, should my semen be checked after recovery?

These questions are much more useful than asking:

"Which one medicine cures epididymitis?"

At **Saira Health Care**, I believe good treatment should provide:

accurate diagnosis, timely infection control, protection of fertility, and responsible integration of Unani medicine.

Conclusion

Epididymitis is inflammation of the **epididymis**, the coiled sperm-maturing and sperm-transporting structure located behind the testicle.

It may be:

- acute,
- chronic,
- or recurrent.

When inflammation involves the testicle as well, it is known as:

epididymo-orchitis.

Common causes include:

- chlamydia,
- gonorrhea,
- other sexually transmitted pathogens,
- E. coli and other urinary bacteria,
- urinary obstruction,
- prostate disease,
- urinary instrumentation,
- tuberculosis,
- viral disease,
- medication reactions such as amiodarone,
- trauma,
- and other non-infectious inflammatory conditions.

Typical symptoms include:

- one-sided scrotal pain,
- swelling,
- warmth,
- tenderness,
- burning urination,
- urinary frequency,
- urethral discharge,
- pelvic discomfort,
- blood in semen,
- and sometimes fever.

The most important competing diagnosis is:

testicular torsion.

Sudden severe unilateral testicular pain requires urgent assessment because torsion can threaten testicular viability.

Diagnosis may include:

- history and examination,
- urine bacterial culture,
- NAAT testing for gonorrhea and chlamydia,
- other STI screening,
- scrotal ultrasound,
- blood investigations,
- and TB testing in selected chronic cases.

Current EAU guidance strongly recommends urine culture and first-void urine pathogen testing in acute epididymitis.

Treatment depends on the cause.

Bacterial epididymitis requires:

appropriate antimicrobial therapy.

Supportive care may include:

- rest,
- scrotal elevation,
- local cooling,
- anti-inflammatory medication,
- and temporary reduction of strenuous activity.

Sexually transmitted epididymitis also requires appropriate:

- partner management,
- abstinence until treatment is completed and symptoms resolve,
- and relevant STI testing.

Patients who fail to improve within approximately 72 hours require reassessment.

Severe disease may occasionally require hospitalization or surgical drainage of an abscess.

Most men do **not** become permanently infertile after an appropriately treated unilateral episode.

Current EAU evidence indicates that semen parameters may temporarily deteriorate during epididymitis and recover after successful treatment.

However, fertility risks become more important with:

- bilateral disease,
- chronic inflammation,
- recurrent infection,
- epididymo-orchitis,
- abscess,
- TB,
- or obstructive scarring.

The **Unani system of medicine** can contribute to management through:

- Mizaj-based individualized care,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- nutrition,
- lifestyle management,
- convalescent support,
- and treatment of associated reproductive-health concerns.

CCRUM's standardized terminology recognizes the epididymis as **Aghdīdūs**, and official AYUSH literature describes dietotherapy, regimenal therapy, pharmacotherapy and surgery as the four major therapeutic approaches of Unani medicine.

But responsible Unani care must recognize an essential limitation:

Herbal treatment should not replace appropriate antibiotics for active bacterial epididymitis or emergency surgical assessment for testicular torsion.

At Saira Health Care, products such as:

- **Spermogenic**
- and **Jawahar-e-Khusia**

may be considered within selected reproductive-health and fertility-support programmes after the patient's clinical condition has been properly assessed.

Other products mentioned in the original material, including **Ativeerya** and **Sperm Plus**, are better described according to their actual current pharmacy positioning as broader fertility-support formulations rather than as proven antimicrobial treatments for epididymitis.

My treatment philosophy at **Saira Health Care** can therefore be summarized as:

Rule out testicular torsion first.

Determine whether infection is sexually transmitted, urinary, tuberculous or non-infectious.

Use appropriate microbiological testing.

Treat bacterial disease with the correct antibiotic.

Treat the sexual partner when an STI is involved.

Use rest and scrotal support appropriately.

Reassess if symptoms do not improve within 72 hours.

Protect fertility in severe, bilateral or chronic disease.

Use Unani medicine rationally for individualized supportive and reproductive care.

Do not use fertility supplements as substitutes for infection treatment.

And refer to urology when abscess, torsion, chronic disease or another serious pathology is suspected.

For every patient with epididymal pain, my central message is:

Epididymitis is usually treatable, and early correct treatment offers the best chance of complete recovery while protecting future reproductive health.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Professional Education & Training

- **BUMS – Hamdard University, Delhi**
- **MD**
- **CGO**
- **Certificate in Infertility – MGBIMS, Delhi**

- **Certificate in Urology – London, UK**
- **Masters in Male Infertility – MasterHealthPro (HealthPro)**
- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**

Dr. Nizamuddin Qasmi's public professional profile at Saira Health Care describes his focused clinical work in sexual disorders and infertility, including male-fertility problems such as azoospermia, oligospermia, asthenospermia, abnormal sperm morphology, varicocele and epididymal disorders.

Saira Health Care's current service directory specifically includes **Epididymitis** among its male reproductive- and infertility-related disease areas.

His treatment approach combines individualized Unani assessment with contemporary diagnostic information, fertility evaluation, lifestyle guidance and appropriate referral for modern medical, antimicrobial or surgical care where indicated.

Medical Disclaimer

This article is intended for general medical education and reproductive-health awareness.

It is not a substitute for:

- an individual medical consultation,
- physical examination,
- urine testing,
- STI testing,
- ultrasound,
- diagnosis,
- or personalized antibiotic treatment.

Sudden severe testicular pain is a medical emergency.

Possible testicular torsion must receive immediate medical or urological assessment and should **not** first be treated at home with:

- painkillers alone,
- herbal preparations,
- massage,
- Hijama,

- or antibiotics.

Do not independently start, change or discontinue:

- antibiotics,
- amiodarone,
- anti-inflammatory drugs,
- Unani medicines,
- herbal formulations,
- fertility supplements,
- or other prescription treatments.

If sexually transmitted epididymitis is suspected or confirmed, appropriate partner evaluation and treatment are important to prevent reinfection.

Spermogenic, Jawahar-e-Khusia, Ativeerya, Sperm Plus or any other reproductive-health formulation should not be interpreted as a replacement for antibiotics in active bacterial epididymitis.

Patients with persistent swelling after antimicrobial treatment should receive appropriate reassessment because other conditions—including abscess, infarction, tumor, tuberculosis or another diagnosis—may need to be excluded.

Where urological surgery, hospitalization, infectious-disease treatment, tuberculosis management or specialist infertility care is required, timely referral should form part of responsible integrative treatment.