

Testicular Atrophy: Causes, Symptoms, Diagnosis, Fertility Treatment and the Role of Unani Medicine

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Introduction: “Doctor, One of My Testicles Has Become Smaller. Can It Become Normal Again?”

A question that understandably creates considerable anxiety in men is:

“Doctor, one or both of my testicles seem to be getting smaller. Does this mean I will become infertile?”

Another patient may ask:

“My ultrasound says the testis is atrophic. Can medicines increase its size?”

A younger man may tell me:

“I have been using testosterone or bodybuilding steroids, and now my testicles have become smaller.”

And an infertility patient may come with:

- small testes,
- high FSH,
- low sperm count,
- or azoospermia.

Although all these patients may use the words **“small testicles,”** the underlying causes can be completely different.



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The medical term **testicular atrophy** refers to loss or reduction of testicular volume compared with the man's previous size, the opposite testis, or the expected volume for his age and clinical circumstances.

The testes perform two major functions:

1. **production of sperm for fertility**, and
2. **production of testosterone and other testicular hormones**.

Therefore, significant damage to testicular tissue can affect:

- sperm production,
- fertility,
- testosterone,
- sexual desire,
- energy,
- muscle and bone health,
- and psychological well-being.

However, I want to reassure patients about one very important point:

A smaller testis does not automatically mean complete infertility or complete loss of testosterone production.

A man may have one atrophic testis while the opposite testis functions normally.

Another may have bilateral small testes but retain some sperm production.

Another may have reduced testicular size because of hormonal suppression that can improve after the cause is removed.

But in some conditions, such as severe torsion, destructive orchitis, genetic testicular failure or extensive fibrosis, established tissue loss may be permanent.

Therefore, my approach at **Saira Health Care** begins with a simple principle:

Do not treat testicular size alone. First determine why the testis has become smaller and how much function remains.

Current male-infertility guidance similarly emphasizes detailed medical history, physical examination, semen analysis and hormonal evaluation in men with atrophic testes or evidence of impaired spermatogenesis.



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What Are the Testicles and What Do They Do?

The testicles, or testes, are two reproductive organs located inside the scrotum.

Their major functions are:

Sperm Production

Inside the testes are many microscopic structures called **seminiferous tubules**.

This is where sperm development occurs.

These tubules constitute a large proportion of testicular volume. Therefore, severe impairment of spermatogenesis is often associated with reduced testicular size.

Testosterone Production

Specialized cells called **Leydig cells** produce testosterone in response to luteinizing hormone, or LH, from the pituitary gland.

Testosterone contributes to:

- sexual desire,
- erectile physiology,
- muscle mass,
- bone strength,
- body and facial hair,
- red-blood-cell production,
- mood,
- and many other functions.

Therefore, testicular atrophy can affect both fertility and hormonal health—but the extent varies considerably between patients.

What Is Testicular Atrophy?

Testicular atrophy means a reduction in the volume of testicular tissue.

It may affect:

- only the right testis,
- only the left testis,
- or both testes.



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It can be:

- mild,
- moderate,
- severe,
- temporary in some settings,
- partially reversible,
- or permanent.

It is important to distinguish:

Naturally Small Testes

from

Testes That Were Previously Normal but Later Became Smaller.

A man may naturally have testicles that are somewhat smaller than another man's.

That alone is not necessarily atrophy.

True atrophy usually implies **loss of previously existing tissue or failure of normal growth.**

How Large Is a Normal Adult Testicle?

There is natural variation between healthy men.

Testicular volume can be measured clinically with an orchidometer or more precisely with ultrasound.

A European Academy of Andrology ultrasound study involving healthy fertile men reported a mean ultrasound-derived testicular volume of approximately **17 mL**.

In that study, the approximate lower limits were:

- **12 mL for the right testis**
- **11 mL for the left testis**

when using the study's ultrasound methodology.

However, these numbers should not be interpreted too rigidly.

Volume varies according to:

- measurement method,
- ultrasound formula,



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- body constitution,
- age,
- and clinical context.

Clinical orchidometer measurements also tend to differ somewhat from ultrasound measurements.

Therefore:

A report of 11 mL does not automatically mean that a testicle is diseased.

The whole clinical situation matters.

Testicular Hypotrophy vs Testicular Atrophy

These terms are sometimes used interchangeably, but there is a useful distinction.

Testicular Hypotrophy

The testis is smaller than expected.

It may never have reached normal adult size.

Testicular Atrophy

The testis has lost previously existing tissue or volume.

For example, a testis may become smaller after:

- torsion,
- orchitis,
- trauma,
- varicocele,
- or prolonged hormonal suppression.

The distinction can sometimes be established only by previous records, ultrasound or comparison with the opposite side.

What Happens Inside an Atrophic Testis?

The effect depends on the cause.

Possible changes include:

- loss of seminiferous tubules,



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- reduced germ cells,
- reduced spermatogenesis,
- fibrosis,
- impaired Leydig-cell function,
- reduced testosterone production,
- impaired blood supply,
- or loss of normal testicular architecture.

Because seminiferous tubules occupy most of testicular volume, severe impairment of sperm production can be associated with smaller and softer testes.

This is why testicular volume forms part of a male infertility examination.

Symptoms of Testicular Atrophy

Some men have no symptoms apart from noticing that the testicle looks smaller.

Possible features include:

- reduction in testicular size,
- softer testicular consistency,
- noticeable asymmetry,
- infertility,
- low sperm count,
- azoospermia,
- reduced sexual desire when testosterone is deficient,
- erectile problems in some hypogonadal men,
- reduced energy,
- reduced body or facial hair,
- reduced muscle mass,
- breast enlargement in certain hormonal conditions,
- or emotional distress about fertility or appearance.

However:



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Testicular atrophy itself does not always cause pain.

Pain may be a symptom of the underlying process—such as:

- torsion,
 - infection,
 - inflammation,
 - trauma,
 - or varicocele.
-

Does Testicular Atrophy Cause Infertility?

It can, but not always.

The effect on fertility depends mainly on:

- whether one or both testes are affected,
- the underlying cause,
- remaining testicular tissue,
- FSH and testosterone levels,
- sperm production,
- and any associated genetic condition.

A man with one severely atrophic testis and one healthy testis may maintain:

- normal testosterone,
- normal sperm production,
- and normal fertility.

By contrast, bilateral severe testicular atrophy can be associated with:

- severe oligozoospermia,
- non-obstructive azoospermia,
- and primary hypogonadism.

The correct fertility test is therefore **not testicular size alone**.

A semen analysis is essential when fertility is a concern.



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Does Testicular Atrophy Cause Erectile Dysfunction?

Not necessarily.

Erection and sperm production are different processes.

A man may have significant testicular damage but retain satisfactory erections if testosterone remains adequate.

However, if bilateral testicular damage causes significant testosterone deficiency, the patient may develop:

- reduced libido,
- reduced spontaneous erections,
- fatigue,
- and sometimes erectile difficulty.

Therefore:

Testicular atrophy and erectile dysfunction may coexist, but they are not the same disease.

Major Causes of Testicular Atrophy

Testicular atrophy should be viewed as an **outcome of an underlying disease or injury**, rather than one universal disease.

Important causes include:

- testicular torsion,
- orchitis and severe infection,
- mumps orchitis,
- varicocele,
- undescended testes,
- genetic disorders,
- primary testicular failure,
- testosterone or anabolic-steroid use,
- pituitary or hypothalamic hormonal disorders,
- chemotherapy,
- radiation,



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- trauma,
- severe testicular vascular injury,
- and certain other medical conditions.

1. Testicular Torsion: An Emergency Cause

Testicular torsion occurs when the spermatic cord twists and cuts off the blood supply to the testis.

The typical presentation includes:

- sudden severe testicular pain,
- rapid swelling,
- nausea or vomiting,
- and sometimes an abnormally positioned testis.

This is a **urological emergency**.

The European Association of Urology states that testicular torsion requires immediate treatment and that the outcome is best when surgical treatment occurs ideally within approximately **4–6 hours** after symptoms begin. Ultrasound can be useful, but it should not delay necessary intervention.

If blood supply remains interrupted for too long, testicular tissue may die.

The result may be:

- permanent loss of the testis,
- severe testicular atrophy,
- or impaired fertility.

Therefore, I tell patients very clearly:

Sudden severe testicular pain should never be treated at home with massage, herbal medicine, painkillers or waiting.

Emergency evaluation comes first.

Can a Testis Recover After Torsion?

If torsion is corrected very early and the testicular blood supply returns before irreversible damage occurs, testicular function may be preserved.



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However, even a testis that appears viable during surgery can sometimes become smaller during subsequent months because microscopic damage has already occurred.

Once major tissue necrosis and fibrosis have developed, no modern, Unani or herbal medicine can reliably recreate destroyed seminiferous tissue.

This is why **prevention of atrophy through early emergency treatment is much more effective than trying to reverse advanced atrophy later.**

2. Mumps Orchitis

Mumps can occasionally cause inflammation of the testis after puberty.

The affected testicle may become:

- swollen,
- painful,
- tender,
- and inflamed.

After the acute inflammation resolves, some affected testes become smaller.

Studies and reviews have historically reported testicular atrophy in a substantial proportion of testes affected by mumps orchitis. The biological process involves inflammation, increased pressure within the testis, damage to seminiferous tubules, fibrosis and eventual atrophy.

A 2026 review of viral orchitis continues to recognize orchitis-related inflammation as an important potential contributor to impaired male fertility.

Does Mumps Orchitis Always Cause Infertility?

No.

Infertility is much more concerning when **both testes** are severely affected.

Unilateral mumps orchitis may reduce semen quality temporarily or permanently to varying degrees, but the opposite healthy testis may compensate.

Bilateral severe disease creates a greater risk of:

- low sperm count,
- azoospermia,
- impaired testosterone production,



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- and infertility.

Prevention through appropriate vaccination remains extremely important.

3. Other Orchitis and Epididymo-Orchitis

Bacterial and other infections can cause inflammation involving the testis or epididymis.

Early diagnosis and treatment are important.

Treatment may include:

- antibiotics when a bacterial infection is confirmed or strongly suspected,
- pain treatment,
- anti-inflammatory care,
- scrotal support,
- and management of the underlying source.

Antibiotics should **not** be given merely because a testis is small.

A chronic atrophic testis with no evidence of active bacterial infection does not become normal simply by taking antibiotics.

4. Varicocele

A **varicocele** is an abnormal enlargement of veins around the testicle.

It is especially common on the left side.

Varicocele can influence testicular function through mechanisms including:

- increased testicular temperature,
- altered blood flow,
- oxidative stress,
- hypoxia,
- and accumulation of potentially harmful metabolites.

Current EAU guidance recognizes that varicocele may be associated with progressive testicular damage and reduced fertility in some men.

A recent 2026 systematic review and meta-analysis also found that men with varicocele had, on average:



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- smaller testicular volume,
- poorer semen parameters,
- lower total testosterone,
- and higher FSH and LH

than comparison groups.

Does Every Varicocele Cause Testicular Atrophy?

No.

Many men have varicocele and remain fertile.

Varicocele is found even in healthy fertile men.

Therefore:

Varicocele on ultrasound does not automatically explain every small testicle or infertility problem.

The clinical significance depends on:

- whether the varicocele is palpable,
 - its severity,
 - testicular size,
 - semen parameters,
 - pain,
 - reproductive goals,
 - and female-partner fertility.
-

Can Varicocele Surgery Increase Testicular Size?

In adolescents with persistent testicular asymmetry, treatment may sometimes allow **catch-up growth**.

Current EAU guidance recommends considering surgery in adolescents with persistent testicular size difference exceeding approximately **2 mL or 20%**, confirmed on repeated assessments.

In adults, however, the effect of varicocele repair on actual testicular volume is inconsistent.



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Some studies show increased volume while others show little change, even when semen parameters improve.

Therefore:

Varicocele treatment should not be advertised to adults as a guaranteed way to regrow an atrophic testicle.

The more important clinical outcomes are:

- testicular function,
- semen quality,
- testosterone where relevant,
- pain,
- and fertility.

5. Undescended Testes – Cryptorchidism

An undescended testis is a testicle that did not move normally into the scrotum during development.

The higher temperature outside the scrotal environment can impair germ-cell development.

The risk to fertility is greater when:

- both testes were undescended,
- the testes remained undescended for a prolonged period,
- or treatment occurred late.

An undescended testis may remain smaller later in life.

It also carries an increased risk of testicular cancer compared with a normally descended testis.

Therefore, a history of childhood cryptorchidism is highly relevant during fertility evaluation.

6. Klinefelter Syndrome and Genetic Testicular Failure

Klinefelter syndrome is one of the best-known genetic causes of primary testicular failure.

The common chromosome pattern is:

47,XXY



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instead of the usual 46,XY male karyotype.

Possible features include:

- small firm testes,
- high FSH and LH,
- low or low-normal testosterone,
- azoospermia,
- infertility,
- reduced body hair,
- gynecomastia,
- or other endocrine features.

The 2024 AUA/ASRM Male Infertility Guideline specifically recommends karyotype testing in appropriately selected infertile men with:

- azoospermia,
- or sperm concentration below 5 million/mL

when accompanied by:

- elevated FSH,
- testicular atrophy,
- or evidence of impaired sperm production.

This is why severe testicular atrophy in an infertility patient should not be treated for years with empirical fertility supplements without considering genetic evaluation.

Y-Chromosome Microdeletions

Some men with severe impairment of sperm production have small testes and genetic abnormalities affecting regions of the Y chromosome that are necessary for spermatogenesis.

Current 2024 AUA/ASRM guidance recommends Y-chromosome microdeletion testing particularly in appropriately selected men with:

- azoospermia,
- or sperm concentration **≤1 million/mL**



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when there is:

- elevated FSH,
- testicular atrophy,
- or another indication of impaired sperm production.

This information can strongly influence:

- prognosis,
- sperm-retrieval decisions,
- and genetic counselling.

7. Testosterone Injections and Anabolic Steroids

This is one of the most important—and preventable—causes of small testes that I see discussed in male sexual-health practice.

A man may begin:

- testosterone injections,
- testosterone gel,
- bodybuilding steroids,
- or anabolic-androgenic drugs

because he wants:

- larger muscles,
- better gym performance,
- more sexual energy,
- or “higher testosterone.”

But external testosterone sends a signal to the brain that enough androgen is already present.

The pituitary then reduces:

- LH,
- FSH.

These hormones are essential for testicular function.

As a result:



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- intratesticular testosterone falls,
- sperm production declines,
- testicular volume may decrease,
- and severe oligozoospermia or azoospermia may develop.

The Endocrine Society specifically lists **shrunk testicles, low sperm count and impaired testosterone function** among recognized consequences of anabolic-steroid abuse.

Current AUA/ASRM male-infertility guidance states clearly:

Men interested in current or future fertility should not receive exogenous testosterone therapy.

Can Testicles Recover After Stopping Testosterone or Steroids?

Sometimes, yes.

This is one of the situations in which testicular suppression can be at least partly reversible.

After testosterone or anabolic steroids are stopped:

- LH and FSH may gradually recover,
- intratesticular testosterone can rise,
- spermatogenesis may restart,
- and testicular volume may improve.

However:

Recovery is not immediate.

Current AUA/ASRM guidance notes that sperm commonly return after cessation of exogenous testosterone, but recovery can take:

- many months,
- and occasionally years.

Long or heavy anabolic-steroid use can sometimes produce prolonged testicular dysfunction.

Therefore, treatment should be supervised by a clinician experienced in male reproductive endocrinology.



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Do Not Start Testosterone Simply Because the Testes Are Small

This deserves special emphasis.

A man with small testes may have low testosterone.

But if he wants children, prescribing external testosterone can make sperm production worse.

The Endocrine Society recommends against starting testosterone therapy in men planning fertility.

Current EAU guidance similarly states that testosterone therapy is contraindicated as a treatment for male infertility.

Depending on the diagnosis and fertility goals, selected men may instead require fertility-preserving endocrine strategies.

The correct choice depends on:

- FSH,
- LH,
- testosterone,
- pituitary function,
- testicular reserve,
- and reproductive goals.

8. Hypogonadotropic Hypogonadism

Sometimes the testes become small or function poorly because they are not receiving adequate hormonal signals from the brain.

This is called:

Secondary or Hypogonadotropic Hypogonadism

Possible causes include:

- congenital hypothalamic disorders,
- pituitary disease,
- severe hyperprolactinemia,
- certain medications,



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- obesity-related functional suppression,
- anabolic steroids,
- and other hypothalamic-pituitary disorders.

The hormonal pattern typically involves:

- low testosterone,
- and low or inappropriately normal LH and FSH.

This is very different from primary testicular failure.

Can Fertility Be Restored in Hypogonadotropic Hypogonadism?

In many appropriately selected men, yes.

Current EAU guidance strongly recommends treatment designed to induce spermatogenesis in men with congenital or acquired hypogonadotropic hypogonadism who want children.

Therapy may involve:

- hCG,
- FSH,
- human menopausal gonadotropin,
- or related fertility-directed hormone treatment.

This is an important example where:

treating the cause can restore testicular activity.

9. Testicular Trauma

Severe injury to the testicle can damage:

- blood vessels,
- seminiferous tubules,
- and hormone-producing tissue.

A severely injured testis may later become smaller.

Urgent assessment is important after substantial trauma, particularly if there is:

- severe pain,



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- swelling,
- bruising,
- or concern about rupture.

10. Chemotherapy and Radiation

Some chemotherapy drugs and radiation treatments can damage rapidly dividing germ cells.

The effect depends on:

- drug type,
- dose,
- radiation exposure,
- age,
- baseline testicular health,
- and individual susceptibility.

Damage may be:

- temporary,
- prolonged,
- or permanent.

Men facing potentially gonadotoxic cancer treatment should be counselled about:

sperm cryopreservation before treatment

whenever medically and practically possible.

Fertility preservation is far easier before irreversible testicular damage has occurred.

11. Testicular Cancer and Other Masses

A smaller testis does not automatically mean cancer.

However, a man should seek prompt evaluation if he notices:

- a hard lump,
- a new area of firmness,
- progressive enlargement of part of the testis,



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- heaviness,
- or unexplained structural change.

Testicular cancer can sometimes occur in a testis with other developmental abnormalities.

The important message is:

Never assume that a new testicular lump is simply “atrophy.”

It requires proper medical evaluation.

12. Aging and General Health

Testicular endocrine and reproductive function can change with age.

However, dramatic unilateral shrinkage should not simply be blamed on getting older.

Marked change in one testis deserves evaluation for:

- previous torsion,
 - varicocele,
 - infection,
 - trauma,
 - vascular disease,
 - or another pathology.
-

Diagnosis of Testicular Atrophy

The diagnosis should answer two different questions:

1. Is the testicle truly smaller?

and

2. Why is it smaller?

The second question is much more important for treatment.

Step 1: Detailed Medical History

I ask about:

- when the change was first noticed,



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- whether one or both testes are involved,
- previous testicular size if known,
- pain,
- swelling,
- fever,
- mumps,
- genital infection,
- testicular torsion,
- childhood undescended testes,
- groin or testicular surgery,
- trauma,
- varicocele,
- testosterone injections,
- bodybuilding steroids,
- fertility medicines,
- chemotherapy,
- radiation,
- sexual function,
- previous fertility,
- and family history.

This history alone can sometimes reveal the cause.

Step 2: Physical Examination

A proper genital examination may assess:

- testicular size,
- consistency,
- symmetry,
- position,



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- epididymis,
- vas deferens,
- varicocele,
- masses,
- secondary sexual characteristics,
- gynecomastia,
- and signs of androgen deficiency.

Small, soft testes may suggest one pattern of dysfunction.

Small, firm testes may suggest another.

Therefore, size alone is not enough.

Step 3: Scrotal Ultrasound

Ultrasound can provide valuable information about:

- testicular dimensions,
- calculated volume,
- internal architecture,
- blood flow,
- masses,
- varicocele,
- previous injury,
- and comparison between the two testes.

The EAA ultrasound study provides contemporary reference data for testicular volume and demonstrates the usefulness of standardized colour-Doppler ultrasound in evaluating male reproductive anatomy.

Does Ultrasound Prove Fertility?

No.

A normal-sized testis does not guarantee normal sperm production.

Likewise, a small testis may retain meaningful function.



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This is why fertility evaluation requires **semen analysis**.

Step 4: Semen Analysis

When the patient wants current or future fertility, semen analysis is extremely important.

It evaluates:

- semen volume,
- sperm concentration,
- total sperm number,
- progressive motility,
- total motility,
- morphology,
- vitality where appropriate,
- and other semen characteristics.

The WHO's first global infertility guideline, published in November 2025, recommends systematic male-factor evaluation using physical examination and semen analysis and emphasizes assessment of both partners.

If semen parameters are abnormal, repeat testing may be appropriate because semen quality naturally varies. WHO suggests repeating an abnormal semen analysis after a minimum of approximately **11 weeks**.

Step 5: Hormonal Evaluation

Current AUA/ASRM guidance specifically recommends hormonal assessment with:

- **FSH**
- and **testosterone**

in infertile men with:

- oligozoospermia,
- azoospermia,
- atrophic testes,
- impaired libido,



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- erectile dysfunction,
- or other evidence of hormonal abnormality.

Depending on findings, I may also consider:

- LH,
- prolactin,
- estradiol,
- thyroid testing,
- or other endocrine investigations.

What Does High FSH Mean?

FSH is produced by the pituitary gland.

When sperm-producing tissue is severely damaged, the brain may increase FSH in an attempt to stimulate the testes.

Therefore:

Small testes + high FSH

often suggests:

Primary testicular or spermatogenic failure.

However, high FSH does not tell us the exact genetic or histological cause.

Further assessment may be needed.

What Do Low FSH and LH Mean?

When:

- testosterone is low,
- FSH is low or inappropriately normal,
- and LH is low or inappropriately normal,

the problem may arise higher in the hormonal pathway—within the hypothalamus or pituitary gland.

This is important because some such conditions are much more treatable from a fertility perspective.



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Step 6: Genetic Testing When Indicated

Genetic testing should not be ordered simply because one testicle looks slightly smaller.

It becomes particularly important when testicular atrophy is associated with:

- azoospermia,
- very severe oligozoospermia,
- elevated FSH,
- or clear evidence of impaired sperm production.

Current AUA/ASRM guidance recommends:

Karyotype testing

for appropriately selected infertile men with azoospermia or sperm concentration below **5 million/mL** when testicular atrophy, high FSH or impaired sperm production is present.

Y-Chromosome Microdeletion Testing

particularly for appropriately selected men with azoospermia or sperm concentration **≤1 million/mL** when atrophy, elevated FSH or impaired sperm production is present.

Can Testicular Atrophy Be Reversed?

This is the question patients most want answered.

The correct answer is:

Sometimes function can improve, but established tissue loss cannot always be reversed.

The possibility depends entirely on the cause.

Situations Where Improvement May Be Possible

Examples include:

Hormonal suppression from testosterone or anabolic steroids

Testicular hormonal activity and spermatogenesis may recover after the offending hormones are stopped, although recovery can take months or occasionally longer.

Hypogonadotropic hypogonadism



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Appropriate gonadotropin treatment can stimulate testicular function and sperm production in many patients.

Varicocele in selected adolescents

Treatment can sometimes result in catch-up testicular growth.

Reversible systemic or nutritional factors

Treating severe nutritional, endocrine or general-health problems may improve testicular function when irreversible tissue destruction has not occurred.

Situations Where Full Regrowth May Not Be Possible

Examples include:

- prolonged severe testicular torsion,
- established post-inflammatory fibrosis,
- extensive mumps-orchitis damage,
- severe genetic primary testicular failure,
- advanced chemotherapy- or radiation-related tissue destruction,
- severe bilateral testicular trauma.

In these situations, the goal changes.

Instead of promising to make the testis physically large again, treatment focuses on:

- preserving remaining function,
- correcting hormone deficiency,
- assessing fertility,
- retrieving sperm where possible,
- protecting the healthy opposite testis,
- and supporting sexual and general health.

Treatment of Testicular Atrophy

There is no universal “**testicle enlargement medicine.**”

Treatment depends on the cause.



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Treatment After Torsion

Acute torsion requires:

urgent surgery.

Not Unani medicine.

Not massage.

Not supplements.

Not waiting overnight.

Early treatment is aimed at preventing the atrophy from occurring in the first place.

Once severe ischemic tissue loss is established, herbal medicine cannot recreate dead tissue.

Treatment of Orchitis

Treatment depends on the cause.

It may involve:

- treatment of bacterial infection when present,
- pain relief,
- anti-inflammatory care,
- scrotal support,
- and appropriate monitoring.

Mumps orchitis is primarily managed supportively because there is no established antiviral treatment that reliably prevents subsequent atrophy.

Treatment of Varicocele

For an infertile adult man with:

- a **clinical palpable varicocele**,
- abnormal semen parameters,
- and otherwise appropriate couple-level fertility circumstances,

varicocele repair may improve fertility outcomes.

Current WHO and EAU guidance support treatment in appropriately selected men, while emphasizing that the effect on live birth and specific parameters varies.



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A tiny varicocele found only on ultrasound should not automatically be operated upon.

Treatment of Hormonal Testicular Suppression

If the problem is hypogonadotropic hypogonadism, treatment may involve fertility-directed hormonal therapy.

If the problem resulted from anabolic steroids or testosterone, stopping the suppressive drug under professional guidance is fundamental.

Selected men may require specialist treatments aimed at stimulating endogenous testicular function.

Testosterone Replacement in Primary Testicular Failure

A man with irreversible bilateral testicular failure may require testosterone treatment for:

- sexual health,
- muscle health,
- bone protection,
- energy,
- and other symptoms of androgen deficiency.

However:

Testosterone replacement is not infertility treatment.

It can further suppress any residual sperm production.

Therefore, fertility goals should be discussed before testosterone is started.

Fertility Treatment When the Testes Are Atrophic

The important question is:

Is any sperm production still occurring?

Depending on the result, possible pathways include:

- natural conception when sperm production remains adequate,
- treatment of reversible hormonal disease,
- IUI in selected mild male-factor cases,



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- IVF,
- ICSI,
- sperm retrieval procedures in selected azoospermic men.

Non-Obstructive Azoospermia and Small Testes

Bilateral small testes with:

- elevated FSH,
- normal-volume ejaculation,
- and azoospermia

often suggest severely impaired sperm production.

However:

No sperm in semen does not always mean there is absolutely no sperm inside the testes.

Sperm production can sometimes occur in small focal areas.

In appropriately selected men with non-obstructive azoospermia, **micro-TESE** may be used to search testicular tissue for sperm that can potentially be used with ICSI.

Genetic findings strongly influence the prognosis.

Klinefelter Syndrome and Sperm Retrieval

Even though many men with Klinefelter syndrome have:

- small testes,
- azoospermia,
- and severe testicular dysfunction,

small areas of sperm production may occasionally remain.

Current AUA/ASRM guidance reports sperm retrieval with micro-TESE in approximately **50–60% of appropriately selected 47,XXY men**, although retrieval is not the same as pregnancy and cannot be guaranteed.

This is why a man should not be told:

“Your testes are small, so biological fatherhood is impossible.”

The diagnosis matters.



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Understanding Testicular Atrophy in the Unani System of Medicine

The Unani system has historically discussed disorders affecting the testis and male reproductive function through concepts involving:

- **Mizaj**
- reproductive-organ strength,
- nutrition,
- humoral balance,
- sexual and reproductive function,
- general vitality,
- and lifestyle.

Interestingly, official CCRUM standardized terminology includes:

Taqallus al-Khusya

as a traditional term corresponding to **testicular atrophy or shrinking of the testes**.

This is useful because it demonstrates that disorders involving reduced testicular size were recognized in traditional Unani literature.

However, modern testicular atrophy encompasses causes—including:

- torsion,
- genetic syndromes,
- endocrine suppression,
- chemotherapy,
- and vascular damage—

that can now be investigated much more precisely.

Therefore, my clinical approach is to combine:

the individualized principles of Unani medicine with contemporary urological and infertility diagnosis.

Mizaj and Testicular Health



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In Unani medicine, **Mizaj**, or temperament, is an important part of individualized assessment.

Traditional Unani theory considers that reproductive function may be influenced by abnormalities affecting the temperament and functional state of the reproductive organs.

This is useful as a traditional clinical framework.

However, I do not tell a patient:

“Your testis is small only because your temperament is cold.”

If ultrasound shows a severely atrophic testis after torsion or if FSH is very high and karyotype shows Klinefelter syndrome, those findings must not be ignored.

The modern diagnosis should guide the treatment.

Akhlat and the Traditional Humoral Framework

Classical Unani medicine describes:

- Dam,
- Balgham,
- Safra,
- Sauda

as the four traditional humors.

Disturbance of their balance is part of the historical Unani explanation of disease.

These concepts should be respected as **traditional medical theory**, but they should not be presented as modern equivalents of:

- testosterone,
- LH,
- FSH,
- sperm concentration,
- chromosomes,
- or ultrasound testicular volume.

Responsible integrative care keeps these systems conceptually distinct.



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Unani Principles Related to Reduced Seminal and Reproductive Function

CCRUM's Standard Unani Treatment Guidelines discuss **Qillat-i-Mani**, or reduced seminal production, and traditional causes including:

- general weakness,
- inadequate nutrition,
- and abnormalities in the functional temperament of semen-producing organs.

The traditional treatment principles include:

- nutritional support,
- improving general health,
- supporting digestion,
- and selecting treatment according to the individual's traditional clinical pattern.

Again, **Qillat-i-Mani is not identical to testicular atrophy**, but these principles may become relevant when an atrophic testis is accompanied by impaired semen production.

Asbab-e-Sitta Zarooriya and Reproductive Health

The Unani whole-person approach gives importance to the six essential factors of health.

These broadly involve:

- air and environment,
- food and drink,
- physical activity and rest,
- mental activity and rest,
- sleep and wakefulness,
- and appropriate retention and elimination.

In testicular and fertility health, these principles can support management through attention to:

- nutrition,
- body weight,
- diabetes,
- smoking,



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- harmful occupational exposures,
- sleep,
- physical activity,
- psychological stress,
- and general metabolic health.

These factors cannot reverse every form of testicular atrophy, but they can improve the overall physiological environment in which remaining testicular tissue functions.

Ilaj-bil-Ghiza: Dietotherapy

Dietotherapy may be useful particularly when a patient has:

- poor nutrition,
- obesity,
- diabetes,
- metabolic syndrome,
- or inadequate dietary quality.

My nutritional approach generally aims to provide:

- adequate protein,
- vegetables and fruits,
- healthy fats,
- whole foods,
- appropriate micronutrients,
- healthy body weight,
- and good metabolic control.

However:

No particular food has been scientifically proven to regenerate a severely fibrosed or destroyed testicle.

The goal is to support remaining testicular and general reproductive function.

Ilaj-bit-Tadbir: Regimenal and Lifestyle Management



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Depending on the patient's condition, regimenal and lifestyle management may include:

- appropriate exercise,
- adequate sleep,
- weight management,
- reduction of chronic stress,
- stopping tobacco,
- avoiding recreational drugs,
- avoiding anabolic steroids,
- minimizing unnecessary chronic testicular heat,
- and improving metabolic health.

This can be particularly valuable when testicular dysfunction is occurring alongside preventable health problems.

Ilaj-bid-Dawa: Individualized Unani Pharmacotherapy

Unani pharmacotherapy should be selected according to:

- cause,
- Mizaj,
- semen profile,
- hormonal status,
- general health,
- testicular reserve,
- and fertility goals.

This means there should not be one standard prescription called:

“Testicular Atrophy Cure.”

The treatment of a man whose testes have shrunk after testosterone abuse should be different from that of a patient with Klinefelter syndrome.

The patient with varicocele is different again.

And the patient with previous torsion is different again.

That is the principle of individualized treatment.



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How Useful Is Unani Medicine in Testicular Atrophy?

I consider Unani medicine most useful when we are precise about its role.

It may contribute to:

- nutritional rehabilitation,
- general reproductive-health support,
- management of lifestyle factors,
- metabolic optimization,
- sleep and stress management,
- general vitality,
- and individualized fertility-support pharmacotherapy.

Published CCRUM material also includes clinical investigation of Unani formulations for male infertility conditions such as oligospermia.

However, current evidence does **not** establish that Unani medicines can reliably regenerate permanently destroyed seminiferous tubules or reverse every case of established testicular atrophy.

I believe saying this openly strengthens rather than weakens Unani medicine.

Saira Health Care's Special Treatment Approach

At Saira Health Care, I do not begin treatment simply by asking:

“Which medicine can increase testicle size?”

My preferred pathway is:

Confirm → identify cause → assess hormones → assess sperm production → correct reversible factors → preserve fertility → integrate suitable Unani support → refer when necessary.

Step 1: Confirm Whether True Atrophy Exists

I compare:

- both testes,



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- previous records,
- clinical examination,
- and ultrasound when indicated.

A temporary retractile position or natural asymmetry should not be mistaken for true atrophy.

Step 2: Identify the Cause

I specifically ask about:

- torsion,
- mumps,
- infection,
- varicocele,
- undescended testes,
- injury,
- testosterone,
- anabolic steroids,
- chemotherapy,
- radiation,
- childhood reproductive disease,
- and fertility history.

Treatment cannot be rational without this step.

Step 3: Assess Hormonal Function

Where appropriate I evaluate:

- FSH,
- LH,
- morning testosterone,
- prolactin,



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- and other relevant hormones.

This helps distinguish:

Primary Testicular Failure

from

Secondary Hormonal Suppression.

These conditions require fundamentally different treatment.

Step 4: Evaluate Sperm Production

If fatherhood is desired, semen analysis is essential.

I evaluate:

- sperm concentration,
- total number,
- motility,
- morphology,
- semen volume,
- and other appropriate parameters.

A testicle can be small yet still produce sperm.

Therefore, fertility should be measured—not guessed from appearance.

Step 5: Consider Genetic Testing in Severe Cases

When atrophic testes are accompanied by:

- azoospermia,
- severe oligozoospermia,
- or elevated FSH,

appropriate genetic testing may be required.

I do not believe such patients should remain indefinitely on empirical medicines without proper diagnosis.



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Step 6: Stop Testicular Suppression

If the patient is using:

- anabolic steroids,
- testosterone injections,
- testosterone gel,
- or other suppressive androgen treatment,

this must be recognized immediately.

If fertility is desired, the treatment plan should be supervised by an appropriately experienced clinician.

Step 7: Correct Reversible Lifestyle and Medical Factors

Depending on the patient, I address:

- smoking,
- obesity,
- diabetes,
- poor nutrition,
- alcohol,
- sleep,
- excessive heat,
- and other health risks.

This is where modern fertility advice and Unani principles of diet and regimen complement each other particularly well.

Step 8: Treat a Significant Varicocele Appropriately

When there is:

- a clinical varicocele,
- abnormal semen,
- infertility,
- and appropriate reproductive circumstances,



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reproductive-urology treatment may be useful.

I do not replace a clinically significant correctable condition with repeated fertility tonics.

Step 9: Use Individualized Traditional Support

Where appropriate, I may incorporate:

- dietotherapy,
- regimenal care,
- selected Unani medicines,
- and other fertility-support formulations

according to the patient's actual diagnosis.

These are used to support:

- general reproductive health,
 - semen parameters where biologically possible,
 - nutrition,
 - energy,
 - and health of remaining testicular function.
-

Step 10: Use Assisted Reproduction When Necessary

If severe irreversible testicular damage has produced:

- extreme oligozoospermia,
- or non-obstructive azoospermia,

I discuss or recommend appropriate evaluation for:

- reproductive urology,
- micro-TESE,
- IVF,
- or ICSI

when clinically indicated.



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A good integrative physician should know when traditional treatment is unlikely to be sufficient.

Saira Health Care Fertility-Support Formulations

The following products are currently listed through Saira Health Care's pharmacy and may be encountered in its male reproductive-health practice.

I believe they should be described accurately.

Spermogenic Powder

Saira Health Care's pharmacy lists **Spermogenic** as a Dr. Qasmi formulation intended to support male reproductive and semen-related concerns and describes ingredients including Asgand, Kaunch, Khulanjan, Musli and other traditional components.

Within an individualized fertility programme, it may be considered as a **traditional herbal fertility-support formulation**.

However:

It should not be advertised as scientifically proven to regrow an atrophic testis.

Its role is supportive and depends on the patient's underlying diagnosis.

Jawahar-e-Khusia

Saira Health Care's pharmacy lists **Jawahar-e-Khusia** as a Unani preparation used traditionally for male reproductive-health support, including spermatogenesis and testicular-health indications.

In my clinical framework, it may be incorporated selectively when appropriate.

But traditional indication should not be confused with proof that the medicine can regenerate testicular tissue destroyed by:

- torsion,
 - genetic failure,
 - chemotherapy,
 - or severe fibrosis.
-



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Dr. Qasmi's Nuskha No. 129 – Vitasem Max

Saira Health Care currently describes **Dr. Qasmi's Nuskha No. 129 (Vitasem Max)** as a Unani preparation used for:

- general weakness,
- energy,
- semen quality,
- and male reproductive support.

This formulation may be incorporated into selected individualized fertility programmes.

Again, its realistic role is to support the patient's overall reproductive-health plan—not to replace:

- endocrine treatment,
- varicocele treatment,
- genetic investigation,
- or assisted reproduction.

Spermzoa Capsule

Saira Health Care's pharmacy currently classifies **Spermzoa Capsule as an Ayurvedic formulation**, rather than a Unani medicine, and markets it for sperm-count and motility support.

If included in an integrative programme, it should therefore be labelled accurately as an **Ayurvedic fertility-support supplement**, not a classical Unani drug.

Semen Gold Plus Capsule

The current Saira Health Care pharmacy page likewise describes **Semen Gold Plus as an Ayurvedic supplement** used for male reproductive-health concerns.

It may be considered as supportive supplementation under professional supervision, but there is insufficient evidence to claim that it reverses established testicular atrophy.

Sperm Plus Capsule



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

It should therefore also be distinguished from classical Unani pharmacotherapy.

An Important Evidence-Based Clarification About These Formulations

Saira Health Care may use various traditional fertility-support products as part of individualized patient care.

However, during my current review I did **not identify high-quality peer-reviewed controlled clinical trials demonstrating that Spermogenic, Jawahar-e-Khusia, Nuskha No. 129, Semen Gold Plus, Spermzoa or Sperm Plus can reliably restore lost testicular volume in men with established testicular atrophy.**

Therefore, I would not professionally make claims such as:

“This medicine will definitely regrow your testes.”

or

“This formulation reverses testicular atrophy in every patient.”

Such claims ignore the biology of conditions such as:

- torsion,
- fibrosis,
- genetic testicular failure,
- and severe gonadal destruction.

The correct message is:

Traditional formulations may support general reproductive health and semen-related treatment in selected men, but the underlying cause determines whether actual testicular function or volume can recover.

What Treatment Success Means in Testicular Atrophy

Success should not be measured only by centimeters or millilitres of testicular volume.

For one patient, success may mean:

Preventing atrophy

because acute torsion was treated immediately.



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Preserving fertility

after early management of a reproductive disorder.

Restoring sperm production

after treatment of hypogonadotropic hypogonadism.

Recovery after testosterone suppression

when sperm production returns after exogenous testosterone is discontinued.

Improving semen quality

after treatment of a clinically significant varicocele.

Identifying a genetic disorder

and preventing years of ineffective treatment.

Retrieving sperm

through micro-TESE in an appropriate patient with non-obstructive azoospermia.

Correcting testosterone deficiency

when fertility is no longer being pursued.

Supporting remaining testicular function

through individualized diet, lifestyle and traditional care.

These are meaningful clinical outcomes.

Why I Avoid Guaranteed “Regrowth” Stories

A patient with testicular atrophy is particularly vulnerable to advertisements promising:

“Increase your testicle size naturally in one month.”

“Regenerate testicular tissue without surgery.”

“Guaranteed sperm production from completely damaged testes.”

These claims should be approached very carefully.

A genuine clinical success story should include:

- actual diagnosis,
- baseline testicular volume,
- hormone profile,



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- semen analysis,
- known cause,
- treatment received,
- follow-up results,
- and patient consent.

Without that information, a dramatic before-and-after claim is not reliable medical evidence.

Common Myths About Testicular Atrophy

Myth: Small testes always mean infertility.

Fact: One healthy testis can often maintain fertility and testosterone production.

Myth: A small testicle can always be made large again with medicine.

Fact: Recovery depends on the cause. Established fibrosis or destroyed testicular tissue may be irreversible.

Myth: Testosterone injections strengthen the testes.

Fact: External testosterone can suppress LH and FSH, shrink the testes and severely reduce sperm production.

Myth: Bodybuilding steroids improve male fertility.

Fact: Anabolic steroids can cause testicular shrinkage, hormonal suppression and infertility.

Myth: Sudden testicular pain can be treated with medicine first.

Fact: Sudden severe unilateral testicular pain may be torsion, a surgical emergency in which treatment is ideally performed within hours.

Myth: Every varicocele should be operated upon.

Fact: Treatment is generally targeted to clinically significant varicoceles in appropriate patients.



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Myth: Varicocele repair always restores adult testicular size.

Fact: Adult testicular-volume recovery is inconsistent even when semen parameters improve.

Myth: Unani medicine has no role because atrophy is a structural problem.

Fact: Unani care may have a useful supportive role in nutrition, lifestyle, metabolic health, reproductive support and selected reversible conditions, but its role depends on the underlying pathology.

Myth: Unani medicine can regenerate every destroyed testicle.

Fact: No responsible medical system can currently guarantee regeneration of permanently destroyed testicular tissue.

Frequently Asked Questions

Can one small testicle cause infertility?

Not necessarily.

If the opposite testis functions normally, sperm production and testosterone may remain adequate.

Can both small testes cause infertility?

Yes, bilateral significant atrophy increases concern for:

- impaired spermatogenesis,
- low sperm count,
- azoospermia,
- and testosterone deficiency.

A semen analysis and hormone evaluation are important.

Can testicular atrophy be reversed naturally?



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Some reversible hormonal or functional causes may improve after appropriate treatment.

Established scarred or destroyed tissue generally cannot simply be regenerated through diet or herbs.

Can testicles grow again after stopping steroids?

They may partially recover after testosterone or anabolic steroids are discontinued.

Sperm production commonly recovers in many men, but recovery can take months and occasionally years.

Should I take testosterone if my testes are small?

Not automatically.

If fertility is desired, external testosterone can suppress sperm production.

The cause of low testosterone should be identified first.

Can varicocele make one testicle smaller?

Yes.

Varicocele is associated with reduced testicular volume and impaired semen parameters in some men.

Can varicocele surgery restore size?

Catch-up growth can occur particularly in some adolescents.

In adults, increased testicular volume is less predictable.

Can mumps cause testicular atrophy?

Yes.

Mumps orchitis after puberty can damage seminiferous tissue and lead to testicular atrophy in some affected men.

Can testicular torsion cause permanent shrinkage?



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Yes.

Prolonged loss of blood supply can permanently damage testicular tissue.

Early surgical treatment is essential.

Can a man father a child with one atrophic testicle?

Yes.

If the other testicle has adequate sperm production, natural fatherhood may remain completely possible.

Can a man with two atrophic testes father a child?

Possibly, depending on remaining spermatogenesis.

Some men retain sperm in the ejaculate.

Some with non-obstructive azoospermia may have sperm retrievable through micro-TESE.

Others may unfortunately have no retrievable sperm.

The underlying diagnosis determines the prognosis.

Is high FSH important in testicular atrophy?

Yes.

Small testes accompanied by elevated FSH often indicate impaired sperm-producing tissue.

This may justify more extensive fertility and genetic evaluation.

Can Unani medicine help testicular atrophy?

It may be useful as part of an individualized integrative programme for:

- nutrition,
- lifestyle,
- general reproductive health,
- metabolic health,
- stress and sleep,



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- semen-quality support,
- and selected reversible conditions.

However, it should not delay urgent treatment of torsion, genetic investigation, endocrine therapy, varicocele management or ART when these are required.

Is Jawahar-e-Khusia useful?

Jawahar-e-Khusia is listed by Saira Health Care's pharmacy as a Unani preparation used traditionally for male reproductive and testicular-health support.

It should be used under professional supervision and should not be interpreted as a guaranteed tissue-regeneration treatment.

Is Nuskha No. 129 useful?

Dr. Qasmi's Nuskha No. 129 is listed as a Unani preparation used for general vitality and semen-quality support.

Its role should be individualized according to the patient's diagnosis.

Is Spermogenic useful?

Spermogenic is used within Saira Health Care's male fertility-support practice and is marketed for semen-related reproductive concerns.

It should be regarded as an adjunctive fertility-support formulation rather than a proven cure for irreversible testicular atrophy.

When Should You Seek Urgent Medical Attention?

Seek **emergency medical care immediately** for:

- sudden severe testicular pain,
- rapidly developing swelling,
- nausea or vomiting with testicular pain,
- a testicle suddenly sitting abnormally high,
- or significant acute scrotal trauma.

These symptoms can indicate testicular torsion.



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Treatment should not be delayed for imaging or traditional medicine when clinical suspicion is high.

When Should You Arrange a Non-Emergency Specialist Consultation?

A proper fertility or urological assessment is advisable when:

- one testis is progressively becoming smaller,
 - both testes seem unusually small,
 - infertility is present,
 - sperm count is low or zero,
 - testosterone is low,
 - FSH is elevated,
 - a varicocele is present,
 - there is a history of undescended testes,
 - mumps orchitis occurred after puberty,
 - chemotherapy or radiation has been received,
 - testosterone or anabolic steroids have been used,
 - or a testicular mass or persistent structural abnormality is present.
-

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 listed for this clinical work include:

- **BUMS – Hamdard University, Delhi**
- **MD**
- **CGO**
- **Certificate in Infertility – MGBIMS, Delhi**
- **Certificate in Urology – London, UK**
- **Masters in Male Infertility – MasterHealthPro (HealthPro)**



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- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**

Saira Health Care's current published professional material uses this profile and identifies sexual disorders and infertility as the principal focus of my clinical work.

This combination of sexual-health, infertility and urological education is particularly relevant to testicular atrophy because the condition may involve:

- urological disease,
- male infertility,
- testosterone deficiency,
- semen abnormalities,
- genetic disorders,
- sexual dysfunction,
- reproductive endocrinology,
- and assisted reproduction.

Saira Health Care's Contribution to Sexual Disorders and Infertility

Men with testicular atrophy frequently receive contradictory information.

One person tells them:

“Nothing can ever be done.”

Another says:

“Take this powder and the testicle will definitely become normal.”

Neither extreme represents good medical practice.

At Saira Health Care, I believe our contribution in sexual disorders and infertility should be based on:

- confidential consultation,
- correct interpretation of semen reports,
- assessment of hormones,
- understanding testicular size and function,
- evaluation of sexual health,
- identification of reversible causes,



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- responsible use of Unani medicine,
- lifestyle and nutritional management,
- recognition of genetic infertility,
- couple-based fertility assessment,
- and appropriate referral to reproductive urology or assisted reproduction when necessary.

The WHO's 2025 global infertility guideline also emphasizes structured investigation of male infertility, parallel evaluation of the female partner and progressive use of fertility treatments according to clinical findings and patient circumstances.

My Integrative Philosophy for Testicular Atrophy

I do not believe good medicine requires choosing:

“Unani OR modern treatment.”

The correct choice depends on what the patient needs.

If the patient has acute torsion

He needs emergency surgery.

If he has hypogonadotropic hypogonadism

He may need fertility-directed hormonal treatment.

If anabolic steroids have suppressed his testes

The suppressive exposure must be stopped and recovery managed properly.

If he has a clinically important varicocele

Reproductive-urology treatment may be appropriate.

If he has Klinefelter syndrome

Genetic counselling and specialist fertility planning become important.

If he has nutritional, metabolic and lifestyle problems

Unani dietotherapy and individualized regimenal treatment can make a meaningful contribution.

If semen quality is impaired but some testicular function remains



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Selected Unani and other fertility-support formulations may be incorporated under supervision.

If irreversible non-obstructive azoospermia is present

Micro-TESE and ICSI may need to be discussed.

This is the form of integrative medicine that I believe best serves patients.

Latest Scientific Perspective in 2026

Current evidence has made the evaluation of testicular atrophy increasingly precise.

The **November 2025 WHO global infertility guideline** recommends structured male evaluation involving history, physical examination and standardized semen analysis and emphasizes parallel evaluation of both partners.

Current AUA/ASRM guidance specifically identifies **atrophic testes** as an indication for hormonal assessment with FSH and testosterone in infertile men.

The **2024 AUA/ASRM amendment** also refined genetic-testing thresholds, recommending karyotype and Y-chromosome investigation in appropriately selected men with severe spermatogenic failure and testicular atrophy.

Current EAU guidance strongly advises against using testosterone as a treatment for male infertility and recommends fertility-directed hormonal treatment for men with hypogonadotropic hypogonadism who want children.

A recent 2026 meta-analysis also strengthens evidence linking **varicocele with reduced testicular volume, poorer semen quality and altered reproductive hormones**, while treatment decisions must still be individualized.

These updates reinforce the same principle:

Testicular atrophy must be treated according to its cause—not according to its appearance alone.

My Final Message to Patients

If you notice that one or both testicles have become smaller, please do not immediately assume:

“My fertility is finished.”

But also do not assume:

“A fertility tonic will make the testicle grow again.”



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Ask the questions that actually matter:

Has the testis truly lost volume?

Is one side affected or both?

Do I have a varicocele?

Was there previous torsion?

Did I have mumps orchitis?

Was the testis undescended during childhood?

Have I used testosterone or anabolic steroids?

What are my FSH, LH and testosterone levels?

What does my semen analysis show?

Do I need genetic testing?

Is some testicular function still present?

Can the cause be treated?

Do I need reproductive-urology or fertility treatment?

These questions tell us much more than testicular size alone.

At Saira Health Care, my approach is based on two principles:

Hope and honesty.

Hope—because many men with small or partially atrophic testes retain useful hormone function, sperm production or fertility-treatment options.

Honesty—because no physician should promise that permanently destroyed testicular tissue can always be regenerated by a medicine, herb or supplement.

Conclusion

Testicular atrophy is a reduction in testicular volume that may affect one or both testes.

It can influence:

- sperm production,
- fertility,
- testosterone,
- sexual health,



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- and overall well-being.

Important causes include:

- testicular torsion,
- mumps and other orchitis,
- varicocele,
- undescended testes,
- genetic conditions such as Klinefelter syndrome,
- hormonal disorders,
- exogenous testosterone,
- anabolic steroids,
- trauma,
- chemotherapy,
- and radiation.

The diagnosis should not be based on appearance alone.

Appropriate evaluation can include:

- detailed history,
- genital examination,
- ultrasound,
- semen analysis,
- FSH,
- LH,
- testosterone,
- other selected hormones,
- and genetic testing when clinically indicated.

The possibility of recovery depends entirely on the underlying cause.

Hormonal suppression from testosterone or anabolic steroids may improve after treatment.

Hypogonadotropic hypogonadism may respond to fertility-directed hormonal therapy.



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Selected varicocele patients may experience improved testicular or reproductive function after repair.

By contrast, severe irreversible damage from:

- prolonged torsion,
- fibrosis,
- destructive orchitis,
- major testicular trauma,
- chemotherapy,
- radiation,
- or genetic primary testicular failure

may not be fully reversible.

The **Unani system of medicine** provides a valuable supportive framework involving:

- Mizaj,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- nutritional support,
- lifestyle management,
- sleep,
- psychological well-being,
- metabolic health,
- and individualized reproductive care.

Official CCRUM terminology also recognizes **Taqallus al-Khusya** as a traditional term corresponding to testicular atrophy.

At Saira Health Care, traditional fertility-support preparations such as:

- Spermogenic,
- Jawahar-e-Khusia,
- and Dr. Qasmi's Nuskha No. 129



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may be incorporated into selected individualized treatment programmes according to the patient's complete clinical picture.

Other products available through Saira Health Care Pharmacy, including:

- Semen Gold Plus,
- Spermzoa,
- and Sperm Plus,

are currently listed by the pharmacy as **Ayurvedic formulations** and should be identified accurately rather than described as classical Unani medicines.

None should be promoted as a guaranteed way to regenerate irreversibly lost testicular tissue.

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

Confirm whether true atrophy exists.

Identify the cause.

Protect the testis urgently when torsion is suspected.

Evaluate hormones and sperm production.

Investigate genetics in appropriate severe infertility cases.

Stop fertility-suppressing testosterone and steroids when relevant.

Treat reversible hormonal and urological causes.

Use Unani medicine rationally to support whole-person reproductive health.

Protect fertility whenever possible.

Use modern reproductive treatments when they offer the better opportunity.

And never make a promise that the biology of the patient's testis cannot support.

For a patient worried about shrinking testes, my central message is:

Testicular size matters, but testicular function matters even more.

The correct next step is not fear and not self-medication.

It is accurate diagnosis followed by cause-specific, individualized treatment.

About the Author

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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 current published professional profile at Saira Health Care identifies his focused clinical work in sexual disorders and infertility and includes the above urological, infertility and reproductive-health training within the professional profile used for Saira Health Care's clinical educational material.

His approach combines traditional Unani clinical assessment with contemporary understanding of:

- male reproductive endocrinology,
- semen analysis,
- infertility,
- testicular disorders,
- sexual health,
- lifestyle,
- and appropriate advanced fertility referral.

Medical Disclaimer

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

It is not a substitute for an individual consultation, physical examination, scrotal ultrasound, semen analysis, hormonal assessment, genetic evaluation or personalized fertility-treatment plan.



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Sudden severe testicular pain is a medical emergency. Possible testicular torsion should receive immediate emergency evaluation and should not be treated first with Unani medicine, massage, herbal remedies or home treatment.

Do not independently start or stop:

- testosterone,
- anabolic steroids,
- fertility hormones,
- antibiotics,
- Unani medicines,
- Ayurvedic medicines,
- herbal preparations,
- or nutritional supplements

without appropriate professional guidance.

Men who want current or future fertility should tell their clinician before beginning testosterone therapy because external testosterone can suppress spermatogenesis and may cause testicular shrinkage.

A small testis does not automatically mean infertility, and testicular size alone cannot determine whether sperm are present.

Likewise, no modern medicine, Unani preparation, Ayurvedic supplement, herbal formulation or fertility package can responsibly guarantee restoration of permanently destroyed testicular tissue.

Where reproductive urology, endocrinology, genetic counselling, varicocele treatment, micro-TESE, IVF or ICSI is required, timely specialist referral should form part of responsible care.



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