

Mechanical, Endocrine, Performance, and Psychometric Effects of Perineal-Compression Injaculation, Ejaculatory Abstinence, and Antegrade Ejaculation

A two-phase, randomized, sham-controlled trial pairing an acute within-subject crossover with an 8-week parallel-group intervention to characterize the “injaculation” technique and to test, under expectancy control, the operationalized claim that ejaculatory redirection or retention produces measurable physiological benefit.

Protocol ID: MLSS-INJ-RCT-001

Sponsor: Landry Industries Inc. (Moncton, NB)

Target enrolment: 140 (≥ 120 evaluable; 30/arm)

Version / Date: 1.0 — June 16, 2026

Design: RCT + crossover lead-in, 4 arms

Registration: ClinicalTrials.gov — prospective, to be filed pre-enrolment (not yet registered)

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1 Protocol Synopsis

Title	Mechanical, endocrine, performance, and psychometric effects of perineal-compression injaculation, ejaculatory abstinence, and antegrade ejaculation in healthy men.
Design	Prospective, randomized, sham-controlled, assessor-blinded trial in two linked phases under one protocol and cohort: Phase 1 within-subject crossover (acute mechanical characterization + manipulation validation); Phase 2 four-arm parallel-group intervention over 8 weeks with repeated measures.
Population	Healthy males aged 18–45, normal baseline gonadal function, able to self-stimulate to orgasm; not seeking conception during the trial.
Arms (Phase 2)	A Antegrade control · B Ejaculatory abstinence (retention) · C Injaculation (verified retrograde via perineal compression) · D Sham-injaculation (sub-bulbar pressure, antegrade preserved; identical framing to C → expectancy control).
Sample size	140 enrolled, ≥120 evaluable (≈30 per arm) — powered for moderate between-arm effects (≈0.5 SD).
Co-primary endpoints	(i) Retrograde fraction under true vs sham compression (Phase 1); (ii) serum total testosterone trajectory across arms over 8 weeks (Phase 2).
Key secondary	Arm C vs D contrast on a pre-specified composite vitality–performance index — isolates physiological redirection from belief.
Domains measured	Mechanical/manipulation, endocrine, reproductive, immune/inflammatory, anaerobic & aerobic performance, cognition, validated psychometrics, sleep, expectancy, urological safety, and a nested sperm-fate mass-balance sub-study.
Primary analysis	Linear mixed-effects models with hierarchical (gatekeeping) testing for confirmatory endpoints and Benjamini–Hochberg FDR for the exploratory panel.
Duration	2-week run-in → Phase 1 sessions → 8-week intervention → 4-week follow-up. ~16 weeks per participant.

2 Background & Scientific Rationale

2.1 The phenomenon and its three separable claims

“Injaculation” denotes deliberate compression of the perineum at orgasm to redirect the ejaculate away from external emission. Folk and Taoist sources frame this as conserving sexual essence and “transmuting sperm into energy.” That popular claim is not one hypothesis but three, with sharply different testability:

- **Mechanical [established]:** Antegrade ejaculation requires a closed bladder neck and a coordinated external sphincter; when bladder-neck resistance is overcome by bulbospongiosus/ischiocavernosus pressure, semen is diverted into the bladder (retrograde ejaculation). Perineal compression is a plausible manual route to this, but has never been studied *as a technique* [1]; notably, the sole randomized trial of perineal self-pressure targets constipation, not ejaculation [2].
- **Conservation [weak / contested]:** That redirecting or retaining semen yields systemic (hormonal, metabolic) benefit. The single most-cited supporting result is a 2003 study reporting a serum-testosterone peak (~145% of baseline) on day 7 of abstinence — which has since been **retracted**, never replicated, and never claimed a lasting effect [3]. Systematic reviews find evidence for sustained testosterone or performance benefit to be weak and inconsistent [4, 5].
- **Energetic [unfalsifiable as literal physics]:** That sperm is converted into usable bodily “energy.” The recoverable chemical energy of an ejaculate is a small fraction of a kilocalorie against ~2,000 kcal/day; no mechanism is proposed. This claim is a category error and is excluded from confirmatory testing; only operationalized vitality/performance proxies are measurable.

2.2 The contested biology underneath

Crucially, even the reassurance that unejaculated sperm is “simply reabsorbed” is not settled. The exact fate of unejaculated human spermatozoa is described in the andrology literature as unknown [6]; some au-

thors find no convincing evidence for significant resorption in normal animals and no quantitative removal rate [7], and the epididymal phagocytosis (“quality-control”) hypothesis has been proposed, discredited, revived, and rebutted [8, 9]. Most evidence is animal-derived and extrapolated to humans. This is a genuine basic-physiology gap that bears directly on the conservation claim and is addressed by a nested mass-balance sub-study (§13).

Diagnostic anchor. Retrograde ejaculation is conventionally confirmed when centrifuged post-ejaculatory urine shows >10–15 spermatozoa per high-power field [10]. Because retained urethral ejaculate also produces sperm in post-void urine in healthy men, the protocol uses a **quantitative retrograde fraction** with split-void sampling (and suprapubic bladder aspiration in a sub-sample) to separate true redirection from urethral washout.

2.3 Why a single trial cannot use one arm structure

The mechanical question (“where does the semen go, and can the technique reliably send it there?”) is best answered *within subject* over a few laboratory sessions. The systemic question (“does sustained redirection/retention change anything?”) requires *sustained between-subject assignment* with repeated sampling. The protocol therefore nests an acute crossover (Phase 1) inside a longitudinal RCT (Phase 2) in the same cohort, so that each participant’s confirmed mechanical responder status informs their longitudinal allocation.

3 Knowledge-Gap → Trial-Element Coverage Matrix

Each previously identified gap is mapped to the design element that addresses it, with an honest note where a gap is only partially resolvable.

#	Knowledge gap	Trial element that addresses it	Resolvability
1	No clinical study of the injaculation technique itself	Phase 1 crossover with instrumented force, PEU, optional SBA & pelvic-floor EMG	Fully addressable
2	Dose-response (force / location / timing) unknown	Phase 1 graded-force dose-finding limb; fractional-polynomial modelling	Fully addressable
3	Completeness of redirection unquantified	Continuous retrograde-fraction endpoint via split-void mass accounting	Fully addressable
4	Human fate of unejaculated sperm contested	Nested mass-balance sub-study (§13) + epididymal/vesicle/prostate biomarkers	Partial — indirect; mechanism needs histology/animal work
5	Injaculation vs plain abstinence never compared	Arms C vs B (matched orgasm cadence vs no orgasm)	Fully addressable
6	Hormonal effects of retrograde specifically unstudied	Full endocrine panel across arms incl. C; arm C vs A contrast	Fully addressable
7	No expectancy-controlled design has existed	Sham arm D + Credibility/Expectancy Questionnaire as covariate/mediator	Fully addressable
8	Retracted testosterone result never replicated at power	wk-1 sampling targets the day-7 claim; powered mixed model; registration planned pre-enrolment	Fully addressable
9	Objective performance under control unmeasured	Anaerobic/aerobic/strength + cognitive batteries at 0/4/8 wk	Fully addressable
10	Safety of the forceful technique unstudied	Uroflow/PVR, IPSS/ICIQ, UTI surveillance, AE log, force ceiling, DSMB	Fully addressable
—	Literal “sperm → energy” transmutation	Explicitly out of scope: unfalsifiable; only proxies tested	Not a testable gap

4 Objectives & Hypotheses

4.1 Primary objectives

- **O1 (mechanical):** Quantify the retrograde fraction produced by standardized true perineal compression vs sham, and the proportion of men who can achieve it.
H1: true compression produces a higher retrograde fraction than sham (H0: no difference).
- **O2 (endocrine):** Determine whether the 8-week ejaculatory condition alters the serum total-testosterone trajectory.
H2: at least one arm differs from antegrade control in testosterone trajectory (H0: identical trajectories).

4.2 Key secondary objective

- **O3 (mechanism vs belief):** Determine whether actual ejaculatory redirection (C) differs from the sham technique with identical framing (D) on a composite vitality–performance index.
H3: $C \neq D$ (H0: any apparent benefit is explained by expectancy, i.e. $C = D$). falsification engine

4.3 Further secondary & exploratory objectives

Between-arm contrasts on free testosterone, SHBG, LH, FSH, prolactin, estradiol, cortisol, DHEA-S, inhibin B; semen parameters and DNA fragmentation; antisperm antibodies; inflammatory markers; anaerobic/aerobic/strength performance; cognition; mood, fatigue, sexual function, sleep; and the sperm-fate mass balance. All are explicitly hypothesis-generating and FDR-controlled.

5 Trial Design Overview

Single-protocol, single-cohort, two-phase design:

Stage	Weeks	What happens	Purpose
Screening & consent	−3 to −2	Eligibility, GU exam, baseline labs, instrument training	Enrol, characterize baseline
Run-in	−2 to 0	Standardized 72-h ejaculatory cadence; duplicate baseline endocrine draws averaged	Stabilize baseline, reduce noise
Phase 1 (crossover)	0	3 laboratory orgasm sessions (no-pressure / true / sham) in randomized order, ≥48 h apart, + dose-finding limb	Mechanical characterization; validate & calibrate the manipulation; assign responder status
Phase 2 (parallel RCT)	0–8	Randomize 1:1:1:1 to A/B/C/D; repeated endocrine, performance, cognitive, psychometric sampling	Test systemic/conservation claims under expectancy control
Follow-up	8–12	Washout, safety re-assessment, endpoint semen analysis	Reversibility & safety

Blinding. A behavioral sexual intervention cannot be double-blinded — a participant always knows whether he reached orgasm. The design mitigates this three ways: (1) outcome assessors, laboratory analysts, and statisticians are blinded to arm; (2) arm **D** delivers a credible sham (perineal pressure at a non-bulbar site, identical instructions and framing to C) so that belief is held constant between the two “technique” arms; (3) expectancy is measured (Credibility/Expectancy Questionnaire) and entered as a covariate and tested as a mediator. Randomization uses permuted blocks stratified by age band and baseline testosterone tertile, with central allocation concealment.

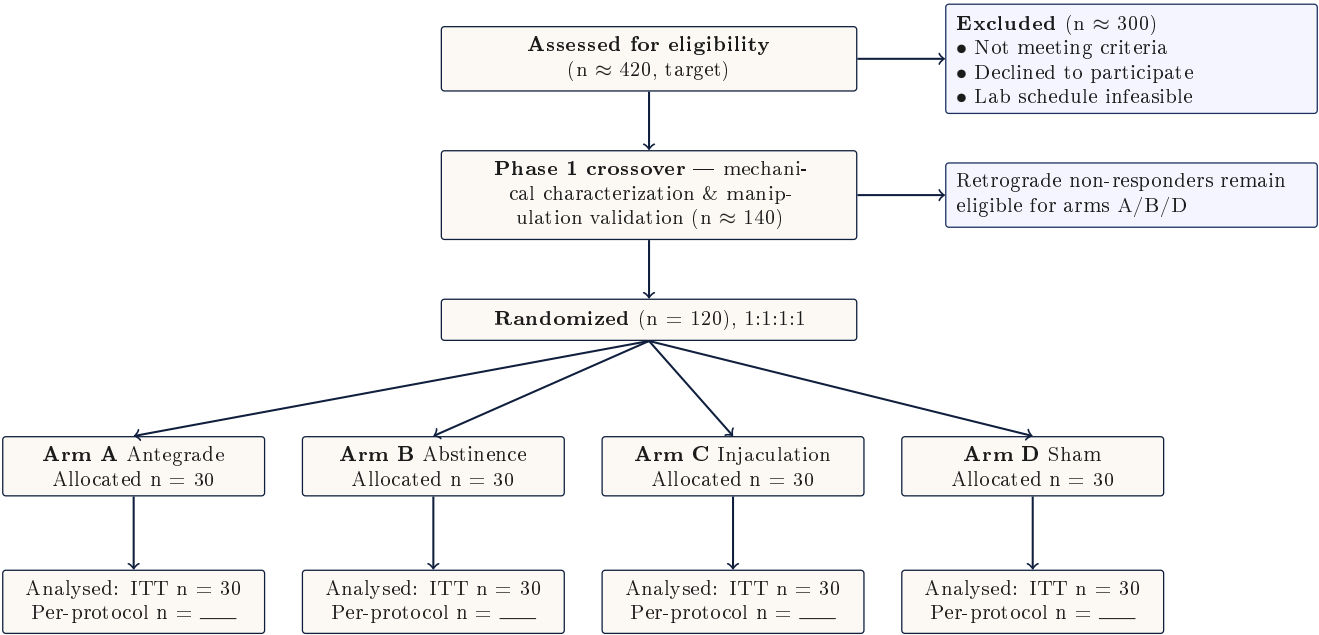


Figure 1. Planned participant flow (CONSORT). Sample sizes are recruitment targets; per-arm discontinuation and per-protocol counts (—) are completed at trial end.

6 Study Population

6.1 Inclusion criteria

- Cisgender or transgender men, 18–45 years, with native testicular endocrine function.
- Baseline morning total testosterone within the laboratory reference range.
- Able to self-stimulate to orgasm and to provide semen/urine samples on schedule.
- Willing to follow the assigned ejaculatory cadence and complete diaries.
- Able to give informed consent in English or French.

6.2 Exclusion criteria

- Hypogonadism, hyperprolactinemia, or other untreated endocrinopathy; diabetes mellitus.
- Chronic prostatitis / chronic pelvic pain syndrome; recurrent UTI; urethral stricture; active hematuria.
- Neurological disease affecting ejaculation (multiple sclerosis, Parkinson disease, spinal cord injury).
- Prior bladder-neck, prostate, or retroperitoneal surgery; pelvic radiotherapy.
- Current α -blockers (e.g., tamsulosin, silodosin), antidepressants affecting ejaculation (SSRIs/SNRIs), 5- α -reductase inhibitors, exogenous androgens, or recreational drugs altering ejaculation.
- Pre-existing anejaculation or diagnosed retrograde ejaculation.
- Couple actively attempting conception during the trial window.
- Night-shift work or recent transmeridian travel (testosterone circadian confound).

Feasibility realism. Recruitment for an intimate, lab-based protocol is hard, and not every participant will achieve retrograde redirection. Phase 1 deliberately precedes randomization so that confirmed mechanical responders can be allocated to arm C; non-responders contribute fully to arms A/B/D and to the mechanical dataset. Target screen-to-enrol ratio $\approx 3:1$.

7 Phase 1 — Acute Mechanical Crossover

7.1 Conditions (within-subject, randomized order, ≥ 48 h apart)

Code	Condition	Manipulation	Collected
P1-N	No pressure (reference)	Orgasm with no perineal contact	Full antegrade ejaculate + split-void PEU
P1-T	True compression	Standardized firm pressure at the bulbar urethra at the onset of emission	Any antegrade ejaculate + split-void PEU (+ SBA in sub-sample)
P1-S	Sham compression	Matched-duration pressure at a non-bulbar perineal site / sub-threshold force	Antegrade ejaculate + split-void PEU
P1-D	Dose-finding limb (sub-set)	Graded force $\times$ timing grid under instrumented sensor	PEU per trial $\rightarrow$ dose-response surface

7.2 Phase 1 endpoints

- **Primary:** retrograde fraction = urine-recovered sperm $\div$ (antegrade + urine-recovered sperm), per condition.

- Categorical confirmation of retrograde ($>10\text{--}15$ sperm/HPF, centrifuged) and responder status (achieves $\geq 50\%$ redirection under P1-T).
- Dose-response: minimal effective force, optimal timing window, location sensitivity.
- Ejaculate volume, antegrade sperm yield, and (optional) bulbospongiosus sEMG amplitude/pattern.
- Acute tolerability (pain, discomfort, hematuria).

All participants self-administer; no investigator physical contact. Instrumented pressure is delivered via a calibrated self-applied sensor logging force and timing.

8 Phase 2 — Longitudinal Parallel-Group RCT

8.1 Arms (1:1:1:1, 8 weeks)

Arm	Protocol	Cadence	Emission route	Framing
A Antegrade control	Ejaculate to completion normally	Every 72 h	Antegrade (verified absent retrograde)	Neutral
B Abstinence	No orgasm for the period	None	n/a	Retention practice
C Injaculation	Orgasm + true bulbar compression	Every 72 h	Retrograde (PEU-confirmed each session)	Retention practice
D Sham-injaculation	Orgasm + sub-bulbar pressure	Every 72 h	Antegrade preserved (PEU-confirmed)	Retention practice (identical to C)

8.2 The contrast logic

Contrast	Isolates	Answers
B vs A	Orgasm vs none	The classic retention question (controlled replication of the abstinence literature)
C vs A	Retrograde vs antegrade at matched cadence	Does the emission route itself matter?
C vs B	Redirection vs simple abstention	Does diverting differ from retaining?
C vs D	Real redirection vs identical belief/ritual	Is any benefit physiological or purely expectancy?
D vs A	Belief/ritual alone	Pure expectancy effect

8.3 Adherence verification

Daily electronic diaries; in-lab confirmatory sessions (PEU each) at weeks 1, 4, 8 to verify retrograde in C and its absence in A/D; biomarker plausibility checks for abstinence in B (seminal-vesicle volume on ultrasound and post-window semen volume). Non-adherence is logged for per-protocol analysis.

9 Outcome Measures — Full Battery

“Measure everything we can,” organized by domain. Confirmatory endpoints are flagged; all others are FDR-controlled exploratory.

9.1 Mechanical / manipulation check **confirmatory (Ph1)**

Retrograde fraction; PEU sperm/HPF; suprapubic bladder aspiration (sub-sample); instrumented perineal force; bulbospongiosus sEMG; ejaculate volume.

9.2 Endocrine (fasting, 0800 ± 30 min) **total T = confirmatory (Ph2)**

Total testosterone; free testosterone (equilibrium dialysis or SHBG/albumin-calculated); SHBG; LH; FSH; prolactin; estradiol; cortisol; DHEA-S; inhibin B. Sampled at baseline (run-in mean of two), week 1, 2, 4, 8. Week-1 sampling specifically targets the retracted day-7 abstinence claim.

9.3 Reproductive

WHO-2021 semen analysis (volume, concentration, total count, progressive motility, morphology, vitality); sperm DNA fragmentation index; antisperm antibodies (MAR/immunobead). Baseline and week 8 for antegrade-producing arms.

9.4 Immune / inflammatory

hs-CRP; IL-6 (exploratory); routine urinalysis and culture (also safety surveillance).

9.5 Physical performance (0 / 4 / 8 wk)

Grip dynamometry; countermovement-jump power; Wingate anaerobic peak and mean power; submaximal aerobic capacity (cycle ergometer); body composition (DXA or BIA).

9.6 Cognition (0 / 2 / 4 / 8 wk)

Psychomotor vigilance task; n-back working memory; simple and choice reaction time; Stroop interference.

9.7 Validated psychometrics (weekly)

Subjective Vitality Scale; Profile of Mood States; Multidimensional Fatigue Inventory (MFI-20); International Index of Erectile Function (IIEF-15); Sexual Desire Inventory (SDI-2); Pittsburgh Sleep Quality Index + wrist actigraphy; Perceived Stress Scale (PSS-10).

9.8 Expectancy / blinding integrity **critical covariate**

Credibility/Expectancy Questionnaire; “guess-your-arm” item; belief-in-retention-benefit scale. Baseline, week 4, exit.

9.9 Urological safety (0 / 8 wk + continuous AE log)

Uroflowmetry (Q_{max}); post-void residual; IPSS; ICIQ-MLUTS / ICIQ-UI SF; dysuria/hematuria/pain diary; genitourinary exam.

Composite vitality–performance index (pre-specified)

To give the “energy” claim one principled operationalization rather than inviting selective reporting, a single z-scored composite is defined a priori: Subjective Vitality (+), MFI fatigue (–), PVT speed (+), grip/CMJ power (+), and POMS vigor–fatigue (+), equally weighted after standardization. This composite is the dependent variable for the key C-vs-D contrast (O3).

10 Schedule of Assessments

Assessment	Screen (−3w)	Run-in (−2→0)	Ph1 sessions	Wk 0 base	Wk 1	Wk 2	Wk 4	Wk 8	F/U (12w)
Eligibility, consent, GU exam	•								•
Instrument / technique training	•	•							
Randomization (1:1:1:1)				•					
Crossover orgasm sessions (N/T/S)			•						
Retrograde fraction / PEU			•		•		•	•	
Endocrine panel (T, free T, SHBG, LH, FSH, PRL, E2, cortisol, DHEA-S, inhibin B)	•	••		•	•	•	•	•	•
Semen analysis + DFI + ASA	•							•	•
hs-CRP / IL-6 / urinalysis+ culture	•			•			•	•	
Performance battery (grip, CMJ, Wingate, aerobic, body comp)				•			•	•	
Cognitive battery (PVT, n-back, RT, Stroop)				•		•	•	•	
Psychometrics (SVS, POMS, MFI, IIEF, SDI-2, PSQI, PSS) — weekly		•		•	•	•	•	•	•
Actigraphy (continuous)		•	•	•	•	•	•	•	
Expectancy (CEQ, guess-arm, belief scale)				•			•	•	
Urological safety (uroflow, PVR, IPSS, ICIQ)	•			•				•	•
Mass-balance sub-study (sub-set)				◦ window	◦				
Adverse-event review (continuous)	•	•	•	•	•	•	•	•	•

• = performed; •• = duplicate baseline averaged; ◦ = nested sub-study window. Diaries are completed daily throughout.

11 Sample Size & Statistical Power

Enrol 140 to yield ≥ 120 evaluable participants (≈ 30 per arm) after an anticipated $\leq 15\%$ attrition.

Phase 2 primary (testosterone trajectory). A linear mixed-effects model with five repeated measurements and an assumed within-subject correlation of $\rho \approx 0.6$ provides $\geq 80\%$ power, at a two-sided $\alpha = 0.025$ reserved for the primary endocrine contrast under the testing hierarchy, to detect a between-arm standardized difference of approximately **0.5 SD** in the testosterone trajectory. The trial is thus powered for **moderate** effects and is deliberately not powered to confirm trivially small ones; a null at this resolution is itself informative, given that the retracted prior report implied a $\sim 45\%$ change that would be detectable many times over.

Phase 1 primary (retrograde fraction). With ≥ 120 participants each contributing paired true-vs-sham sessions, the within-subject design yields $> 90\%$ power to detect a 0.20 absolute difference in retrograde fraction at $\alpha = 0.05$, and precise estimation of responder prevalence (95% CI half-width < 0.10).

Key secondary (C vs D). Powered to detect ≈ 0.6 SD on the composite vitality index between the two technique arms — the smallest difference that would distinguish a physiological signal from expectancy at the planned n .

If recruitment is the binding constraint, a pre-specified fallback collapses to three arms (A/B/C) or converts Phase 2 to a within-subject crossover with washout, raising power for fixed n at the cost of carry-over assumptions.

12 Statistical Analysis Plan

12.1 Models

- **Primary (Phase 2):** `outcome ~ arm × time + baseline + age + BMI + expectancy0 + (1 | subject)`, REML estimation, unstructured or AR(1) covariance selected by information criteria. Pre-specified contrasts as in §8.2.
- **Primary (Phase 1):** mixed model / GEE on retrograde fraction across conditions; logistic regression for responder status; dose-response by fractional polynomials.

12.2 Multiplicity — the central discipline of a “measure-everything” trial

A hierarchical gatekeeping procedure protects family-wise error for confirmatory claims, tested in fixed order: **(1)** Phase 1 retrograde fraction → **(2)** Phase 2 total-testosterone arm×time → **(3)** composite vitality index, C vs D. Testing stops at the first non-significant gate. The entire remaining panel (all other hormones, semen, immune, performance, cognition, psychometrics) is **exploratory**, controlled by Benjamini–Hochberg FDR at $q = 0.05$, and may not support confirmatory conclusions.

12.3 Mechanism vs belief

Causal mediation analysis tests whether expectancy (CEQ) mediates any arm effect on the vitality composite; a large mediated proportion would indicate a placebo-dominated effect even if C vs A is “positive.”

12.4 Populations & missing data

Intention-to-treat (primary); per-protocol (adherence- and PEU-verified, including confirmed retrograde in C); safety set. Mixed models accommodate data missing at random; sensitivity analyses use multiple imputation and a tipping-point analysis. The SAP will be locked, and the trial prospectively registered

on ClinicalTrials.gov, before enrolment and before any data unblinding. **This protocol has not yet been registered; prospective registration is a prerequisite to commencing enrolment, not a step already completed.**

13 Biochemical-Fate Sub-Study (Gap #4)

In a nested subset ($n \approx 20\text{--}30$) during a controlled abstinence window, serial quantification estimates where unejaculated sperm goes:

- **Mass balance:** daily split-void PEU sperm counts (voided fraction) plus full semen sampling at window open/close. The fraction not accounted for by voiding or terminal ejaculate constitutes the inferred resorbed/cleared fraction.
- **Compartment localization via accessory-gland biomarkers:** neutral α -glucosidase (epididymal), fructose (seminal vesicle), zinc and citrate (prostate) — to localize where retained fluid is processed.
- **Immune exposure:** antisperm-antibody dynamics across the window, relevant to the resorption and retrograde-exposure questions.

Honest limitation. The definitive human mechanism — whether and where spermatozoa are phagocytosed or dissolved, and at what rate — is not resolvable non-invasively. This sub-study yields an *indirect* mass-balance estimate and hypotheses; mechanistic closure requires histological and animal work that is outside the scope of a human trial. The protocol states this explicitly rather than over-claiming.

14 Safety Monitoring & Risk Controls

- **Force ceiling:** a urologist sets an instrumented maximum pressure below the tissue-injury threshold; the self-applied sensor enforces a hard cutoff.
- **Known/theoretical risks monitored:** urethral trauma, hematuria, dysuria, urinary tract infection, and exacerbation of pelvic-floor dysfunction. Chronic retrograde flow itself is generally benign (fluid is voided), so the novel risk is the manual technique, not the redirection.
- **Surveillance:** AE diary (CTCAE-graded), urinalysis/culture at each in-lab visit, uroflow/PVR and symptom scores at baseline and week 8.
- **Oversight:** an independent Data & Safety Monitoring Board reviews pooled AEs; pre-specified stopping rules for excess genitourinary injury or infection.
- **Exclusion safety net:** active hematuria, UTI, or stricture at screening defers or excludes.

15 Ethics, Consent & Reporting

- Research-ethics-board approval before enrolment; conduct per the Declaration of Helsinki and applicable Canadian TCPS-2 standards.
- Detailed informed consent addressing the intimate nature of procedures; all stimulation is self-administered in private facilities with no investigator physical contact.
- Bilingual (English/French) consent and materials.
- De-identified data handling; secure storage; participant right to withdraw without penalty; compensation for time and travel.
- Prospective registration on ClinicalTrials.gov before first enrolment; reporting per CONSORT (with the non-pharmacologic and harms extensions); SAP and protocol archived and version-controlled.

16 Limitations & Scope Boundaries

- **Unblindable intervention.** Participants know whether they reached orgasm; the sham arm and expectancy covariate mitigate but cannot eliminate this. The C-vs-D contrast is the strongest available defense.
- **The literal “transmutation into energy” claim is out of scope** — it is unfalsifiable as physics and is not tested; only operationalized vitality/performance proxies are. A positive proxy result is not evidence of “energy transmutation,” and the report will say so.
- **Human sperm-fate mechanism is only partially addressable** (see §13).
- **Generalizability.** Healthy men 18–45; any effects may differ by age, comorbidity, or baseline hormonal status.
- **Adherence in self-report arms** (especially abstinence) depends on honest diaries, partially corroborated by biomarkers.

Within these bounds, the trial closes every *testable* gap identified: it characterizes and doses the technique, quantifies redirection, separates redirection from abstention and from belief, measures the full endocrine/reproductive/immune/performance/cognitive/psychometric footprint, surveils safety, and estimates the contested fate of retained sperm — while refusing to manufacture an answer to the one claim that is not a scientific question.

17 References (Key Sources)

- [1] M. Gray et al. Contemporary management of ejaculatory dysfunction. *Translational Andrology and Urology*, 2018.
- [2] Ryan Abbott, Ian Ayres, Edward Hui, and Ka-Kit Hui. Effect of perineal self-acupressure on constipation: a randomized controlled trial. *Journal of General Internal Medicine*, 2015. The sole randomized trial of perineal self-pressure — for constipation, not ejaculation.
- [3] Ming Jiang, Xin Jiang, Qiang Zou, and Jin-wen Shen. A research on the relationship between ejaculation and serum testosterone level in men. *Journal of Zhejiang University-Science A*, 4(2):236–240, 2003. doi: 10.1631/jzus.2003.0236. Retracted article.
- [4] I. A. Wibisono et al. Does sexual abstinence affect hormone levels in men? a systematic review. *Andrologia*, 53(9): e14144, 2021.
- [5] B. M. Ayad et al. Revisiting the relationship between the ejaculatory abstinence period and semen characteristics. *International Journal of Fertility and Sterility*, 11(4):238–246, 2018.
- [6] Center for Male Reproductive Medicine and Microsurgery. The epididymis. <https://maleinfertility.org>, 2026. States the exact fate of unejaculated human epididymal spermatozoa is unknown.
- [7] Sperm survival versus degradation in the mammalian epididymis: a hypothesis. *Biology of Reproduction*, 71(5):1405, 2004. PMID 15215193.
- [8] Rebuttal of a role for the epididymis in sperm quality control by phagocytosis of defective sperm. *Journal of Cell Science*, 115(1):5, 2002.
- [9] B. Lino, A. Braden, and K. Turnbull. Fate of unejaculated spermatozoa. *Nature*, 213:594–595, 1967. doi: 10.1038/213594a0.
- [10] A. Mehta et al. Defining the “normal” postejaculate urinalysis. *Journal of Andrology*, 2012. doi: 10.2164/jandrol.111.015974.
- [11] Snopes. Does not ejaculating for 7 days increase testosterone by 45%? Snopes fact-check, 2024. Claim rated False; underlying study retracted and unreplicated.
- [12] R. Clay et al. Ejaculatory frequency and male fertility: a literature review of evidence-based recommendations. *Translational Andrology and Urology*, 2026.
- [13] Sperm recovery from urine in men with retrograde ejaculation. *Advances in Laboratory Medicine*, 2024. Reviews lack of consensus on post-ejaculatory urinalysis criteria.
- [14] Suprapubic bladder aspiration: a novel method in the diagnosis of retrograde ejaculation, 2022. Distinguishes true retrograde from retained urethral ejaculate.

Source status legend used throughout: **established** (physiology of emission direction; PEU diagnostic anchor), **contested** (human sperm fate; conservation/testosterone effects), **unfalsifiable** / **out of scope** (literal energetic transmutation). Volatile claims were live-verified at protocol authoring.