

# **Utilizing Acutonics Therapy in the Non-Invasive Treatment of Peyronie's Disease**

Tami Holly

8/12/26

# Table of Contents

|                                                                                 |         |
|---------------------------------------------------------------------------------|---------|
| <b>Literature Review</b>                                                        | 2       |
| 1.1 Overview of Peyronie's Disease                                              | 2       |
| 1.2 Alternative and Complementary Treatments for Peyronie's Disease             | 8       |
| 1.3 Acutonics Sound Therapy: Theory and Mechanism                               | 15      |
| 1.4 Sound Therapy in the Context of Erectile Dysfunction and Peyronie's Disease | 23      |
| <br><b>Case Study as a Research Model</b>                                       | <br>31  |
| 2.1 Rationale for Case Study Approach                                           | 31      |
| 2.2 Case Study Participant                                                      | 39      |
| 2.3 Description of the Case Study Protocol                                      | 46      |
| 2.4 Data Collection Methodology                                                 | 55      |
| <br><b>Study</b>                                                                | <br>64  |
| 3.1 Study Design and Methodology                                                | 71      |
| 3.2 Treatment Administration and Monitoring                                     | 80      |
| 3.3 Data Analysis Techniques                                                    | 80      |
| <br><b>Outcomes and Summary</b>                                                 | <br>89  |
| 4.1 Results of the Study                                                        | 89      |
| 4.2 Interpretation of Results                                                   | 100     |
| 4.3 Implications for Future Research and Clinical Practice                      | 114     |
| 4.4 Summary                                                                     | 127     |
| <br>References                                                                  | <br>143 |

## 1.1 Overview of Peyronie's Disease

Peyronie's disease is a disorder of the penis marked by the formation of fibrous scar tissue, known as plaque, within the tunica albuginea. The tunica albuginea is the dense, elastic tissue that surrounds the erectile bodies of the penis and helps maintain rigidity during an erection. When plaque develops, the affected tissue loses some of its normal stretch. This uneven change in the tissue can pull the erect penis toward the affected area and lead to curvature, shortening, narrowing, indentation, or other changes in shape. (National Institute of Diabetes and Digestive and Kidney Diseases [NIDDK], 2019; Sandean et al., 2024)

The exact cause of Peyronie's disease is not known in every case. Penile injury is one widely accepted factor in its development. An injury may occur as a single event or through repeated smaller injuries during sexual activity, sports, or other physical activity. Damage to the tunica albuginea can cause localized bleeding and inflammation. Abnormal wound healing may then lead to fibrosis and plaque formation. Many men, however, do not recall a specific injury before their symptoms began. Autoimmune processes and a predisposition toward connective tissue disorders may also play a role in some cases. (NIDDK, 2019; Sandean et al., 2024)

## Clinical Presentation

Peyronie's disease can affect far more than the angle of an erection. Common signs and symptoms include a palpable plaque or hard area within the penis, penile curvature, pain, loss of length or girth, narrowing or indentation, and erectile dysfunction. Symptoms vary widely. Some men retain the ability to have intercourse, while a more severe deformity can make penetration difficult, painful, or impossible. (European Association of Urology [EAU], 2026; NIDDK, 2019)

The disease has traditionally been described as having an active, or acute, phase followed by a stable, or chronic, phase. During the active phase, plaque develops and penile shape may continue to change. Pain, particularly during erections, may occur during this period. The active phase can last for several months and, in some cases, as long as 18 months. The stable phase begins once the deformity stops changing for a sustained period. Pain often decreases with time, although curvature, shortening, plaque, and erectile problems may remain. (EAU, 2026; NIDDK, 2019)

This distinction matters because pain alone does not provide a fully reliable way to determine whether the disease remains active. Current clinical literature places greater weight on whether the curvature and other features of the deformity continue to change over time. (EAU, 2026)

## Diagnosis and Assessment

A urologist can often diagnose Peyronie's disease through a medical and sexual history combined with a physical examination. The history may include the onset and course of symptoms, pain, changes in penile shape, erectile function, ability to have intercourse, previous penile or pelvic injury, family history, and other health conditions. During the physical examination, the clinician may be able to feel plaque even when the penis is not erect. (EAU, 2026; NIDDK, 2019)

Assessment of the erect penis provides further information about the direction and degree of curvature and other deformities. A clinician may induce an erection with an injection when a direct examination is needed, while photographs taken at home may also help document curvature over time. Ultrasound is not required for every diagnosis, but it can provide added information about plaque and penile tissue when clinically indicated. (EAU, 2026; NIDDK, 2019)

Tracking these features over time is especially useful because Peyronie's disease can change during its active phase. Measurements of curvature, penile length, erectile function, pain, and the patient's ability to engage in sexual activity can provide a broader picture than curvature alone. (EAU, 2026)

## Prevalence and Quality of Life

Estimates of how many men have Peyronie's disease vary greatly. The National Institute of Diabetes and Digestive and Kidney Diseases reports that about 1 in 100 adult men in the United States have received a diagnosis, while symptom-based research suggests that the true number may exceed 1 in 10. A recent clinical review likewise notes a wide range in published prevalence estimates and places a reasonable overall estimate near 9 to 10 percent of adult men. Differences in study methods, diagnostic criteria, age groups, and willingness to report symptoms make an exact prevalence difficult to establish. (NIDDK, 2019; Sandean et al., 2024)

Underreporting deserves particular attention. Peyronie's disease affects a part of the body closely tied to sexuality, body image, and intimate relationships. Embarrassment may keep some men from seeking care or discussing their symptoms. The effects can include difficulty with intercourse, erectile dysfunction, anxiety or depression, concerns about penile appearance and sexual ability, and strain within intimate relationships. (NIDDK, 2019; Nelson & Mulhall, 2013; Sandean et al., 2024)

These effects make quality of life an important part of assessment. A change in penile curvature can be measured in degrees, yet that number alone does not show how the condition has affected a man's confidence,

sexual function, partnership, or sense of well-being. (EAU, 2026; Nelson & Mulhall, 2013)

## **Current Treatment Options**

Treatment depends on the stage of the disease, the degree and type of deformity, pain, erectile function, and the extent to which Peyronie's disease interferes with sexual activity. Some men with mild curvature, little or no pain, and no meaningful trouble with intercourse may not need active treatment. Men with more disruptive symptoms may consider nonsurgical or surgical care. (EAU, 2026; NIDDK, 2019)

Nonsurgical approaches include penile traction or vacuum devices, intralesional injections, pain management, and other medical therapies. Collagenase injections have been used to break down components of plaque and reduce curvature in selected patients. Other injectable treatments have included interferon and verapamil. Oral drug therapy has shown limited ability to correct penile curvature, while extracorporeal shockwave therapy has been studied chiefly for relief of penile pain rather than correction of the deformity itself. (EAU, 2026; NIDDK, 2019)

Surgery remains an option for men with stable disease when the deformity prevents satisfactory sexual intercourse or when other approaches have not provided an acceptable result. Surgical methods include plication, plaque

incision or excision with grafting, and penile prosthesis placement when significant erectile dysfunction is also present. Each approach carries its own risks and tradeoffs, including possible changes in penile length, sensation, and erectile function. (EAU, 2026)

The range of available treatments reflects the complexity of Peyronie's disease. Fibrosis and curvature form only part of the clinical picture. Erectile function, pain, penile length and shape, sexual function, emotional well-being, and relationship effects may all influence how a man experiences the condition and what he considers a meaningful treatment outcome. This broader view provides an important foundation for examining complementary, non-invasive approaches and the role they might play alongside established medical care. (EAU, 2026; Nelson & Mulhall, 2013)

## **1.2 Alternative and Complementary Treatments for Peyronie's Disease**

The search for effective non-surgical treatment has long been part of Peyronie's disease care. Surgery can correct severe deformity in selected men, yet many patients seek ways to reduce symptoms or improve function without an operation. Conservative care has therefore included oral drugs, penile traction, vacuum devices, intralesional injections, extracorporeal shockwave

therapy, and combinations of these methods. Researchers have also explored newer approaches such as platelet-rich plasma and other regenerative therapies. Evidence for many of these treatments remains mixed. (Aditya et al., 2020; Chierigo et al., 2026; European Association of Urology [EAU], 2026)

This uncertainty creates a difficult setting for both patients and clinicians. Peyronie's disease can affect penile shape, erectile function, sexual activity, body image, and intimate relationships, while the response to treatment differs from one man to another. Current European Association of Urology guidance states that studies of conservative treatment often produce conflicting results, which makes firm recommendations difficult. A 2026 comparison of major Peyronie's disease guidelines reached a similar conclusion and identified non-surgical treatment as an area where evidence remains limited and recommendations still differ. (Chierigo et al., 2026; EAU, 2026)

## **The Search for Non-Invasive Treatment**

Interest in non-invasive care reflects a basic treatment need: some men want symptom relief and improved sexual function while avoiding surgery or injections. Conservative treatment may be especially relevant during the active stage of Peyronie's disease, when pain or changes in deformity may still be present. Treatment goals can include pain relief, preservation or recovery of penile length, improvement in curvature, support of erectile function, and

prevention of further loss of function. The evidence supporting each approach varies considerably. (El-Sakka, 2021; EAU, 2026)

Penile traction therapy is one of the better studied mechanical approaches. Traction devices apply a sustained stretching force to penile tissue over repeated treatment periods. Current European guidelines state that traction therapy, either alone or as part of a multimodal approach, may reduce curvature and increase penile length, although the studies supporting it have important limitations. (Almsaoud et al., 2023; EAU, 2026)

Vacuum erection devices have also been explored as a mechanical treatment. Both traction and vacuum approaches are appealing because they work without surgery and seek to influence tissue through physical force. Research has examined these therapies alone and in combination with other treatments, but evidence has not established one conservative combination as consistently superior. A systematic review and meta-analysis of combination therapies found that the available evidence was insufficient to support the conservative combinations it examined over monotherapy. The authors also noted methodological concerns in many of the included studies. (El-Sakka, 2021; Pyrgidis et al., 2022)

## **Extracorporeal Shockwave Therapy**

Extracorporeal shockwave therapy is particularly relevant to the study of non-invasive Peyronie's treatment because it applies mechanical energy to tissue from outside the body. The therapy has been investigated for its possible effects on pain, plaque, curvature, and erectile function. (Wang et al., 2023)

Results have differed across studies and outcome measures. A systematic review of randomized trials found evidence that extracorporeal shockwave therapy may reduce pain and plaque size, but it did not find a significant improvement in penile curvature or sexual function. Current European guidelines likewise state that shockwave therapy may be offered for penile pain during the active phase but should not be expected to improve curvature or plaque size. (EAU, 2026; Wang et al., 2023)

These findings are important because improvement in one feature of Peyronie's disease does not mean that the underlying deformity has improved. Pain, plaque characteristics, curvature, erectile function, penile length, and sexual function are separate outcomes and should be measured as such. (EAU, 2026; Wang et al., 2023)

The shockwave literature also raises a question that is relevant to this thesis: whether externally applied forms of mechanical energy can affect symptoms associated with Peyronie's disease. Existing shockwave studies cannot

answer whether sound-based vibrational therapy would produce the same, similar, or different effects. The forms of energy, methods of delivery, treatment intensity, and proposed mechanisms are not interchangeable.

## **Acupuncture, Massage, and Complementary Care**

Complementary medicine offers another way of approaching chronic health problems, particularly when symptoms involve both physical and emotional well-being. Acupuncture, therapeutic massage, mind-body practices, and other non-invasive methods may be used alongside conventional care for many health conditions. (National Center for Complementary and Integrative Health [NCCIH], 2025)

I cannot verify from the clinical literature reviewed for this section that acupuncture or therapeutic massage can reduce Peyronie's plaque, correct penile curvature, or reverse the structural changes of Peyronie's disease. They should therefore not be presented as established treatments for the disease.

That distinction is important for an integrative study. A therapy may have value for relaxation, pain, stress, or general well-being without evidence that it changes penile fibrosis. Those outcomes should remain separate when evaluating complementary treatment. (NCCIH, 2025)

Acupuncture is particularly relevant to the theoretical framework of Acutonics because Acutonics draws upon acupuncture points and meridian

theory while applying vibration rather than needles. The relationship provides a conceptual bridge between Traditional Chinese Medicine and sound-based treatment. It does not, however, establish clinical efficacy for Peyronie's disease. Evidence for Acutonics must be assessed on its own terms rather than assumed from the use of acupuncture points. (Acutonics Institute of Integrative Medicine, n.d.)

## **Integrative Care and the Limits of Current Evidence**

The growing number of conservative treatments reflects how difficult Peyronie's disease can be to manage. A systematic review of medical, non-invasive, and minimally invasive therapies concluded that an ideal conservative treatment had yet to be established and stressed the need for well-designed, randomized, placebo-controlled studies. A later network meta-analysis of 24 randomized studies involving 1,643 participants also found that results depended in part on the statistical method used, highlighting continued uncertainty within the treatment literature. (El-Sakka, 2021; Lee et al., 2024)

Non-conventional therapies have expanded as well. Researchers have investigated approaches including platelet-rich plasma, hyaluronic acid, extracorporeal shockwave therapy, stem cell therapy, and other experimental treatments. A review of these therapies found that much of the evidence was

preliminary and that several approaches had been studied mainly in animal models or small human studies. (Aditya et al., 2020)

These gaps leave room for careful exploratory research, but they also place limits on the conclusions that such research can support. A complementary therapy should not be described as effective for Peyronie's disease simply because a patient improves during treatment. Changes must be documented, competing explanations considered, and physical outcomes separated from subjective experiences. (Yin, 2018)

This distinction is especially important for a single-participant case study. Such a study can document what was done, what changed over time, what the participant experienced, and whether the findings warrant further study. It cannot establish that a treatment caused those changes or predict how other men with Peyronie's disease would respond. (Yin, 2018)

The limited state of conservative treatment research provides the setting for the present investigation of Acutonics. The purpose is exploratory. The case study examines whether measurable and self-reported changes occur during a course of Acutonics treatment while documenting the treatment process in enough detail to support critical review. This approach allows Acutonics to be examined as a complementary therapy without assuming its effectiveness in advance. (Chierigo et al., 2026; El-Sakka, 2021)

### **1.3 Acutonics Sound Therapy: Theory and Mechanism**

Acutonics is a non-invasive sound therapy system that combines tuning forks, sound, vibration, acupuncture points, and concepts drawn from Traditional Chinese Medicine. The method uses calibrated tuning forks placed directly on the body or held within the field around the body. Acutonics describes its approach as a blend of sound healing, Chinese medicine, psychology, and energetic medicine. Within the system, practitioners choose points and frequencies according to the needs and patterns they identify in each client. (Acutonics Institute of Integrative Medicine, n.d.; Carey & de Muynck, 2007)

The use of acupuncture points gives Acutonics a framework that differs from sound therapies based mainly on listening to music or receiving low-frequency vibration through a chair, table, mattress, or other device. Acutonics practitioners may place activated tuning forks on acupuncture points, trigger points, areas of pain, or other selected sites. Treatment may also include chimes, gongs, singing bowls, and other sound tools. (Acutonics Institute of Integrative Medicine, n.d.; Carey & de Muynck, 2007)

## **Foundations in Traditional Chinese Medicine**

Traditional Chinese Medicine provides one of the main frameworks for Acutonics practice. Within this model, health depends in part on the balanced movement of Qi and Blood through the body. Acupuncture uses selected points along meridians to address patterns of imbalance. Acutonics uses many of these same points but stimulates them with the vibration of tuning forks rather than acupuncture needles. Acutonics describes these points as access sites through which vibration can reach the meridian and energetic systems. (Carey & de Muynck, 2007; Ponton & Ponton, 2019)

This distinction is central to the treatment model used in the present case study. The initial assessment identified Qi stagnation and Blood stasis as the primary Traditional Chinese Medicine patterns, with treatment goals of regulating Qi, moving Blood, reducing scar tissue, and increasing penile length.

The early treatment planning also considered Kidney and Liver patterns, circulation, inflammation, Blood stasis, and local scar tissue. Proposed acupuncture points included Ren 4, Ren 6, Du 4, Liver 3, Liver 8, Spleen 4, Spleen 6, Stomach 36, Du 20, and Kidney 3.

These concepts belong to the theoretical framework of Traditional Chinese Medicine and should not be treated as equivalent to biomedical descriptions of penile fibrosis, vascular function, inflammation, or connective

tissue repair. The two systems use different models to describe health and disease.

## **Frequency, Vibration, and Resonance**

Sound begins with vibration. A tuning fork oscillates at a set frequency when struck, producing both an audible tone and mechanical vibration. When an activated fork makes contact with the body, that vibration can be physically felt at the point of contact. (Acutonics Institute of Integrative Medicine, n.d.; National Museum of American History, n.d.)

Acutonics builds a therapeutic system around this basic physical property. Its tuning forks use frequencies associated within the Acutonics system with the Earth, Moon, Sun, planets, and other celestial bodies. Practitioners use individual frequencies and intervals according to their stated therapeutic and archetypal qualities. (Acutonics Institute of Integrative Medicine, n.d.; Carey & de Muynck, 2007)

Acutonics describes frequency, resonance, and vibration as core principles of the method. The practitioner selects combinations of forks and treatment points based on the client's presentation rather than applying one fixed frequency to every condition. (Acutonics Institute of Integrative Medicine, n.d.; Carey & de Muynck, 2007)

The treatment record in this case reflects that individualized approach. Frequencies and point combinations changed as treatment progressed and as the participant reported new experiences. The first treatments included combinations such as Sedna Octave, Chiron/Mars, Venus, Solar, Mars/Earth Day, Pluto/New Moon, Uranus, Neptune, Zodiac, and Jupiter. Later sessions placed greater emphasis on direct work over the penile scar tissue and repeatedly used combinations involving Uranus, Neptune, Jupiter, New Moon, Hygiea, Mercury, Chiron, Zodiac, and Sedna.

### **What Might Vibration Do in the Body?**

The physical transmission of vibration into the body is not unique to Acutonics. Vibroacoustic therapy is a broader field in which low-frequency sound produces vibration that a person can hear and feel. Researchers have studied vibroacoustic methods in settings such as pain management and rehabilitation. (Kantor et al., 2022)

A 2022 scoping review examined 20 studies of vibroacoustic therapy in adults with pain. The studies varied greatly in treatment methods, frequencies, devices, and clinical populations. The authors found that the research was too sparse to determine which properties of vibroacoustic therapy, if any, provide reliable benefits for pain. They called for randomized controlled trials and better

reporting of treatment variables such as frequency, amplitude, pulsation, and loudness. (Kantor et al., 2022)

This research provides useful background for a study involving therapeutic vibration, but vibroacoustic therapy should not be treated as interchangeable with Acutonics. The methods differ in how vibration is produced, where it is applied, the frequencies used, treatment duration, and the theory guiding treatment. (Kantor et al., 2022)

Direct placement of a vibrating tuning fork over or near an affected area creates a possible mechanical pathway through which vibration reaches local tissue. The fact that vibration reaches tissue does not establish that it can remodel Peyronie's plaque, reduce fibrosis, restore penile blood flow, or alter the course of Peyronie's disease.

I cannot verify that Acutonics tuning fork frequencies break down fibrotic plaque, alter collagen structure, increase penile circulation, or produce tissue regeneration in Peyronie's disease. These possible mechanisms should therefore be treated as research questions rather than established effects.

## **Planetary Frequencies and Therapeutic Meaning**

Acutonics also assigns therapeutic and archetypal qualities to its planetary frequencies and intervals. This aspect of the system moves beyond

the mechanical effects of vibration and into its energetic and psycho-spiritual framework. Acutonics states that its tuning forks are calibrated according to frequencies associated with planetary bodies and that practitioners select these frequencies according to their therapeutic qualities. (Acutonics Institute of Integrative Medicine, n.d.; Carey & de Muynck, 2007)

This framework shaped the treatment choices in the present case. Early planning associated Mars with inflammation, Jupiter with expansion and growth, Neptune with dissolution and unknown origins, Zodiac with scar tissue and dispersion, and Pluto with themes involving sexuality and intimacy.

These associations form part of Acutonics theory. I cannot verify through biomedical research that planetary frequencies have the specific biological effects assigned to them within the Acutonics system. For this reason, the case study records these frequency choices as elements of the treatment protocol rather than presenting their proposed effects as established physiology. (Carey & de Muynck, 2007)

## **Acutonics as a Whole-Person Treatment**

Acutonics treatment also considers emotional and psycho-spiritual patterns alongside physical symptoms. This whole-person framework became relevant during the case study because the participant's response did not always match the practitioner's expectations. (Carey & de Muynck, 2007)

The treatment notes state that the first sessions were planned partly around how the practitioner expected Peyronie's disease to affect the participant emotionally. During treatment, the practitioner observed that he appeared to process his condition differently than expected. The plan then changed, and later sessions placed greater weight on direct scar-tissue work while psycho-spiritual treatment was used when themes arose from the participant's history or conversations.

This change illustrates an important feature of individualized treatment. The protocol developed in response to the participant rather than remaining fixed around assumptions made before treatment began.

The participant later discussed childhood instability, his relationship with his mother, and patterns within romantic relationships. These conversations led to treatment focused on the Chong Mai and other points and frequencies chosen within the Acutonics framework for emotional and psycho-spiritual work. These experiences form part of the case narrative, although they do not establish a causal relationship between emotional history and Peyronie's disease.

## **Current Evidence for Acutonics**

Acutonics reports a history of clinical case studies and practitioner documentation and states that its methods have been developed through decades of clinical use. Its published materials include case-study collections

describing applications of the system across a range of conditions. (Ponton & Ponton, 2010)

That body of practitioner experience differs from the type of evidence produced through controlled clinical trials.

I cannot verify a body of peer-reviewed randomized controlled trials that establishes the clinical effectiveness of Acutonics for Peyronie's disease. I also cannot verify clinical research showing that Acutonics can reduce penile plaque or curvature.

Independent research on vibroacoustic therapy provides broader evidence that therapeutic sound and vibration are being studied in clinical settings, particularly in relation to pain. The evidence remains limited and highly varied, and it cannot be used as proof that Acutonics produces the same outcomes. (Kantor et al., 2022)

This gap in the literature helps define the role of the present case study. The study does not begin with the assumption that Acutonics can treat Peyronie's disease. It documents an individual course of care, the frequencies and points used, changes in treatment strategy, measurable physical findings, and the participant's reported experience. The results can then be considered alongside what is known about Peyronie's disease, sound and vibration, and the limits of a single-participant research model.

## **1.4 Sound Therapy in the Context of Erectile Dysfunction and Peyronie's Disease**

Research directly examining sound therapy for Peyronie's disease remains sparse. I cannot verify published clinical trials that have tested Acutonics as a treatment for Peyronie's disease. Research on other forms of externally applied acoustic or mechanical energy, however, offers useful context for asking whether this type of non-invasive therapy warrants further study.

Extracorporeal shockwave therapy has received the most attention in Peyronie's research. Low-intensity pulsed ultrasound has also been studied in erectile dysfunction. These therapies differ substantially from Acutonics in their energy levels, equipment, treatment protocols, and proposed biological effects. Their findings cannot be transferred to Acutonics. They do show that researchers have investigated the use of externally delivered acoustic energy within male sexual medicine. (Wang et al., 2023; Yilmaz et al., 2026)

### **Extracorporeal Shockwave Therapy and Peyronie's Disease**

Extracorporeal shockwave therapy, or ESWT, sends focused acoustic pressure waves into tissue from outside the body. Its use in Peyronie's disease has

been studied for more than two decades, with mixed results. (Hauck et al., 2000; Wang et al., 2023)

Early studies produced some encouraging findings. A 2000 case-controlled study of 22 men treated with ESWT reported a decrease in penile curvature, although improvement in pain, subjective symptoms, and quality of intercourse did not differ significantly from the control group. Other early studies reported changes in pain, plaque characteristics, or curvature in subsets of patients. The methods and outcomes differed considerably between studies, which made the overall evidence difficult to interpret. (Hauck et al., 2000)

Later research has produced a more restrained view. A 2023 systematic review and meta-analysis examined randomized controlled trials published between 2000 and 2022. The authors found that ESWT showed significant effects on plaque size and pain scores but did not significantly improve penile curvature or sexual function. They concluded that ESWT may have value for pain and plaque-related outcomes while acknowledging the limits of the available evidence. (Wang et al., 2023)

The distinction among these outcomes matters. A therapy might reduce pain without correcting curvature. A change in plaque size might occur without a meaningful improvement in sexual function. Peyronie's disease therefore

requires more than one measure when treatment results are assessed.

(European Association of Urology [EAU], 2026; Wang et al., 2023)

Current European Association of Urology guidance reflects this distinction. The guideline supports the possible use of ESWT to treat penile pain during the active phase but states that ESWT does not improve penile curvature or plaque size. The evidence for a dependable structural effect remains insufficient. (EAU, 2026)

## **Acoustic Energy and Erectile Function**

Erectile function is another relevant part of this discussion because Peyronie's disease and erectile dysfunction often occur together. Erectile dysfunction may arise from vascular factors, difficulty caused by the penile deformity, psychological distress, or a combination of factors. (EAU, 2026; Sandean et al., 2024)

Low-intensity pulsed ultrasound, or LIPUS, has recently drawn interest as a non-invasive treatment for erectile dysfunction. Unlike diagnostic ultrasound, LIPUS delivers low-intensity acoustic energy for a proposed therapeutic effect. (Yilmaz et al., 2026)

A 2026 systematic review identified six clinical studies involving 615 patients who received LIPUS for erectile dysfunction. Three were randomized

controlled trials and three were non-randomized studies. The review included research involving erectile dysfunction associated with Peyronie's disease as well as other conditions. The authors found encouraging results but also stressed the need for standardized protocols, longer follow-up, and larger randomized trials. (Yilmaz et al., 2026)

This research remains distinct from Acutonics. LIPUS devices generate acoustic energy under controlled technical parameters and should not be treated as equivalent to tuning forks. The findings therefore cannot establish that Acutonics will improve erectile function.

They do broaden the research setting. Male sexual medicine has investigated several non-invasive energy-based methods rather than limiting treatment research to drugs, injections, traction, and surgery. (Wang et al., 2023; Yilmaz et al., 2026)

## **Mechanical Energy and Fibrotic Tissue**

The presence of fibrotic plaque makes the question of tissue response especially important in Peyronie's disease. Plaque develops within the tunica albuginea and can limit the normal stretch of the tissue during erection. A treatment intended to change curvature would therefore need to influence the structural problem itself or alter the way the affected and surrounding tissues respond during erection. (Sandean et al., 2024)

Some early ESWT researchers proposed that shockwaves might act directly on Peyronie's plaques. Ultrasound-guided studies examined plaque size and structure before and after treatment, with some reporting changes in subsets of participants. Later research has failed to establish a consistent structural effect. (De Berardinis et al., 2010; Hauck et al., 2000; Wang et al., 2023)

A long-term study of 150 eligible men treated with ESWT found improvement in pain and curvature among some participants but did not find a statistically significant reduction in plaque size. The researchers concluded that pain showed the strongest response, while plaque size and sexual intercourse outcomes were less satisfactory. (De Berardinis et al., 2010)

These mixed findings caution against a simple assumption that applying acoustic energy to fibrotic tissue will break apart scar tissue. (De Berardinis et al., 2010; Wang et al., 2023)

A physically vibrating tuning fork placed near Peyronie's plaque raises a research question about how mechanical vibration interacts with fibrotic penile tissue. I cannot verify that Acutonics vibration breaks down collagen, softens Peyronie's plaque, remodels the tunica albuginea, or produces the tissue effects sought through ESWT or other energy-based therapies.

The difference in scale is also important. Shockwave therapy uses specialized medical equipment to produce acoustic pressure waves under

defined treatment settings. Acutonics uses tuning forks whose vibrations are applied through direct contact or within the surrounding field. Similar language involving sound, vibration, or frequency does not mean that the treatments deliver the same physical stimulus. (Acutonics Institute of Integrative Medicine, n.d.; Hauck et al., 2000)

## **Why Acutonics Warrants Separate Study**

The rationale for examining Acutonics in Peyronie's disease therefore does not depend on claiming that shockwave or ultrasound research proves a mechanism for tuning forks. A more defensible rationale begins with the characteristics of the therapy itself.

Acutonics provides a non-invasive means of applying vibration directly to selected areas of the body and to acupuncture points. The treatment can also be adapted throughout a course of care according to the practitioner's assessment and the participant's response. This makes it possible to study physical findings alongside pain, erectile function, sexual function, and the participant's experience of treatment. (Acutonics Institute of Integrative Medicine, n.d.)

The present case also provides a clear reason to explore that question. The participant reported that his Peyronie's symptoms began after a serious motorcycle collision. Several weeks after the accident, he noticed bruising and

blood pooling around the testicles, followed by painful erections and, within several months, penile deformity. At the start of this study, he had received no treatment for his Peyronie's symptoms. The initial case record documented approximately 60 degrees of curvature, visible scar tissue, penile deformity, loss of length and girth, and reduced confidence in his sexual ability.

This history shaped the early treatment goals. The planning notes identified reduction of scar tissue, increased penile length, reduction of erection-related pain, improved circulation, and attention to Blood stasis within the Traditional Chinese Medicine framework. They also proposed direct local treatment of the scar tissue during each session.

The treatment record later shows that local scar-tissue work became a major part of the protocol. During one February treatment period, two sessions per day focused solely on scar tissue and repeatedly used combinations of Uranus/Neptune, Jupiter/New Moon, Mercury/Jupiter, and Hygiea/Nibiru.

Those treatment choices belong to the Acutonics framework. The case study can document the frequencies used and changes observed during the treatment period, but it cannot establish a biomedical mechanism for those frequencies.

## **Establishing an Exploratory Rationale**

The scientific gap surrounding Acutonics makes careful study more important, rather than less. Research begins with questions that can be observed and recorded. In this case, those questions include whether penile curvature changes during treatment, whether the participant reports changes in erectile function or sexual activity, whether penile length or girth changes, whether pain changes, and how the participant experiences the treatment process.

The case record contains measures that can help address several of these questions. The initial assessment recorded curvature at approximately 60 degrees, an erectile dysfunction severity rating of 4 to 5, a pain rating of zero, and an International Index of Erectile Function score of 56. Later assessments recorded curvature measurements of 50 degrees, 45 degrees, and 40 degrees, along with changes in self-reported erectile function.

Those observations are meaningful case-study data. They do not, on their own, show that Acutonics caused the changes. Natural variation, measurement error, the course of the disease, other activities or health factors, and other unknown influences must remain possible explanations.

This distinction defines the purpose of the present study. The existing literature shows that researchers have explored non-invasive acoustic and

mechanical energy in Peyronie's disease and erectile dysfunction, but it does not establish Acutonics as a treatment for either condition. The present case study therefore asks a narrower question: what measurable and self-reported changes occurred during one participant's course of Acutonics therapy, and do those observations provide enough grounds to support further study? (Wang et al., 2023; Yilmaz et al., 2026)

That question allows the work to remain exploratory while still taking the participant's physical changes and lived experience seriously.

## **2. Case Study as a Research Model**

### **2.1 Rationale for the Case Study Approach**

The case study has a long history as a means of building and sharing knowledge in Chinese medicine. Rather than seeking only general principles that apply across large populations, the case preserves knowledge that arises from a particular practitioner, patient, place, and course of treatment. Morris describes this as local and context-dependent knowledge, in which the practitioner's observations, choices, and actions become part of what the case has to teach. The value of the case therefore extends beyond the final

outcome. It also lies in documenting how the practitioner thought through the problem and how that thinking changed as the case unfolded. (Morris, n.d.)

This approach is well suited to the present study of Acutonics therapy and Peyronie's disease. The purpose of this case is not to create a treatment formula for Peyronie's disease or to suggest that one participant's experience predicts how another person will respond. The case instead documents one participant's course of treatment in depth. It preserves his history and symptoms alongside the Traditional Chinese Medicine assessment, Acutonics treatment choices, physical measures, participant reports, practitioner observations, and changes in clinical strategy.

## **The Case as a Form of Clinical Knowledge**

Chinese medical case writing has historically placed strong emphasis on clinical rationale, pattern differentiation, treatment, and the progress of care. Morris contrasts this with the greater emphasis Western medical cases tend to place on signs, symptoms, disease processes, laboratory findings, imaging, and therapeutics. Chinese medical cases often place the practitioner's thought and treatment strategy closer to the center of the record. (Morris, n.d.)

This distinction matters in the present study because the treatment did not follow a fixed protocol from beginning to end. The practitioner began with a working assessment of Qi stagnation and Blood stasis and treatment goals that

included regulating Qi, moving Blood, reducing scar tissue, and increasing penile length. The first treatment plan drew from this assessment as well as the practitioner's expectations about the physical and emotional effects of Peyronie's disease.

Clinical experience with the participant soon challenged some of those expectations.

During the first three-day treatment period, the practitioner observed that the participant did not appear to process his condition in the way she had expected. She concluded that some of the points and frequencies chosen during the first two sessions had been ineffective or only marginally useful. On the third day, she substantially changed the treatment plan.

Within a standardized clinical trial, such variation could be viewed mainly as a problem because it makes the intervention harder to reproduce. Within a Chinese medical case study, the change also carries information. The reasoning that led to the change, the participant's response, and the treatment choices that followed become part of the case. (Morris, n.d.; Yin, 2018)

Morris describes the Chinese medical case as one that captures the clinical interaction through pertinent history, signs and symptoms, diagnosis, treatment planning, and treatment. He further notes that a sequence of treatments allows the practitioner to describe a strategy and then show how the

next course of treatment developed from it. That process closely reflects the structure of this case. (Morris, n.d.)

## **Local Knowledge and the Individual Participant**

The present study is best understood as an intrinsic case study. Morris describes the intrinsic case as an examination of a single event whose value lies in the unique experience itself. Such a case does not depend on proving that the findings apply to a wider population. (Morris, n.d.)

This distinction is important when studying Peyronie's disease. Men can differ in the cause and severity of the condition, location of plaque, type of deformity, erectile function, pain, disease stage, medical history, emotional response, and effect on intimate relationships. The participant in this study also brought a specific history that shaped the case. (European Association of Urology [EAU], 2026)

His symptoms followed a serious motorcycle collision in 2020. Several weeks after the accident, he noticed bruising and blood pooling around the testicles. Painful erections followed, and penile deformity became apparent within several months. At intake, the case record documented approximately 60 degrees of curvature, visible scar tissue, changes in the head of the penis, loss of length and girth, erectile difficulties, and reduced confidence in his sexual ability.

The value of the case lies partly in keeping these details together. Removing the participant's history in favor of curvature measurements alone would leave out much of the setting in which assessment and treatment took place.

## **Clinical Reasoning as Part of the Case**

Morris places particular value on the case as a record of expert observation and action. In this model, clinical reasoning is not background material that disappears from the final report. The practitioner's decisions form part of the knowledge being documented. (Morris, n.d.)

That principle is especially relevant to Acutonics, where treatment selection may draw from acupuncture theory, energetic assessment, physical findings, participant feedback, and the practitioner's response to changes observed during treatment. (Acutonics Institute of Integrative Medicine, n.d.)

The treatment record shows this process throughout the case. Early sessions included work along the Du Mai, Ren Mai, Chong Mai, Kidney points, Bladder points, and direct treatment over scar tissue. By February, treatment had shifted toward repeated direct work over the penile scar tissue. Later sessions again broadened when the participant discussed family history, emotional patterns, and relationships, leading to treatment that included the Chong Mai and a psycho-spiritual focus.

The case study makes it possible to preserve this sequence rather than presenting the final treatment strategy as though it had been known from the beginning. (Morris, n.d.)

This is an important part of clinical learning. Morris notes that both successful and failed approaches can contribute to the growth of knowledge when they receive critical thought. Earlier Chinese medical case literature tended to favor successful cases, while contemporary practice has increasingly recognized that cases involving failure or a series of unsuccessful approaches may also offer useful lessons. (Morris, n.d.)

The early treatments that appeared less useful therefore remain relevant to this thesis. They show how the practitioner tested an initial understanding of the case, observed the participant's response, questioned her assumptions, and revised the treatment strategy.

## **Qualitative and Quantitative Knowledge**

The Chinese medical case does not require a choice between numerical measurement and lived experience. Morris notes that case presentations can contain both quantitative and qualitative data. The essential element is the preservation of the practitioner's thought and treatment strategy within the management of the case. (Morris, n.d.)

The present case follows that model.

Quantitative records include measurements of penile curvature and standardized patient-reported measures of erectile, sexual, and Peyronie's-specific outcomes. At intake, curvature was recorded at approximately 60 degrees and the International Index of Erectile Function score was 56. Later assessments recorded curvature at 50 degrees, 45 degrees, and 40 degrees, while the IIEF score increased to 65 during part of the treatment period. The Peyronie's Disease Questionnaire was also administered repeatedly during the study to document Peyronie's-specific patient-reported outcomes.

Qualitative information includes the participant's descriptions of sexual function, confidence, bodily changes, emotional experience, and response to treatment. Practitioner observations and clinical reasoning add another layer to the record.

These forms of information serve different purposes. A participant's report should remain identified as a participant report. A practitioner's energetic perception should remain identified as a practitioner observation. A physical measurement should be presented as a measurement. Keeping those categories distinct allows the reader to consider the full case without treating every form of observation as equivalent evidence.

## **The Boundaries of Knowledge From a Single Case**

The strength of the case study is also its boundary. Its knowledge remains closely tied to the person and circumstances from which it arose. Morris argues that the case provides access to concrete, practical knowledge and can contribute to scientific thought without necessarily producing the law-like or probabilistic generalizations sought through population research. Instead, cases provide resources for comparison, critical thought, and further inquiry. (Morris, n.d.)

The present study therefore does not seek to prove that Acutonics treats Peyronie's disease. A single case cannot establish such a claim. The absence of a control group also means that changes occurring during treatment cannot automatically be attributed to Acutonics. (Morris, n.d.; Yin, 2018)

The case can answer a different set of questions. It can document what was observed in this participant, how treatment decisions were made, how those decisions changed over time, what the participant reported, what measurable changes occurred during the study period, and what the practitioner learned through the course of care. (Morris, n.d.)

This distinction allows the case to retain both clinical meaning and appropriate limits. The participant is not reduced to a set of measurements, and the observations are not expanded beyond what a single case can support.

The result is a detailed record of one therapeutic encounter that can serve as a source of reflection, critical thought, and questions for future study. (Morris, n.d.)

## **2.2 Case Study Participant**

The participant in this case study was a 59-year-old man who had recently retired. At the beginning of the study, he described himself as active and generally healthy. He worked out with weights each day, was sober, and described himself as happy and positive.

His history with Peyronie's disease began after a serious motorcycle accident in 2020.

### **Participant History**

In late summer 2020, the participant was involved in a head-on motorcycle collision. The accident caused extensive injuries along the left side of his body, including a broken rib, punctured lung, and hip pain. Several weeks later, he noticed bruising and blood pooling around his testicles. Painful erections followed. Within several months, he noticed a change in the shape of his penis.

The participant also reported a penile injury during childhood. He recalled a toilet seat slamming onto his penis, leaving a vertical scar that remained visible along the length of the penis.

The case records do not establish whether this childhood injury played a role in his later Peyronie's disease. The participant's history places the onset of painful erections and penile deformity after the 2020 motorcycle accident. The case therefore records both injuries while avoiding a conclusion about their relationship to the disease.

At the initial assessment, the participant had visible scar tissue, deformity of the head of the penis, loss of penile length and girth, and approximately 60 degrees of curvature. He reported reduced confidence in his sexual ability. His pain level was zero at the start of the study, his self-rated erectile dysfunction severity was 4 to 5, and his International Index of Erectile Function score was 56. The Peyronie's Disease Questionnaire was also administered as a Peyronie's-specific patient-reported outcome measure.

The absence of pain at intake did not reflect his earlier experience with the condition. He reported that painful erections had begun after the motorcycle accident and lasted for approximately one year.

Peyronie's disease had also changed his sexual life. During the initial interview, he described sexual activities that he could no longer do, or could not

do as well as he had before the onset of the condition. His earlier research interview also documented a loss of approximately one inch of penile length and a period during which he and his wife stopped having sex because his erections were painful.

The participant had not received treatment for his Peyronie's symptoms before entering this case study. He did not want surgery. His comments reflected concern about the possible outcome of surgery and a preference for a non-surgical approach.

These factors supported his participation in an exploratory study of a non-invasive Acutonics approach.

## **The Initial Interview**

The interview became an important part of understanding the participant's experience.

The participant and I had known each other for approximately 18 years. We had discussed intimate subjects during our friendship, yet I had not known about the genital injury following his motorcycle accident or the extent to which Peyronie's disease had affected his sexual life and marriage. We had not been in contact at the time of the accident.

I used open-ended questions during the interview and encouraged him to expand on his answers. This approach brought forward details that might not have emerged through questions focused only on physical symptoms.

The conversation was difficult for him at times. My notes record visible anxiety and self-consciousness while he discussed his condition, including physical shaking. As the interview continued, he shared more about the effect of the disease on his sexual relationship, his confidence, and his experience following the accident.

His response during the interview reinforced the need to give him space to describe the condition in his own words rather than assuming what Peyronie's disease meant to him.

## **Practitioner Perspective**

My interest in studying Peyronie's disease developed before this case began. I had been reading clinical research as well as conversations among men discussing their experiences with the disease. What I found led me to think more deeply about the lack of simple, reliable, non-invasive treatment choices for men living with penile curvature and related sexual changes.

The personal accounts affected me as much as the clinical information. Men were describing changes in sexual function, intimate relationships,

confidence, and their feelings about their bodies. Those accounts led me to think about Peyronie's disease as a condition whose effects could reach well beyond the physical presence of scar tissue.

My early treatment planning reflected that broad view. I considered the penile scar tissue and circulation along with inflammation, Blood stasis, Qi stagnation, and the possible emotional and psycho-spiritual effects of the condition. My proposed treatment goals included reducing scar tissue, increasing penile length, improving circulation, and addressing pain if it was present.

I also entered the study with assumptions about how Peyronie's disease might affect this participant emotionally.

Those assumptions became one of my first lessons in the case.

During the first two treatment days, I chose some points and frequencies based on how I thought a man would process the physical and emotional effects of Peyronie's disease. As I worked with the participant and listened to him, I began to see that his response did not fit the picture I had formed before treatment. My notes from the first treatment period record my conclusion that some of those early choices were ineffective or only marginally useful. I changed the treatment plan on the third day.

This change shaped the rest of the case. I began placing greater weight on what the participant was showing and telling me during treatment rather than on what I expected him to experience.

Direct treatment of the penile scar tissue became a stronger part of the approach. Later sessions also returned to emotional and psycho-spiritual work when the participant himself brought forward family history, childhood experiences, and relationship patterns during our conversations.

The difference was important to me. I did not want to assign an emotional meaning to his Peyronie's disease and then treat that assumption as though it came from him. When personal themes emerged through his own account, I could consider them within the Acutonics framework while keeping his experience at the center of the treatment.

## **My Relationship to the Case**

My existing friendship with the participant is an important part of the study and should be stated openly. I was not meeting him for the first time as a research subject. Our long history may have helped create enough trust for him to discuss highly personal aspects of his condition. At the same time, knowing him before the study may have shaped my expectations and interpretations.

I also held several roles during the case. I interviewed the participant, developed the treatment strategy, administered the Acutonics treatments, recorded physical and subjective findings, observed his responses, and changed the protocol as the case developed.

These roles create the possibility of practitioner bias. My observations should therefore remain distinguishable from the participant's own reports and from numerical measurements. (Yin, 2018)

This distinction becomes particularly important when evaluating physical changes. A participant's statement that his erection felt fuller is evidence of his experience. My observation that the penis appeared fuller is a practitioner observation. A recorded curvature measurement is a separate form of data. None of these should be substituted for another.

My connection to the participant also gave the case personal meaning. I had known him for many years without knowing what he had experienced after the accident or how deeply the condition had entered his intimate life. His willingness to speak about it showed me how easily a condition involving sexual health can remain hidden, even from people someone knows well.

The case therefore began with an interest in whether Acutonics might be useful for a man with Peyronie's disease, but the participant's story shaped how I approached that question. His history, preferences, physical findings, sexual

experience, and responses during treatment guided the course of care. My role was to document that process while remaining aware of the difference between what I measured, what I observed, and what he told me.

## **2.3 Description of the Case Study Protocol**

The Acutonics treatment protocol developed throughout the case in response to the participant's history, physical presentation, Traditional Chinese Medicine assessment, practitioner observations, and feedback during treatment. The study did not use one fixed set of points and frequencies for every session. Treatment changed as the case progressed.

The initial assessment identified Qi stagnation and Blood stasis as the primary Traditional Chinese Medicine patterns. The original treatment goals were to regulate Qi, move Blood, reduce scar tissue, and increase penile length. Early planning also considered circulation, inflammation, the effects of physical trauma, and direct treatment of the penile scar tissue.

Acutonics tuning forks were applied to selected acupuncture points and Extraordinary Vessels, along the spine and other areas of the body, and directly to the penile scar tissue. Treatment included both broader constitutional work and focused local treatment. The balance between these approaches changed over the course of the study.

## **Initial Treatment Period: January 29-31**

The first treatment period took place over three consecutive days, January 29 through January 31. The participant was moving his office at the time, which limited the schedule to one treatment each day. The first visit also included an extensive intake and interview.

The January 29 treatment began with Kidney 1 and Kidney 3 using Sedna Octave. Hua Tuo Jia Ji points were treated with Chiron/Mars, followed by Kidney 3 and Bladder 23 with Venus 6th and Solar 7th. Treatment along the Du Mai included Venus, Mars, and Mars/Hygiea combinations. Du 4, Du 20, Bladder 17, Ren 4, Ren 6, and Ren 17 were also included. Direct work on the penile scar tissue and injured left hip used Uranus 5th, Neptune 5th, Zodiac 3rd, and Jupiter.

The January 30 session continued some of the constitutional treatment while introducing other points and vessels. The treatment included Kidney 1 and Kidney 3, Hua Tuo Jia Ji, Kidney 3 and Bladder 23, the Chong Mai, Yang Wei Mai, Kidney 9, Liver 3, and Liver 8. Direct treatment of the penile scar tissue again included Uranus, Neptune, Zodiac, and Jupiter.

The treatment strategy changed more substantially on January 31. Sedna/New Moon and Low Mars/Earth Day combinations were applied across several points and vessels, including Du 4, Spleen 6, Du 6, Ren 14, Chong Mai,

Spleen 4, Ren 4, Ren 6, and Stomach 36. Direct treatment of the penile scar tissue and left hip continued.

The change followed my reassessment of the first two sessions. I had entered the case with assumptions about how the participant might experience Peyronie's disease physically and emotionally. His response did not fit some of those expectations. My notes from this period record my assessment that some of the original treatment choices seemed ineffective or only marginally useful. I therefore changed the treatment plan on the third day.

The January 31 session also included softly played theta frequencies in the background, a BioMat, Andara crystals, and approximately ten minutes of Reiki near the end of treatment. These additional therapies are included in the case record because they formed part of the treatment environment.

## **February 12-17: Focus on Scar Tissue**

The second concentrated treatment period took place from February 12 through February 17. The focus during this period shifted toward direct treatment of the penile scar tissue.

The treatment notes describe the intended schedule for this period as two treatments per day focused solely on scar tissue. The core sequence used

Uranus/Neptune, Jupiter/New Moon, Mercury/Jupiter, and Hygiea/Nibiru over the affected area.

Two treatments were recorded on February 12 and February 13. One treatment was recorded on February 14, followed by two treatments each on February 15, February 16, and February 17.

The frequency combinations continued to change within this period. Mars/Solar and Venus/Saturn were added on February 13. Sedna/Pluto was also tried during this session, although my notes record little apparent response to that combination at the time.

The February 14 session included Mercury/Jupiter, Hygiea/Nibiru, and Low Venus/Mars on Ren 1. The following treatments continued direct work on the penile scar tissue with variations of the frequency combinations used earlier in the week.

The participant reported a change in the appearance of the penis on February 16. He stated that the head appeared larger and seemed to have greater blood flow. My notes also record an observation of increased fullness. These observations were recorded as part of the treatment course. No vascular testing was performed to verify a change in penile blood flow.

## March Treatment

Direct scar-tissue treatment continued during March.

On March 3 and March 4, two short treatments were recorded on each treatment day. Frequencies used during these sessions included Uranus/Neptune, Jupiter, New Moon, Zodiac, and Hygiea. Saturn and Sedna/Pluto were added during the March 4 treatment.

The treatment broadened on March 6 after conversations with the participant brought forward personal and family experiences that became relevant to my Acutonics assessment. The session included Kidney 1 and Kidney 3, Hua Tuo Jia Ji, Ba Liao and the coccyx, Bladder 23 and Bladder 52, Spleen 9, and the Chong Mai. Frequencies included Sedna, Jupiter, Sun, Mars, Solar, Mercury, Pluto, Uranus, Neptune, New Moon, Chiron, Saturn, Venus, Nibiru, Earth Day, Ceres, and Hygiea. Direct treatment of the penile scar tissue was also included.

On March 7, direct scar-tissue treatment continued with Uranus/Neptune, Zodiac, Jupiter, New Moon, Hygiea, and Mars/Jupiter. The participant reported that he had awakened with an erection and felt that the curve appeared to be straightening.

Treatments between March 10 and March 14 continued to combine local scar-tissue work with broader treatment. The frequencies recorded during these

sessions included Uranus, Neptune, Jupiter, New Moon, Zodiac, Saturn, Mars, Pluto, Chiron, Venus, Mercury, and Hygiea.

## **Development of the Sedna-Based Approach**

The treatment strategy shifted again during the second half of March. Sedna became more prominent in the direct scar-tissue protocol.

On March 18, I used Sedna with Jupiter, Chiron/Nibiru, Mars, Zodiac, Saturn, Mercury, and Hygiea over the scar tissue. My treatment notes record my impression that Sedna appeared more effective within the Acutonics treatment than the Ohm-based approach I had been using.

This was a practitioner observation made within the Acutonics framework. I cannot verify that the Sedna frequency had a biological effect on the penile scar tissue.

The approach continued during treatments on March 20, 23, 24, 25, 29, 30, and 31. Sedna was paired with frequencies that included Zodiac, Uranus, Neptune, Mars, Jupiter, New Moon, Mercury, Chiron, Nibiru, and Hygiea. During later March sessions, the treatment often involved placing the Sedna fork on one side of the penis while applying a planetary fork to the other side.

This method became one of the more consistent features of the later local treatment protocol.

## **April Treatment Interruption and Resumption**

The participant was out of town from April 1 through April 22, creating an interruption in treatment.

Treatment resumed on April 23. Direct work on the penile scar tissue continued with Sedna paired with Uranus, Neptune, Zodiac, Jupiter, Nibiru, Full Moon, Mars, and Mercury. Chiron Unison and Chiron/Nibiru combinations were also used.

The April 26 session included broader body treatment in addition to direct scar-tissue work. Kidney 1 and Kidney 3 were treated with Sedna Octave. Hua Tuo Jia Ji received Mars/Venus and Solar/Jupiter, while Spleen 6 and Stomach 36 received Low Mars/Earth Day. Venus/Mars and Mercury/Jupiter were also used over areas associated within the treatment plan with the heart and throat.

An infrared cup was used on the participant's left hip and then on the lower back because marked tension was noted in that area. Direct penile scar-tissue treatment followed.

Scar-tissue treatments continued on April 28 and April 29 and again on May 1 and May 2. Two short treatments were recorded on May 2.

## **Treatment Frequency and Duration**

Treatment frequency varied throughout the case.

The January treatment period consisted of one session per day for three consecutive days. The February period was more intensive, with two treatments performed on several days. March included repeated local treatments as well as broader Acutonics sessions. The participant was out of town from April 1 through April 22, after which treatment resumed.

The May 5 notes record a discussion about increasing future treatment consistency to approximately nine or ten sessions each week, including at least one longer session.

The case records do not document a standard duration for every treatment. Several sessions are identified as short treatments, while later notes distinguish these from a proposed treatment lasting an hour or longer. I cannot verify a uniform session length from the available records.

## **Additional Therapies**

Acutonics tuning-fork treatment was the primary therapy under study, but other methods were used during some sessions.

The January 31 treatment included theta frequencies played softly in the background, a BioMat, Andara crystals, and approximately ten minutes of Reiki. Infrared cupping was used during the April 26 treatment for tension involving the participant's hip and lower back.

These methods were not used consistently throughout the entire case. Their inclusion is documented so that the treatment course reflects what the participant actually received.

The presence of adjunctive therapies also limits the ability to attribute any observed change solely to Acutonics. The case records what occurred during the overall treatment period rather than isolating the effect of each individual component. (Yin, 2018)

## **Evolution of the Protocol**

The treatment protocol developed through several stages. Early sessions used broader constitutional, Extraordinary Vessel, psycho-spiritual, and local approaches. The February treatments narrowed the focus toward repeated direct work on the penile scar tissue. March included both focused local work and broader treatments based on information that arose during the case. Sedna later became a more prominent part of the local protocol, and direct scar-tissue work remained central through the documented treatments on May 2.

No single Acutonics frequency or point combination was used as a standardized Peyronie's disease protocol throughout the study.

The record instead documents an individualized course of treatment. Frequencies and points were retained, changed, added, or removed according to my assessment of the participant and his response during the case. Direct application over the penile scar tissue became the most consistent feature of the treatment.

The protocol described here represents the treatment given to this participant. It should not be interpreted as an established Acutonics protocol for Peyronie's disease. I cannot verify that any individual frequency, interval, acupuncture point, or combination used in this case has a proven biological effect on Peyronie's plaque or penile fibrosis.

## **2.4 Data Collection Methods**

Data collection combined physical measurements, photographic documentation, standardized self-report questionnaires, participant reports, practitioner observations, and treatment records. These different forms of data were kept distinct so that measured findings, participant-reported experiences, and practitioner observations could be interpreted according to the type of evidence they represented.

## **P.D.A.D. Curvature Measurement**

Penile curvature was measured using the Peyronie's Disease Assessment Device, or P.D.A.D. The device provided a consistent method for recording the angle of curvature in degrees. (Urology Health Store, n.d.)

The baseline P.D.A.D. assessment documented approximately 60 degrees of curvature. Repeated measurements were taken during the study to track change over time.

Curvature decreased from approximately 60 degrees at baseline to 50 degrees in February and then to 45 degrees in March. The 45-degree measurement remained documented in April and during the May 4 through May 10 assessment period. On May 30, 2025, a photograph documented curvature at 40 degrees. This measurement occurred before the documented self-treatment period began.

The self-treatment log begins on June 8. A June 17 photograph again documented 40 degrees of curvature during the participant's self-treatment period. On August 19, 2025, after the self-treatment period, the final P.D.A.D. measurement with photographic documentation also showed 40 degrees.

## **Photographic Documentation**

Photographs were used with the P.D.A.D. measurements to document penile curvature over time. Each documented curvature result was photographed so that the recorded angle could be retained as part of the case record.

The photographs documented external penile curvature. They were not medical imaging and could not document the internal structure, size, composition, or density of the Peyronie's plaque.

The May 30 photograph is particularly important to the study chronology because it establishes that the 40-degree curvature had been documented before the recorded self-treatment period began. The June 17 and August 19 photographs subsequently documented the same 40-degree curvature during and after the self-treatment period.

## **Monitoring Erectile and Sexual Function**

Erectile and sexual function were monitored through the International Index of Erectile Function (IIEF), the Peyronie's Disease Questionnaire (PDQ), the participant's separate self-rating of erectile dysfunction severity, and reports made during and between treatment sessions.

The IIEF provided a standardized measure of erectile and sexual function, while the PDQ provided a validated Peyronie's-specific patient-reported measure of physical and psychological symptoms, penile pain, and symptom bother. (Hellstrom et al., 2013; Rosen et al., 1997)

The participant was encouraged to describe changes he noticed in erection quality, fullness, curvature, sexual function, and other aspects of his experience. These reports were entered into the treatment record as participant-reported findings.

The IIEF and PDQ served as standardized self-report measures and were administered repeatedly throughout the study, allowing changes in erectile and sexual function and the participant's experience of Peyronie's disease to be followed over time. The participant's separate erectile dysfunction severity rating was recorded as his own assessment and was not treated as a standardized clinical severity score.

This distinction allowed the study to retain standardized questionnaire data alongside the participant's own account of changes that mattered to him.

## **Monitoring Pain**

Pain was monitored because painful erections had been part of the participant's earlier history with Peyronie's disease.

Pain had resolved by the beginning of the Acutonics treatment period. The participant reported a pain score of zero at baseline, and the February, March, and April formal assessments also recorded zero. The May 4 through May 10 assessment recorded a pain rating of 1.

Because baseline pain was already zero, pain was not used as evidence of treatment improvement. It was monitored to document whether pain appeared or returned during the study.

## **Participant Feedback During Treatment**

Participant feedback formed an important part of ongoing monitoring.

Rather than waiting for formal assessment dates, I recorded changes the participant noticed between treatments.

These reports included his perceptions of penile curvature, erection quality, fullness, sexual function, and other changes that arose during the course of treatment. Participant feedback also helped guide later treatment decisions.

Self-reported findings were kept separate from physical measurements. A participant report that his erection felt fuller, for example, documented his experience but did not establish a measured change in penile girth or blood flow.

## **Practitioner Observation**

I monitored the participant's response during each clinical session and recorded observations that could help guide subsequent treatment.

These observations included responses to tuning-fork application, visible changes in penile appearance, perceived changes in the scarred area, emotional responses, and energetic findings assessed within the Acutonics framework.

Practitioner observations served a different role from P.D.A.D. measurements, photographs, and standardized questionnaires. They informed the clinical treatment process but were not treated as objective evidence of changes in internal penile tissue. (Yin, 2018)

This separation was especially important when working directly with the scarred area. Changes that could be seen or felt during treatment could be recorded as observations, but they could not confirm biological changes in the Peyronie's plaque.

## **Self-Treatment Outside the Clinical Protocol**

After the May 30 assessment and photograph documenting 40 degrees of curvature, the participant began self-treatment with Acutonics. The documented self-treatment log begins on June 8 and continues into August.

I cannot independently verify the participant's self-treatment methods, adherence, frequency or duration of treatment, which tuning forks or frequencies he used, or where and how he applied them.

For this reason, self-treatment was not considered an extension of the practitioner-administered clinical treatment protocol. Findings obtained after the documented self-treatment period began were identified separately when that distinction affected their interpretation.

Importantly, the May 30 photograph documenting 40 degrees occurred before the recorded self-treatment period began. The June 17 and August 19 measurements also documented 40 degrees, but those later findings cannot establish an additional treatment effect from self-treatment.

## **Treatment Records**

SOAP notes were maintained throughout the practitioner-administered portion of the study and provided the main chronological record of treatment and assessment.

The notes documented treatment dates, acupuncture points, Extraordinary Vessels, Acutonics frequencies and intervals, direct scar-tissue treatments, participant statements, practitioner observations, measurements, and changes in treatment strategy.

The records also documented variations in treatment frequency and interruptions in care. The treatment record allowed the timing of curvature measurements, photographs, participant reports, PDQ and IIEF assessments, and treatment changes to be viewed alongside the treatments I administered.

## **Medical Imaging**

Medical imaging, including ultrasound, was considered during the planning stage as a possible means of assessing changes in penile plaque and tissue. (European Association of Urology [EAU], 2026)

I cannot verify from the available records that penile ultrasound or another form of medical imaging was performed during the study.

Medical imaging is therefore not included as a completed data collection method. The study does not use imaging to make claims about plaque size, plaque composition, calcification, penile blood flow, collagen structure, or other internal tissue changes.

The photographs used throughout the study should also be distinguished from medical imaging. They documented external penile curvature and the P.D.A.D. measurements but did not show the internal structure of the Peyronie's plaque.

## Organization of the Data

The data were organized chronologically so that baseline findings could be compared with later measurements, photographs, questionnaire scores, participant reports, and practitioner observations during the defined study period.

Quantitative and documented physical data included P.D.A.D. curvature measurements and their accompanying photographs.

Standardized self-reported data included both the IIEF and the PDQ. The IIEF provided information about erectile and sexual function, while the PDQ provided Peyronie's-specific patient-reported information. (Hellstrom et al., 2013; Rosen et al., 1997)

Additional participant-reported data included erectile dysfunction severity ratings, erection quality, penile fullness, perceived changes in curvature, sexual function, confidence, and other experiences described during interviews and treatment.

Practitioner-recorded data included visual and tactile observations, energetic assessments within the Acutonics framework, clinical impressions, and changes made to the treatment plan.

Keeping these categories separate allowed each type of information to contribute to the case without assigning the same weight to every finding. A photographed P.D.A.D. curvature measurement, an IIEF or PDQ response, a participant's report of a fuller erection, and my observation of the scar tissue each provide different information. (Yin, 2018)

### **3. Study**

#### **3.1 Study Design and Methodology**

This study used an exploratory single-participant case study design to examine the use of Acutonics sound therapy in a participant with Peyronie's disease. The study followed the participant through an initial assessment, a series of practitioner-administered Acutonics treatments, repeated assessments during treatment, and follow-up. (Yin, 2018)

A case study design was chosen because Acutonics has not been established as a treatment for Peyronie's disease, and the purpose of this study was exploratory. The design allowed changes in the participant's condition to be followed over time while preserving detailed records of the treatment process, physical measurements, standardized patient-reported measures, participant reports, and practitioner observations. (Yin, 2018)

The central research question was:

“Can Acutonics sound therapy reduce the symptoms and progression of Peyronie’s disease?”

This question guided the study without assuming that treatment would produce a positive result. The main areas of interest were penile curvature, erectile and sexual function, Peyronie’s-specific symptoms and symptom bother, penile length and girth, pain, and the participant’s experience of his condition.

## **Initial Assessment**

The study began with a detailed intake and baseline assessment. The participant’s history included a serious motorcycle accident in 2020, followed by bruising and blood pooling around the testicles, painful erections, and the later development of penile deformity. He also reported a penile injury during childhood that left a visible vertical scar.

The baseline assessment documented approximately 60 degrees of penile curvature, visible scar tissue, deformity of the head of the penis, and reported loss of penile length and girth. Pain was zero at the start of the study. The participant self-rated his erectile dysfunction severity at 4 to 5, and his baseline International Index of Erectile Function score was 56.

The Peyronie's Disease Questionnaire (PDQ) and International Index of Erectile Function (IIEF) were used as standardized patient-reported measures throughout the study. The PDQ provided a Peyronie's-specific measure of physical and psychological symptoms, penile pain, and symptom bother, while the IIEF provided a standardized measure of erectile and sexual function. (Hellstrom et al., 2013; Rosen et al., 1997)

The initial assessment established the physical measurements, standardized questionnaire data, and participant-reported findings that would be used for comparison during the treatment period.

## **Practitioner-Administered Treatment Phase**

Following the baseline assessment, the participant received a series of Acutonics treatments in the clinical setting. Treatment involved the use of tuning forks on acupuncture points, Extraordinary Vessels, and selected areas of the body, as well as direct application to the penile scar tissue.

The treatment plan developed over the course of the case. Participant responses, practitioner observations, and changes recorded between sessions informed later treatment choices. This adaptive approach allowed the protocol to respond to the individual case rather than requiring the same sequence of frequencies and points at every session.

Treatment frequency also varied during the study. Some periods involved treatment on consecutive days, while February included days with more than one treatment. An interruption occurred when the participant was away from April 1 through April 22, after which in-clinic treatment resumed.

The specific Acutonics frequencies, intervals, acupuncture points, treatment locations, and changes to the protocol are described in Sections 2.3 and 3.2.

## **Assessment During Treatment**

The participant was reassessed throughout the practitioner-administered treatment period rather than only at its beginning and end.

Penile curvature was measured using the P.D.A.D. Peyronie's Disease Assessment Device. Each documented curvature result was photographed, providing both a numerical angle and a visual record of the penile curvature at the time of assessment. (Urology Health Store, n.d.)

The documented curvature measurements progressed from approximately 60 degrees at baseline to 50 degrees in February, 45 degrees in March and April, and 40 degrees on May 30. The May 30 photograph was obtained before the documented self-treatment period began.

Erectile and sexual function were followed with the International Index of Erectile Function, the Peyronie's Disease Questionnaire, the participant's separate self-rating of erectile dysfunction severity, and participant reports made during and between treatment sessions. (Hellstrom et al., 2013; Rosen et al., 1997)

The IIEF and PDQ were administered repeatedly throughout the study. The use of both instruments allowed erectile and sexual function to be considered alongside Peyronie's-specific symptoms and symptom bother rather than relying on a single patient-reported measure. The participant also described changes he noticed in erection quality, penile fullness, curvature, sexual function, and other aspects of his experience.

Pain remained part of the assessment because painful erections had occurred earlier in the course of his Peyronie's disease. Pain was already absent at baseline. Baseline, February, March, and April assessments recorded a pain score of zero, while the May 4 through May 10 assessment recorded a pain rating of 1.

Practitioner observations were recorded throughout the treatment period. These observations were kept distinct from photographed measurements, standardized questionnaire data, and participant reports.

## **Follow-Up and Study Boundary**

The formal practitioner-administered portion of the study was limited to the period in which the practitioner personally administered and documented the participant's Acutonics treatments.

A May 30, 2025 photograph documented curvature at 40 degrees before the recorded self-treatment period began. The documented self-treatment log begins on June 8 and continues into August.

The participant subsequently reported continuing Acutonics treatment on his own. His treatment methods, the frequencies or techniques used, the frequency or duration of the sessions, placement methods, adherence, and whether the treatments were performed as reported could not be independently verified.

For this reason, the self-treatment period was kept separate from the practitioner-administered treatment phase.

A June 17 photograph documented curvature at 40 degrees during the self-treatment period. On August 19, 2025, after the reported self-treatment period, a final P.D.A.D. measurement with photographic documentation again showed 40 degrees. These later measurements were retained as follow-up findings and were not used to establish an additional treatment effect from the participant's self-treatment.

The May 30 measurement is therefore the final documented 40-degree curvature measurement obtained before the recorded self-treatment period began. The measurable reduction from approximately 60 degrees at baseline to 40 degrees had already occurred before the unverified intervention.

## **Approach to Outcome Assessment**

The study used both quantitative and qualitative data.

Quantitative and documented physical measures included penile curvature in degrees and the accompanying photographs. Standardized patient-reported measures included both the IIEF and the PDQ. The IIEF provided information about erectile and sexual function, while the PDQ provided information specific to the participant's experience of Peyronie's disease. (Hellstrom et al., 2013; Rosen et al., 1997)

The participant's separate erectile dysfunction severity ratings and descriptions provided additional information about erection quality, penile fullness, sexual experience, perceived curvature, and other changes that mattered to him.

Practitioner observations added another layer to the case record but were not treated as equivalent to photographed physical measurements or standardized questionnaire data. For example, observed or reported changes in

penile fullness were not used as evidence of increased blood flow because vascular testing was not performed. Changes in the appearance or feel of scar tissue were also not used to claim changes in plaque size or internal tissue structure because medical imaging was not available to verify them.

The study was designed to document changes occurring during the treatment period rather than establish causation. As a single-participant case study without a control group, it cannot determine whether Acutonics caused the observed changes. The results instead provide a detailed record of the participant's course during a defined period of practitioner-administered Acutonics treatment and subsequent follow-up. (Yin, 2018)

### **3.2 Treatment Administration and Monitoring**

The treatment phase followed the Acutonics protocol described in Section 2.3 while allowing the treatment plan to change in response to the participant's presentation and his response to prior sessions. The study outline called for this section to describe session structure, areas of application, adjunctive approaches, and the tools used to monitor progress.

#### **Structure of the Acutonics Sessions**

Acutonics treatments were administered in the clinical setting using calibrated tuning forks applied to selected acupuncture points, Extraordinary

Vessels, and areas chosen in response to the participant's presentation. Direct application to the penile scar tissue was also incorporated into the treatment protocol. (Acutonics Institute of Integrative Medicine, n.d.; Carey & de Muynck, 2007)

The treatment schedule was not uniform throughout the study. The January treatment period consisted of one treatment per day for three days. February included several days when the participant received two treatments. Treatment continued through March, followed by an interruption when the participant was out of town from April 1 through April 22. Treatment resumed after his return.

This schedule allowed the case to include both concentrated periods of treatment and longer intervals between sessions. The variation in treatment frequency was documented as part of the study rather than treated as a standardized dosing schedule.

## **Selection of Acutonics Frequencies and Treatment Areas**

Treatment was individualized according to the participant's presentation and response. The protocol included work with acupuncture points and Extraordinary Vessels as well as direct treatment of the penile scar tissue.

The initial treatment approach did not remain fixed. Responses observed during the first treatment period led me to reassess parts of the protocol and make changes by the third treatment day. Later responses during direct work on the scar tissue also influenced which frequencies and combinations I continued, changed, or discontinued.

This adaptive process was part of the clinical nature of the case study. Each session drew on information from the participant's previous treatment response, his reports between sessions, and my observations during treatment. (Yin, 2018)

The full treatment record documents the individual frequencies, intervals, points, and combinations used during the study. These records were maintained so that changes in the treatment approach could be followed alongside changes in the participant's condition.

## **Direct Treatment of the Scar Tissue**

Direct application of Acutonics tuning forks to the penile scar tissue became a significant part of the treatment protocol.

The scarred area was treated directly with selected frequencies while the participant's response was observed. Changes in the appearance and feel of

the tissue were recorded as practitioner observations and were used to help guide later treatment choices.

These observations were not treated as measurements of the Peyronie's plaque. No ultrasound or other medical imaging was available to determine whether plaque size, thickness, calcification, collagen structure, or fibrosis changed during treatment.

The distinction between external observation and internal tissue change was maintained throughout the study.

## **Monitoring Penile Curvature**

Penile curvature was monitored at several points during the treatment period using the P.D.A.D. Peyronie's Disease Assessment Device. (Urology Health Store, n.d.)

Each documented curvature result was photographed. This created a visual record that accompanied the numerical measurement and allowed the shape and measured angle of the erection to be reviewed across the study period.

The documented measurements progressed from approximately 60 degrees at baseline to 50 degrees in February, 45 degrees in March and April,

and 40 degrees in the May 30 photograph. The May 30 measurement occurred before the documented self-treatment period began.

The purpose of monitoring in this section was to determine whether the participant's physical presentation was changing as treatment progressed. The complete numerical results and interpretation of the photographs are presented in Section 4.1.

## **Monitoring Erectile and Sexual Function**

Erectile and sexual function were monitored through the International Index of Erectile Function (IIEF), the Peyronie's Disease Questionnaire (PDQ), the participant's separate self-rating of erectile dysfunction severity, and reports made during and between treatment sessions.

The IIEF provided a standardized measure of erectile and sexual function. The PDQ provided a validated Peyronie's-specific patient-reported measure of physical and psychological symptoms, penile pain, and symptom bother. (Hellstrom et al., 2013; Rosen et al., 1997)

The use of both instruments was part of the study plan. The participant's consent materials identify the PDQ and IIEF as questionnaires intended to track symptoms and sexual health throughout treatment.

The participant was encouraged to describe changes he noticed in erection quality, fullness, curvature, sexual function, and other aspects of his experience. These reports were entered into the treatment record as participant-reported findings.

The IIEF and PDQ were administered repeatedly throughout the study, allowing erectile and sexual function and the participant's Peyronie's-specific experience to be followed over time. The participant's separate erectile dysfunction severity rating was recorded as his own assessment and was not treated as a standardized clinical severity score.

This distinction allowed the study to retain standardized questionnaire data alongside the participant's own account of changes that mattered to him.

## **Monitoring Pain**

Pain was monitored because painful erections had been part of the participant's earlier history with Peyronie's disease.

Pain had already resolved by the beginning of the Acutonics treatment period. The participant reported no pain at baseline, and the February, March, and April formal assessments also recorded zero. The May 4 through May 10 assessment recorded a pain rating of 1.

Because baseline pain was zero, pain was not used as evidence of treatment improvement. It remained a monitored variable so that any recurrence or change could be documented.

## **Participant Feedback During Treatment**

Participant feedback formed an important part of ongoing monitoring.

Rather than waiting for formal assessment dates, I recorded changes the participant noticed between treatments.

These reports included his perceptions of penile curvature, erection quality, fullness, sexual function, and other changes that arose during the course of treatment. Participant feedback also helped guide later treatment decisions.

Self-reported findings were kept separate from physical measurements. A participant report that his erection felt fuller, for example, documented his experience but did not establish a measured change in penile girth or blood flow.

## **Practitioner Observation**

I monitored the participant's response during each clinical session and recorded observations that could help guide subsequent treatment.

These observations included responses to tuning-fork application, visible changes in penile appearance, perceived changes in the scarred area, emotional responses, and energetic findings assessed within the Acutonics framework.

Practitioner observations served a different role from P.D.A.D. measurements, photographs, PDQ and IIEF assessments, and participant reports. They informed the clinical treatment process but were not treated as objective evidence of changes in internal penile tissue. (Yin, 2018)

This separation was especially important when working directly with the scarred area. Changes that could be seen or felt during treatment could be recorded as observations, but they could not confirm biological changes in the Peyronie's plaque.

## **Self-Treatment Outside the Clinical Protocol**

The May 30 photograph documented curvature at 40 degrees before the participant began the recorded self-treatment period. The documented self-treatment log begins on June 8.

The participant subsequently reported continuing Acutonics treatment on his own. I cannot independently verify his treatment methods, which tuning forks

or frequencies he used, where he applied them, how long or how often he treated himself, or whether the treatments were carried out as reported.

For this reason, self-treatment was not considered an extension of the practitioner-administered clinical protocol.

A June 17 photograph documented curvature at 40 degrees during the self-treatment period, and the final August 19, 2025 P.D.A.D. assessment also documented 40 degrees. These later measurements show that the 40-degree curvature remained documented, but they do not establish an additional effect from the participant's self-treatment.

## **Treatment Documentation**

Treatment and monitoring data were recorded throughout the clinical phase of the study. The records included treatment dates, Acutonics frequencies and intervals, acupuncture points, Extraordinary Vessels, direct scar-tissue applications, participant statements, practitioner observations, P.D.A.D. measurements, photographs, PDQ and IIEF assessments, and changes made to the treatment approach.

This ongoing record allowed the treatment process and participant response to be viewed together. It also provided the basis for separating

measured findings, standardized patient-reported measures, participant reports, and practitioner observations before the data were analyzed. (Yin, 2018)

### **3.3 Data Analysis Techniques**

Data analysis combined quantitative and qualitative methods to examine changes recorded during the practitioner-administered treatment period. The analysis included penile curvature, erectile and sexual function, Peyronie's-specific patient-reported outcomes, pain, participant feedback, and practitioner observations.

Because this was a single-participant exploratory case study, the analysis focused on change over time within the case. The study did not include a control group or a sample large enough for inferential statistical testing. Results were therefore examined through direct comparison of measurements, questionnaire scores, photographs, participant reports, and practitioner observations. (Yin, 2018)

#### **Quantitative Analysis of Penile Curvature**

Penile curvature served as the primary physical measure. P.D.A.D. measurements were compared chronologically from baseline through the end

of the verified practitioner-administered treatment period. (Urology Health Store, n.d.)

Change in curvature was examined in two ways: the absolute difference in degrees from baseline and the percentage change from the baseline angle.

The percentage change was calculated as:

Percentage change =  $[(\text{baseline curvature} - \text{later curvature}) \div \text{baseline curvature}] \times 100$

The baseline measurement of approximately 60 degrees served as the reference point for subsequent measurements. Each documented curvature result was also photographed. The photographs were used as supporting visual documentation of the recorded P.D.A.D. measurements.

The documented sequence included approximately 60 degrees at baseline, 50 degrees in February, 45 degrees in March and April, and 40 degrees on May 30. The May 30 photograph occurred before the documented self-treatment period began, so the 40-degree result was included in the practitioner-period analysis.

From approximately 60 degrees at baseline to 40 degrees on May 30, the measured difference was approximately 20 degrees.

Using the formula above:

$$[(60 - 40) \div 60] \times 100 = \text{approximately } 33 \text{ percent}$$

The documented curvature therefore decreased by approximately 33 percent from baseline to the May 30 measurement.

## **Analysis of Erectile and Sexual Function**

Changes in erectile and sexual function were assessed through the International Index of Erectile Function (IIEF), the Peyronie's Disease Questionnaire (PDQ), the participant's separate self-rating of erectile dysfunction severity, and participant reports made during and between treatment sessions. (Hellstrom et al., 2013; Rosen et al., 1997)

The IIEF scores were compared directly between assessment points to describe changes in erectile and sexual function over time.

The PDQ was also administered repeatedly throughout the study. PDQ responses were reviewed across assessment points as a Peyronie's-specific patient-reported measure of physical and psychological symptoms, penile pain, and symptom bother. Because the PDQ evaluates aspects of the condition that are not captured fully by the IIEF, it was considered alongside the erectile-function data rather than treated as a substitute for it. (Hellstrom et al., 2013)

The participant's erectile dysfunction severity ratings were also compared over time. These ratings were self-reported and were analyzed as such. They

were not converted into clinical categories or treated as scores from a validated erectile dysfunction severity instrument.

Participant descriptions of erection quality, fullness, sexual function, curvature, and related changes were considered alongside the standardized questionnaire data. This allowed the analysis to include both structured self-report measures and the participant's own account of his experience.

## **Analysis of Pain**

Pain scores were reviewed across the treatment period.

The participant's baseline pain score was zero. February, March, and April formal assessments also recorded zero. The May 4 through May 10 assessment recorded a pain rating of 1.

Because pain was absent at baseline, no reduction in pain could be calculated or attributed to treatment. Pain was therefore treated as a monitored clinical variable rather than an outcome demonstrating improvement.

## **Analysis of Penile Length and Girth**

Loss of penile length and girth was part of the participant's baseline presentation and was relevant to the original treatment goals.

The available records did not contain a complete set of standardized pre-treatment and post-treatment measurements for penile length and girth. These outcomes were therefore not analyzed quantitatively.

Participant reports or practitioner observations of greater fullness were retained as qualitative findings. They were not converted into claims of increased girth or recovered penile length.

## **Qualitative Analysis**

Qualitative data came from participant interviews, statements made during and between treatment sessions, and practitioner observations. (Yin, 2018)

The participant's reports were reviewed chronologically to identify changes in areas relevant to the study question, including perceived curvature, erection quality, penile fullness, sexual function, confidence, and his broader experience of the condition.

The analysis preserved the distinction between what the participant reported and what was physically measured. A statement that an erection appeared straighter, for example, was treated as a participant-reported perception unless accompanied by a P.D.A.D. measurement and photograph.

Practitioner observations were reviewed separately. These included visible changes, perceived changes in the scarred area, responses during tuning-fork application, emotional responses, and energetic findings within the Acutonics framework.

Energetic observations were analyzed within the context of Acutonics practice and were not interpreted as biomedical measurements.

## **Comparison Across the Treatment Timeline**

Quantitative and qualitative findings were arranged chronologically to examine whether changes appeared during the course of practitioner-administered treatment.

This approach allowed P.D.A.D. measurements and photographs to be considered alongside IIEF scores, PDQ responses, erectile dysfunction self-ratings, participant reports, practitioner observations, treatment dates, and changes in the Acutonics protocol.

The timeline was also used to identify periods when treatment was interrupted. This included the participant's absence from April 1 through April 22. Treatment interruptions were retained as part of the case rather than removed from the analysis because they form part of the actual treatment course.

## **Treatment Period and Follow-Up Analysis**

The primary analysis included documented findings obtained before the recorded self-treatment period began. The May 30 photograph documented curvature at 40 degrees before the self-treatment log began on June 8. It was therefore included in the practitioner-period curvature analysis rather than classified as a post-self-treatment finding.

After May 30, the participant reported self-treatment with Acutonics. His treatment methods, adherence, frequency or duration of treatment, and the Acutonics techniques and frequencies used could not be independently verified.

Data collected after the documented self-treatment period began were therefore classified separately as follow-up findings.

A June 17 photograph documented curvature at 40 degrees during the self-treatment period, and the final August 19, 2025, P.D.A.D. assessment again documented 40 degrees. These later measurements were retained in the longitudinal record, but they were not used to establish an additional effect from the participant's self-treatment.

## **Descriptive Analysis**

No inferential statistical tests were used. A single-participant case study does not provide the sample size needed to determine statistical significance or establish whether the observed findings would occur in a larger population. (Yin, 2018)

Instead, descriptive analysis was used to report:

- absolute change in penile curvature measured in degrees
- percentage change in curvature from baseline
- change in IIEF scores
- change in PDQ responses over time
- change in the participant's self-rated erectile dysfunction severity
- stability or change in pain scores
- participant-reported changes over time
- practitioner-observed changes during treatment
- follow-up findings outside the verified practitioner-administered

treatment period

This approach allowed numerical and questionnaire changes to be reported without assigning statistical significance to a single case. (Yin, 2018)

## **Approach to Interpretation**

The analysis was designed to answer the study question at the level supported by the available evidence. The original question was whether Acutonics sound therapy can reduce the symptoms and progression of Peyronie's disease.

The study can document whether symptoms, standardized patient-reported outcomes, and measured findings changed during the period of Acutonics treatment. It cannot determine from one case whether Acutonics caused those changes or whether the findings can be generalized to other men with Peyronie's disease. (Yin, 2018)

For this reason, P.D.A.D. measurements and photographs, IIEF and PDQ data, participant reports, practitioner observations, and later follow-up findings were analyzed as separate forms of evidence.

The results of this analysis, including changes in penile curvature, erectile and sexual function, PDQ findings, and participant-reported experience, are presented in Section 4.1.

## **4. Outcomes and Summary**

### **4.1 Results of the Study**

The results were evaluated across the documented practitioner-administered treatment period and the later follow-up period. The primary physical outcome was change in penile curvature. Additional outcomes included erectile and sexual function, Peyronie's-specific patient-reported outcomes, penile fullness and appearance, pain, and perceived changes in the palpable scarred tissue.

Measured findings, standardized patient-reported measures, participant reports, and practitioner observations were considered separately so that each finding could be interpreted according to the way the information was collected.

#### **Penile Curvature**

Penile curvature showed the clearest measurable physical change during the study.

At baseline, curvature measured approximately 60 degrees using the P.D.A.D. Peyronie's Disease Assessment Device. The initial assessment also documented visible scar tissue, deformity of the head of the penis, and reported loss of penile length and girth. (Urology Health Store, n.d.)

The February assessment documented curvature at 50 degrees. On March 15, curvature measured 45 degrees. The April assessment again documented 45 degrees following the participant's absence from April 1 through April 22. The May 4 through May 10 assessment period also documented curvature at 45 degrees.

On May 30, 2025, a photograph documented curvature at 40 degrees. This measurement occurred before the documented self-treatment period began on June 8. Each documented curvature result was photographed, providing a visual record alongside the numerical P.D.A.D. measurement.

| <b>Assessment</b> | <b>Curvature</b> | <b>Change From Baseline</b> | <b>Percentage Change</b> |
|-------------------|------------------|-----------------------------|--------------------------|
| Baseline          | ~60°             | Baseline                    | Baseline                 |
| February          | 50°              | ~10° decrease               | ~17%                     |
| March 15          | 45°              | ~15° decrease               | 25%                      |
| April 23          | 45°              | ~15° decrease               | 25%                      |
| May assessment    | 45°              | ~15° decrease               | 25%                      |
| May 30            | 40°              | ~20° decrease               | ~33%                     |

The documented curvature therefore decreased from approximately 60 degrees at baseline to 40 degrees by May 30. This represents an approximately 20-degree reduction, or 33 percent of the baseline angle. Because the May 30 photograph was obtained before the documented self-treatment period

began, this measurement belongs within the practitioner-period outcome record.

The change occurred progressively rather than appearing only at the May 30 assessment. Curvature decreased from approximately 60 degrees to 50 degrees, then to 45 degrees, remained at 45 degrees through April and the early May assessment, and reached 40 degrees by May 30.

The participant also reported perceiving a change before the March measurement. On March 7, he stated that he had awakened with an erection and felt that the curvature appeared to be straightening. This statement was recorded before the subsequent measured reduction to 45 degrees.

### **Curvature During Self-Treatment and Final Follow-Up**

After the May 30 photograph documenting 40 degrees of curvature, the participant began a period of self-treatment with Acutonics. The documented self-treatment log begins on June 8.

I cannot independently verify his adherence, treatment methods, treatment frequency or duration, tuning-fork selection, frequencies used, placement, or whether each treatment was performed as recorded.

A June 17 photograph documented curvature at 40 degrees during the self-treatment period. On August 19, 2025, after the reported self-treatment

period, the final P.D.A.D. measurement with photographic documentation again showed 40 degrees.

The June 17 and August 19 measurements therefore document that the 40-degree curvature first recorded on May 30 remained at 40 degrees during and after the self-treatment period. No additional reduction in measured curvature was documented between May 30 and August 19. These later measurements cannot establish an effect from the participant's self-treatment because the reduction from approximately 60 degrees to 40 degrees had already been documented before the self-treatment log began.

## **Erectile and Sexual Function**

Erectile and sexual function also changed during the study period.

At baseline, the participant self-rated his erectile dysfunction severity at 4 to 5. His initial International Index of Erectile Function (IIEF) score was 56. The IIEF was used as a standardized patient-reported measure of erectile and sexual function. (Rosen et al., 1997)

By February, the participant's self-rated erectile dysfunction severity had changed to 2 to 3, and his IIEF score had increased to 65. The March and April assessments also recorded an IIEF score of 65. During the May 4 through May 10 assessment period, the IIEF score increased to 66, while the participant rated his

erectile dysfunction severity at 1. The May 30 IIEF assessment recorded a total score of 70.

Across the documented study period, the IIEF score therefore increased from 56 at baseline to 70 on May 30, an increase of 14 points. This finding represents a change in a standardized patient-reported measure of erectile and sexual function. It does not establish the physiological cause of that change.

The participant's own reports showed the same general direction of change. On March 7, he reported waking with an erection. Later in March, he described his erection as harder and fuller and reported some improvement in body image associated with the fuller erection.

## **Peyronie's Disease Questionnaire Findings**

The Peyronie's Disease Questionnaire (PDQ) was administered repeatedly throughout the study.

The PDQ provided a validated Peyronie's-specific patient-reported measure that complemented the IIEF. While the IIEF assessed erectile and sexual function, the PDQ addressed aspects of the participant's experience specific to Peyronie's disease, including physical and psychological symptoms, penile pain, and symptom bother. (Hellstrom et al., 2013)

Repeated administration of the PDQ allowed the participant's Peyronie's-specific experience to be followed over time rather than reconstructed only at the conclusion of treatment. The PDQ data were considered alongside curvature measurements and photographs, IIEF scores, participant reports, and practitioner observations.

The PDQ and IIEF therefore provided complementary standardized patient-reported measures within the case. The IIEF assessed erectile and sexual function, while the PDQ assessed aspects of the participant's experience specifically related to Peyronie's disease.

## **Changes in Penile Fullness and Appearance**

Changes in penile appearance were documented during the treatment period.

During the February treatment period, the participant reported that the head of his penis appeared larger and that he believed blood flow had increased. I also recorded a visible increase in penile fullness.

By March 18, the treatment notes described the penis as visibly straighter and showing greater girth. In April, I again recorded that the penis appeared visibly straighter.

No vascular testing was performed, so increased penile blood flow cannot be verified. The findings supported by the case record are the participant's reports of harder and fuller erections and the practitioner-observed changes in penile fullness and appearance.

## **Palpable Changes in Scarred Tissue**

A substantial change was perceived in the physical characteristics of the palpable scarred tissue during the course of treatment.

At the beginning of the case, the participant described the affected tissue as long, smooth, firm, and shaped like a bullet, with tapered ends. By the end of practitioner-administered treatment, he described the area as shorter and softer, comparing its shape and texture to a cork.

I also palpated the affected area and perceived a marked change in its physical characteristics. By the end of treatment, small depressions or spaces could be felt within the affected tissue at locations where the ends of the tuning forks had repeatedly been applied.

The treatment records document changing tactile observations over time. During February, I recorded the impression that I had moved beneath the scarred tissue and that the affected area seemed to be separating rather than remaining as one continuous area. In March, I recorded the sensation that

treatment was beginning to “pierce” the scarred tissue while the penis appeared visibly straighter and fuller.

These findings were tactile practitioner observations rather than medical imaging findings. They document perceived changes in the shape, firmness, texture, and continuity of the palpable tissue. They cannot establish what occurred within the Peyronie's plaque at a microscopic or structural level.

No ultrasound or other medical imaging was performed to verify changes in plaque size, collagen structure, calcification, fibrosis, tissue elasticity, or other internal tissue characteristics.

## **Pain**

Pain did not represent an outcome showing improvement because the participant entered the study with a baseline pain score of zero.

He reported that painful erections had begun after the motorcycle accident and continued for approximately one year. Baseline, February, March, and April formal assessments recorded pain at zero. The May assessment recorded a pain rating of 1.

Because pain was absent at baseline, the case cannot support a conclusion that Acutonics reduced Peyronie's-related pain. Pain was monitored

for recurrence or change rather than used as evidence of treatment improvement.

## **Penile Length and Girth**

Loss of penile length and girth was documented at baseline. The participant reported losing approximately one inch of penile length.

The case did not include a complete series of standardized pre-treatment and post-treatment measurements of penile length or girth. Changes in these outcomes therefore cannot be verified quantitatively.

The participant's reports of greater fullness and the practitioner's observations of increased fullness and girth were retained as qualitative findings rather than presented as measured increases in penile dimensions.

## **Unexpected Findings and Study Challenges**

One unexpected aspect of the case was the extent of the perceived change in the palpable scarred tissue. Although reducing scar tissue was among the initial treatment goals, medical imaging was not available to assess the plaque itself. The tactile changes perceived by the participant and practitioner therefore remain observations whose biological basis cannot be determined from the available data.

Another notable finding was the change in reported erectile and sexual function. The IIEF score increased from 56 at baseline to 70 on May 30, while the participant's separate erectile dysfunction self-rating and reports of harder and fuller erections changed in the same general direction. Repeated PDQ assessments provided additional standardized patient-reported information specific to his experience of Peyronie's disease.

Several factors limit interpretation of the results. Treatment frequency varied, the participant had a three-week absence in April, and the treatment protocol changed during the case. Adjunctive methods were used during some sessions. Medical imaging and vascular testing were not performed, and standardized penile length and girth measurements were incomplete.

The participant's later self-treatment created an additional boundary for interpretation. The 40-degree curvature had already been photographed on May 30 before the documented self-treatment log began. The same 40-degree curvature was documented again on June 17 and August 19.

## **Summary of Results**

The primary measurable physical result was a decrease in photographed penile curvature from approximately 60 degrees at baseline to 40 degrees by May 30, 2025. This represents an approximately 20-degree reduction, or 33

percent of the baseline angle, documented before the self-treatment period began.

Erectile and sexual function also changed during the study. The participant's IIEF score increased from 56 at baseline to 70 on May 30, while his separate self-rating of erectile dysfunction moved toward less perceived difficulty. He also reported harder and fuller erections.

Repeated PDQ assessments provided a standardized record of the participant's Peyronie's-specific symptoms and symptom bother throughout the study. The PDQ complemented the IIEF by documenting aspects of the condition that erectile and sexual-function assessment alone did not capture. (Hellstrom et al., 2013; Rosen et al., 1997)

A further finding involved the perceived change in the palpable scarred tissue. The participant described the affected area as changing from long, smooth, firm, and bullet-shaped to shorter, softer, and cork-like. Practitioner observations also documented changing tactile impressions within the scarred area.

A June 17 photograph documented curvature at 40 degrees during the participant's self-treatment period, and the final August 19, 2025 P.D.A.D. measurement with photographic documentation again showed 40 degrees. These findings document that the 40-degree curvature measured on May 30

remained at the same measured angle through the final follow-up. They do not establish an additional treatment effect from the participant's unverified self-treatment.

The results therefore document a measurable change in external penile curvature, changes in standardized patient-reported outcomes, participant-reported changes in erectile function and penile fullness, practitioner-observed changes in penile appearance, and perceived changes in the physical characteristics of the palpable scarred tissue during the course of the case.

## **4.2 Interpretation of Results**

The findings of this case show several changes occurring during the practitioner-administered Acutonics treatment period. The strongest measured finding was a reduction in penile curvature. The participant also showed changes in standardized patient-reported measures of erectile and sexual function and Peyronie's-specific symptoms, while both the participant and practitioner perceived a marked change in the physical characteristics of the scarred tissue.

The findings are notable because several different forms of evidence changed during the same period. Their convergence increases the clinical interest of the case, but a single-participant study cannot establish that Acutonics caused these changes. (Yin, 2018)

## **Interpreting the Change in Curvature**

The participant began with approximately 60 degrees of measured curvature. Curvature decreased to 50 degrees in February, 45 degrees in March, remained at 45 degrees in April and during the early May assessment period, and was photographed at 40 degrees on May 30, 2025.

The May 30 measurement is important because it occurred before the documented self-treatment period began. The self-treatment log begins on June 8. The decrease from approximately 60 degrees to 40 degrees therefore occurred before documented self-treatment and represents an approximately 20-degree, or 33 percent, reduction in the measured angle.

The photographic record adds strength to this finding. The change did not depend only on participant memory or practitioner impression. P.D.A.D. measurements were accompanied by photographs, allowing the progression in external curvature to be documented over time.

The sequence was also gradual rather than appearing only at the final measurement. Curvature decreased from approximately 60 degrees to 50 degrees and then to 45 degrees before reaching 40 degrees by May 30.

The evidence therefore supports the conclusion that the participant's external penile curvature changed during the practitioner-administered study period. It does not establish why the change occurred.

## **Relationship Between Treatment and the Physical Findings**

The timing of the curvature change occurred alongside changes in the treatment strategy.

Early sessions included broader constitutional, Extraordinary Vessel, local, and psycho-spiritual approaches. The participant's response led me to alter parts of the original treatment plan. Direct treatment of the penile scar tissue later became a central and repeated part of the protocol.

By February, after a concentrated period that included direct scar-tissue treatment, curvature measured 50 degrees. By March, curvature had reached 45 degrees, and the treatment notes also described the penis as visibly straighter and fuller. The curvature later reached 40 degrees by May 30.

The timing creates an association between the treatment period and the physical changes. It cannot show that one frequency, one point, direct tuning-fork placement, or Acutonics as a whole produced the result.

## **Interpretation of the Palpable Scar-Tissue Change**

The tactile change in the affected area adds another dimension to the curvature findings.

The participant described the scar tissue at the beginning of the case as long, smooth, firm, and shaped like a bullet, with tapered ends. By the end of

practitioner-administered treatment, he described the area as shorter, softer, and more cork-like.

I also perceived a substantial difference through palpation. Small depressions or spaces could be felt within the scarred area at sites where the ends of the tuning forks had repeatedly been applied.

The contemporaneous treatment records show that perceptions of tissue change developed during the treatment period rather than appearing only in retrospective recollection. In February, I described a sense of getting beneath the scarred area and perceiving separation within the affected tissue. In March, I recorded a sense that treatment was beginning to “pierce” the scar tissue while the penis appeared straighter and fuller.

These tactile observations are important because they occurred alongside the photographed reduction in curvature. Two aspects of the physical presentation changed during the same period: the measured external angle of deformity and the perceived physical characteristics of the palpable scarred tissue.

The limits of palpation remain important. Touch can establish that tissue feels different to the participant or practitioner, but it cannot determine whether plaque collagen changed, plaque volume decreased, calcification changed, fibrosis decreased, or the tunica albuginea remodeled.

The case therefore supports reporting a perceived change in tissue shape, firmness, texture, and continuity. It does not establish an internal biological mechanism.

## **Relationship Between Scar-Tissue Change and Curvature**

The simultaneous change in curvature and palpable tissue characteristics raises an important clinical question.

Peyronie's curvature results from restricted expansion of affected penile tissue during erection. Changes in the mechanical properties of the affected area could theoretically influence the resulting deformity. (EAU, 2026)

The present study did not measure plaque composition or tissue elasticity, so it cannot determine whether such a process occurred.

What can be stated is that photographed curvature decreased while the affected area was also perceived by the participant and practitioner as shorter, softer, and less uniformly firm.

These findings warrant further study using objective methods capable of evaluating plaque structure and tissue characteristics.

## **Erectile and Sexual Function**

Changes in erectile and sexual function occurred alongside the physical findings.

At baseline, the participant's IIEF score was 56. It increased to 65 during February, March, and April, to 66 during the May 4 through May 10 assessment period, and to 70 on May 30. His separate erectile dysfunction self-rating also moved toward less perceived difficulty.

The May 30 IIEF score of 70 represents a 14-point increase from the baseline score of 56.

The participant also described harder and fuller erections. These changes occurred in the same general period in which curvature decreased.

The agreement between the standardized IIEF data and the participant's own reports is clinically relevant within the case. The participant did not only report that the penis appeared straighter. He also reported changes in how his erections felt and functioned. (Rosen et al., 1997)

The study cannot determine why erectile function changed. No vascular study was performed, and the available evidence cannot distinguish vascular, mechanical, psychological, or other possible contributors.

## **Peyronie's-Specific Patient-Reported Outcomes**

The PDQ adds an important layer to the interpretation because it was administered repeatedly throughout the study.

The IIEF measures erectile and sexual function, but it was not designed to capture the broader experience of Peyronie's disease. The PDQ is a validated 15-item Peyronie's-specific patient-reported instrument that assesses psychological and physical symptoms, penile pain, and symptom bother. (Hellstrom et al., 2013; Rosen et al., 1997)

Repeated PDQ administration allowed the participant's Peyronie's-specific experience to be followed over time rather than reconstructed only at the end of the case. The PDQ data could therefore be considered alongside curvature measurements, photographs, IIEF scores, participant reports, and practitioner observations.

The IIEF and PDQ provided complementary information. The IIEF documented erectile and sexual function, while the PDQ documented aspects of the participant's experience specific to Peyronie's disease.

This distinction strengthens the interpretation of the results because improvement was not assessed through curvature measurement or erectile-function reporting alone.

## **Penile Fullness and Blood Flow**

The participant reported that the head of the penis appeared larger and that he believed blood flow had improved. I also observed greater fullness.

These findings should not be presented as proof of improved circulation.

I cannot verify increased penile blood flow because Doppler ultrasound or another vascular test was not performed.

The supported finding is that penile fullness and erection hardness appeared to change during the same period in which curvature decreased.

## **Possible Role of Acutonics**

The central research question asks whether Acutonics sound therapy can reduce the symptoms and progression of Peyronie's disease.

This single case does not establish efficacy. It does, however, document enough measured, standardized patient-reported, participant-reported, and practitioner-observed change to support further investigation of the question.

Direct tuning-fork application over the scarred area became one of the most consistent components of the later treatment protocol. The participant and practitioner perceived changes in the tissue during this period, while photographed curvature also decreased.

The study cannot verify that Acutonics vibration breaks down collagen, remodels plaque, reduces fibrosis, increases circulation, repairs the tunica albuginea, or produces another specific biological effect. Those mechanisms were not measured.

The results therefore support further research into the observed association rather than a biological claim.

## **Comparison With Conventional Treatment**

Conventional Peyronie's management may include observation, penile traction, intralesional therapy, and surgery depending on disease stage, severity, erectile function, and the effect of deformity on sexual activity. (EAU, 2026)

The findings from this single case are not sufficient to recommend Acutonics as a replacement for established medical care.

A more appropriate interpretation is that Acutonics represents a non-invasive complementary approach that may warrant structured clinical investigation.

Penile traction is useful as a research comparison because studies of traction also use curvature and penile dimensions as physical outcomes. The two approaches should not be assumed to share a mechanism. Traction applies

sustained mechanical force, whereas Acutonics applies vibration through tuning forks.

The present case cannot establish that these approaches affect tissue in the same way.

## **Pain**

Pain does not provide evidence of treatment benefit in this case.

The participant had previously experienced painful erections, but his pain score was zero when the study began. Baseline, February, March, and April assessments recorded zero. The May assessment recorded a pain rating of 1.

Because the participant began the study pain-free, the case cannot support a conclusion that Acutonics reduced Peyronie's-related pain.

The May rating of 1 also means the study should not state that pain remained at zero throughout every formal assessment.

## **Emotional and Personal Effects**

The participant's experience extended beyond physical deformity. Peyronie's disease had affected his sexual life, confidence, and intimate relationship.

The case also showed that I entered treatment with assumptions about how he might process the condition emotionally. His actual responses led me to revise the protocol and rely more strongly on what he reported rather than what I expected.

The study included the PDQ, which provided a validated Peyronie's-specific patient-reported measure that included psychological and physical symptoms and symptom bother. (Hellstrom et al., 2013)

However, the study did not include a separate validated instrument specifically designed to measure broader outcomes such as relationship quality, generalized anxiety, shame, body image, or overall emotional well-being. Those areas were explored through participant reports and interviews rather than through a separate standardized psychological or relationship measure.

The interviews still contributed meaningfully to the case because they allowed the participant's own experience to guide later clinical choices.

## **Interpretation of the 40-Degree Measurement and Follow-Up**

The May 30 photograph documenting 40 degrees is part of the practitioner-period record because it was obtained before the documented self-treatment period began.

The complete photographic sequence therefore documents a change from approximately 60 degrees at baseline to 40 degrees by May 30. This represents an overall difference of approximately 20 degrees, or 33 percent.

After the May 30 assessment, the participant began self-treatment. The documented self-treatment log begins on June 8. I cannot independently verify his treatment methods, adherence, frequency, duration, tuning-fork selection, or placement.

A June 17 photograph documented curvature at 40 degrees during the self-treatment period. On August 19, 2025, after the reported self-treatment period, the final P.D.A.D. measurement with photographic documentation again showed 40 degrees.

These later measurements do not represent an additional five-degree improvement. The 40-degree curvature had already been documented before self-treatment began.

The June and August measurements instead show that the May 30 measurement remained documented during and after the reported self-treatment period. No further reduction in curvature was measured.

## **Alternative Explanations**

Several possible explanations for the findings remain. (Yin, 2018)

Peyronie's disease can change over time, and measurement variation may account for some difference between assessments. Differences in erection quality could also influence measured curvature. The study had no untreated control period or comparison participant. (EAU, 2026)

The treatment protocol changed over time, and some sessions included adjunctive methods. These factors prevent the outcome from being isolated to one Acutonics treatment variable.

The palpable tissue findings, repeated PDQ and IIEF data, participant reports, and photographed curvature changes make the case clinically interesting, but they do not eliminate these alternative explanations.

## **Overall Interpretation**

The findings provide a coherent pattern of change during the practitioner-administered study period.

Penile curvature decreased from approximately 60 degrees at baseline to 40 degrees by May 30 and was documented through repeated P.D.A.D. measurements and photographs. The IIEF increased from 56 at baseline to 70 on May 30. Repeated PDQ assessments documented the participant's Peyronie's-specific experience throughout the study. His separate erectile dysfunction rating improved, and he reported harder and fuller erections. The palpable

scarred area was also perceived by the participant and practitioner to change substantially in shape, length, firmness, and texture.

These findings came from different forms of evidence and should not be treated as interchangeable. A photographed curvature measurement, an IIEF score, a PDQ response, a participant report, and a practitioner palpation finding each answer a different type of question.

Their occurrence during the same treatment period makes the case worthy of further investigation.

The study cannot establish that Acutonics caused the changes or identify a biological mechanism. No medical imaging, vascular testing, tissue analysis, control comparison, or independent outcome assessment was available.

The most supportable conclusion from this case is that measurable curvature reduction, changes in standardized patient-reported outcomes, improved self-reported erectile function, and marked perceived changes in the palpable scarred area occurred during a course of practitioner-administered Acutonics treatment.

The 40-degree curvature was documented before the participant's self-treatment began and remained at 40 degrees during the June and August follow-up measurements. This chronology is important because it places the measurable 20-degree reduction within the documented practitioner-period

record rather than attributing any portion of that reduction to the unverified self-treatment period.

These findings provide a basis for future research using standardized Acutonics protocols, repeated photography, objective plaque assessment, tissue-elasticity measures, penile length and girth measurements, vascular evaluation, repeated PDQ and IIEF assessment, and independent outcome evaluation.

### **4.3 Implications for Future Research and Clinical Practice**

The findings from this case support further study of Acutonics as a non-invasive approach to Peyronie's disease. They do not support its use as an established treatment or as a replacement for urologic care. The next step should be to test the questions raised by this case under a more structured research design. (Yin, 2018)

### **Need for Larger Studies**

The most important next step would be a prospective study involving more participants.

A larger sample would help determine whether the changes observed in this case occur in other men with Peyronie's disease or were specific to this participant. It would also allow researchers to examine whether factors such as

disease duration, plaque location, baseline curvature, erectile function, age, or history of injury influence response.

A future study should begin with clearly defined inclusion and exclusion criteria and a predetermined treatment period. Participants should receive the same core treatment schedule so that treatment exposure can be compared across cases.

A controlled study would provide stronger evidence. An Acutonics group could be compared with observation alone, standard conservative care, or another appropriate control condition. Randomization, when feasible, would further reduce the effect of selection bias and differences between groups. (Yin, 2018)

Such a design would allow researchers to ask a more rigorous question than the present case can answer: whether changes associated with Acutonics exceed changes that occur without the intervention. (Yin, 2018)

## **A More Standardized Acutonics Protocol**

The individualized nature of the present treatment provided useful clinical information, but it makes it difficult to determine which parts of the protocol may have mattered.

Future studies should therefore define a reproducible core Acutonics protocol before treatment begins.

That protocol could specify the principal frequencies, point combinations, direct scar-tissue applications, treatment length, number of treatments per week, total treatment period, and method of tuning-fork placement. Any individualized additions could be recorded separately.

A standardized protocol would make it easier to compare results among participants and across future studies. It would also help distinguish the effects associated with the core treatment from those associated with individualized modifications.

The present case suggests that direct application to the scarred area deserves particular attention in future research because it became a prominent part of the treatment as the case progressed. However, this study cannot determine whether direct application, other elements of the Acutonics protocol, the combination of approaches, or factors unrelated to treatment accounted for the observed changes.

## **Objective Assessment of Penile Plaque and Tissue**

Future research should include objective assessment of the Peyronie's plaque and surrounding penile tissue.

The present study documented external curvature photographically and recorded palpable changes in the scarred area, but it did not include medical imaging capable of determining whether the internal plaque changed.

Penile ultrasound could provide information about plaque characteristics and, when clinically indicated, penile vascular function. Other appropriate imaging or measurement methods could help determine whether changes in external curvature are accompanied by measurable changes in plaque size, calcification, tissue structure, or other relevant physical characteristics. (EAU, 2026)

This would be especially valuable in evaluating the palpable changes observed in the present case. The participant and practitioner both perceived substantial changes in the shape, firmness, and texture of the scarred area, but palpation cannot establish what occurred within the tissue.

Future studies should therefore distinguish clearly between external curvature, palpable findings, and objectively assessed internal tissue characteristics.

## **Standardized Curvature Measurement and Photography**

Future studies should continue to use repeated curvature measurements with photographic documentation.

The photographic record was one of the strongest features of the present case because it provided visual documentation accompanying the recorded P.D.A.D. measurements. The approximately 60-degree baseline curvature and subsequent 50-degree, 45-degree, and 40-degree measurements could therefore be considered as a chronological series rather than relying on participant recollection alone.

Future research could strengthen this approach further by standardizing erection quality, participant position, camera angle, distance, measurement technique, and photographic conditions at each assessment.

Independent review of curvature measurements would also reduce the possibility of practitioner measurement bias.

## **Penile Length and Girth**

Future studies should include standardized measurements of penile length and girth at baseline and predetermined follow-up points.

Loss of length and girth was part of this participant's presentation, and increasing penile length was one of the original treatment goals. However, the available records did not contain a complete standardized series of measurements that would allow these outcomes to be analyzed quantitatively.

Participant reports of greater fullness and practitioner observations of increased fullness are clinically relevant qualitative findings, but they cannot substitute for measured changes in penile dimensions.

Consistent measurement would allow future research to determine whether any change in curvature occurs alongside changes in penile length or girth.

## **Erectile and Sexual Function**

Future studies should continue to assess erectile and sexual function with validated patient-reported measures.

The IIEF provided standardized information about erectile and sexual function in this case, while the PDQ provided Peyronie's-specific information about physical and psychological symptoms, penile pain, and symptom bother. (Hellstrom et al., 2013; Rosen et al., 1997)

Using both instruments in future research would preserve these different dimensions of the participant's experience. Assessments should be performed at predetermined intervals so that changes can be compared consistently across participants and treatment periods.

The participant's own descriptions should also remain part of the research record. Standardized questionnaires provide structured data, but interviews and

treatment reports may identify changes that are important to the participant and are not fully represented by questionnaire scores.

## **Assessment of Erectile Hemodynamics**

The participant reported harder and fuller erections, and greater penile fullness was also observed during treatment. The present study did not include vascular testing, so these findings cannot establish increased penile blood flow.

Future studies could include appropriate vascular assessment when clinically justified. This would allow researchers to determine whether reported or observed changes in erection quality are accompanied by measurable changes in penile hemodynamics.

Such testing would also help separate changes in erectile function from changes in curvature or perceived tissue characteristics.

## **Longer Follow-Up**

Longer follow-up would help determine whether changes observed during treatment persist after practitioner-administered care ends.

The present case included follow-up measurements after the practitioner-administered treatment period. Curvature was documented at 40 degrees on May 30 before the recorded self-treatment period began, remained at 40

degrees in the June 17 photograph during self-treatment, and was again documented at 40 degrees on August 19 after the reported self-treatment period.

These findings show that the documented 40-degree curvature remained stable during the available follow-up period. They do not establish what would happen over a longer period.

Future studies should include predetermined follow-up assessments after treatment ends, ideally without introducing an unverified intervention between the end of practitioner treatment and the final assessment.

## **Control of Self-Treatment and Other Interventions**

The participant's self-treatment created an important methodological issue in the later portion of this case.

Because the May 30 photograph documented 40 degrees before the recorded self-treatment period began, the reduction from approximately 60 degrees to 40 degrees remained within the practitioner-period record. However, findings collected after self-treatment began had to be interpreted separately because the participant's methods, adherence, treatment frequency and duration, tuning-fork selection, and placement could not be independently verified.

Future studies should establish clear rules concerning treatment outside the research protocol. Participants should be asked to report other Peyronie's treatments, self-treatment, medications, devices, supplements, or other interventions that could affect interpretation of the findings.

Where possible, concurrent interventions should either be restricted during the study period or documented in enough detail to permit appropriate analysis.

### **Practitioner Bias and Independent Assessment**

The practitioner in this case administered the treatment, interviewed the participant, made clinical observations, recorded findings, and adapted the treatment protocol. The practitioner also had a longstanding friendship with the participant before the study began.

These factors are important sources of potential bias. (Yin, 2018)

Future studies could reduce this concern by separating treatment from outcome assessment. An independent examiner could perform curvature measurements, review photographs, administer questionnaires, or assess other physical outcomes without knowing the practitioner's expectations or previous findings.

Blinding may not be possible for every aspect of an Acutonics study, but independent assessment would strengthen confidence in the recorded outcomes.

## **Integration With Urologic Care**

If future research supports the findings observed in this case, Acutonics could be studied as a complementary approach within urologic care rather than as a substitute for medical evaluation.

Peyronie's disease can involve penile deformity, erectile dysfunction, pain, loss of penile length, and difficulties with sexual intercourse. Medical evaluation remains important for diagnosis, assessment of disease stage, evaluation of erectile function, and consideration of established treatment options. (EAU, 2026)

A collaborative research model could combine urologic assessment with Acutonics treatment. Urologists could provide diagnostic evaluation, objective curvature assessment, ultrasound or vascular testing when indicated, and monitoring of disease status. Acutonics practitioners could administer a defined complementary treatment protocol.

Such collaboration would allow complementary treatment to be evaluated while maintaining appropriate medical oversight.

## **Broader Implications for Non-Invasive Research**

The present case also raises a broader question about non-invasive approaches to Peyronie's disease.

Existing conservative treatments include mechanical therapies such as penile traction and vacuum devices, while extracorporeal shockwave therapy has also been investigated. Evidence and recommendations vary according to the intervention and outcome being considered. (EAU, 2026)

Acutonics differs from these approaches in its method of application and theoretical framework. The findings from this case do not establish that Acutonics acts through the same mechanisms as traction, shockwave therapy, or other physical treatments.

Future research should therefore examine Acutonics on its own terms rather than infer its effects from other non-invasive therapies.

The broader value of such research would be to determine whether a non-invasive complementary intervention can produce reproducible changes in outcomes that matter to men with Peyronie's disease while avoiding unsupported assumptions about mechanism or efficacy.

## Implications for Clinical Practice

The present findings are not sufficient to establish a clinical treatment recommendation.

Practitioners should not use this single case to claim that Acutonics reduces Peyronie's plaque, reverses fibrosis, increases penile blood flow, or reliably corrects penile curvature.

The case does provide a detailed record of measurable and reported changes occurring during practitioner-administered Acutonics treatment. It also identifies practical issues that would matter if the approach were investigated further, including direct treatment of the scarred area, treatment frequency, standardized outcome measurement, participant feedback, independent assessment, and long-term follow-up.

For Acutonics practitioners, the case also illustrates the importance of distinguishing clinical observation from biomedical evidence. A change perceived through palpation can inform treatment, but it should remain identified as a practitioner observation unless an objective measure confirms the underlying tissue change.

Similarly, participant reports of improved erection quality or fullness should remain identified as patient-reported outcomes unless physical testing establishes the proposed physiological change.

## **Direction for Future Research**

The most useful next step would be a prospective study using a clearly defined Acutonics protocol, multiple participants, standardized treatment frequency, repeated photographic curvature measurements, validated PDQ and IIEF assessments, standardized penile length and girth measurements, objective plaque assessment, and independent outcome evaluation.

A controlled design would provide stronger evidence about whether changes occurring during Acutonics treatment differ from those expected from the natural course of Peyronie's disease, measurement variability, or other influences.

Longer follow-up would also be necessary to determine whether any observed changes persist after treatment ends.

The present case cannot answer those questions. Its contribution is to identify findings that can now be examined more rigorously. The documented reduction in curvature, changes in standardized patient-reported measures, participant reports, and perceived changes in the scarred tissue provide specific outcomes that future research can test under more controlled conditions.

## **4.4 Summary**

This case study began with a focused question: can Acutonics sound therapy reduce the symptoms and progression of Peyronie's disease? The purpose was exploratory. Acutonics has not been established as a treatment for Peyronie's disease, and a single case cannot determine efficacy. The value of this study lies in the detailed record of what occurred during a defined period of practitioner-administered treatment, the use of repeated physical and patient-reported measures, and the questions those findings raise for future research. (Yin, 2018)

### **Summary of the Case**

The participant entered the study with a history of Peyronie's disease that began after a serious motorcycle accident in 2020. He described painful erections after the injury, followed within several months by penile deformity. By the time the case study began, pain had resolved, but curvature, loss of penile length and girth, changes in erection quality, and the effects of the deformity on sexual activity remained.

Before treatment, he described the condition as affecting his confidence during intimacy and limiting some sexual positions. He also reported more difficulty maintaining an erection than he had experienced before the onset of Peyronie's disease.

His expectations were measured. He did not expect a complete return to his pre-Peyronie's condition. He hoped to see some improvement, particularly less curvature or recovery of lost length.

The baseline P.D.A.D. assessment documented approximately 60 degrees of curvature. The initial clinical record also documented visible scar tissue, deformity of the head of the penis, erectile dysfunction self-rated at 4 to 5, and an IIEF score of 56. (Rosen et al., 1997; Urology Health Store, n.d.)

The Peyronie's Disease Questionnaire (PDQ) and International Index of Erectile Function (IIEF) were administered repeatedly throughout the study. These instruments provided standardized patient-reported measures that could be considered alongside curvature measurements, photographs, participant reports, practitioner observations, and palpable findings. The PDQ provided a Peyronie's-specific measure of physical and psychological symptoms, penile pain, and symptom bother, while the IIEF measured erectile and sexual function. (Hellstrom et al., 2013; Rosen et al., 1997)

Treatment used Acutonics tuning forks through a changing protocol that included acupuncture points, Extraordinary Vessels, broader constitutional treatment, and direct application over the affected penile tissue. Direct work on the scarred area became increasingly important as the case developed. (Acutonics Institute of Integrative Medicine, n.d.; Carey & de Muynck, 2007)

## Summary of the Physical and Patient-Reported Results

The clearest measured physical outcome was penile curvature.

Curvature decreased from approximately 60 degrees at baseline to 50 degrees in February and then to 45 degrees in March. A 45-degree measurement was again documented in April. On May 30, 2025, a photograph documented curvature at 40 degrees.

This May 30 finding is important to the interpretation of the case because it was documented before the participant began his documented period of self-treatment. The 40-degree measurement therefore belongs within the documented practitioner-administered treatment record rather than being treated solely as a later follow-up finding.

From the approximately 60-degree baseline measurement to the May 30 measurement of 40 degrees, the documented curvature decreased by approximately 20 degrees. This represents an approximately 33 percent reduction in the measured angle over the course of the practitioner-administered study period.

The participant's sexual-function findings also changed during the study. His IIEF score increased from 56 at baseline to 65 during the February, March, and April assessments, to 66 during the May 4 through May 10 assessment period, and to 70 on May 30. His separate self-rating of erectile dysfunction also

improved. He reported harder and fuller erections and began noticing that his penis appeared straighter. (Rosen et al., 1997)

The repeated PDQ assessments provided a second standardized patient-reported record. Because the PDQ is specific to Peyronie's disease, it captured aspects of the participant's experience that could not be represented by curvature measurements or the IIEF alone, including physical and psychological symptoms, pain, and symptom bother associated with the condition. (Hellstrom et al., 2013)

The physical appearance of the penis also changed during the case. Treatment notes described increased fullness and a visibly straighter appearance as treatment progressed.

Another important finding involved the palpable scar tissue. The participant described the affected tissue at the beginning of the study as long, smooth, hard, and shaped like a bullet, with tapered ends. By the end of practitioner-administered treatment, he described it as shorter and softer, with a cork-like shape and texture.

Both participant and practitioner perceived a marked difference in the way the affected area felt. Areas within the scar tissue could also be palpated that felt like openings or separations in locations where the ends of the tuning forks had been applied. The contemporaneous treatment notes document a

progression of tactile impressions during treatment, including a sense of getting beneath the scarred area, separation within the affected tissue, and later a perception that treatment was beginning to “pierce” the scar tissue.

These tactile findings cannot establish that the internal structure, composition, size, or density of the Peyronie's plaque changed because medical imaging was not performed. They remain important observations within the case because the perceived physical changes occurred during the same period as the measured and photographed reduction in penile curvature and changes in the participant's reported sexual function. (European Association of Urology [EAU], 2026)

## **Self-Treatment and Final Follow-Up**

After the May 30 photograph documenting 40 degrees of curvature, the participant began a period of self-treatment with Acutonics.

The documented self-treatment log begins on June 8 and continues into August. The participant's methodology, frequency and duration of treatment, choice of frequencies, placement techniques, adherence, and whether the treatments were performed as reported could not be independently verified.

For that reason, the self-treatment period was kept separate from the practitioner-administered clinical treatment period.

This distinction does not require excluding the May 30 measurement of 40 degrees from the primary clinical record. The May 30 photograph was obtained before the documented self-treatment period began and therefore documents that the curvature had already reached 40 degrees before the unverified intervention began.

A June 17 photograph documented curvature at 40 degrees during the participant's self-treatment period.

On August 19, 2025, after the participant had completed his reported period of self-treatment, a final P.D.A.D. measurement was performed and documented photographically. The curvature measured 40 degrees.

The August 19 result matched the 40-degree measurements documented on May 30 and June 17. The longitudinal record therefore shows a reduction from approximately 60 degrees at baseline to 40 degrees by May 30, followed by continued photographic documentation of 40 degrees during the self-treatment period and at the final August 19 assessment.

No additional reduction in measured curvature was documented between the May 30 and August 19 assessments.

The study therefore does not attribute an additional curvature change to the participant's self-treatment. The measurable 20-degree reduction,

approximately 33 percent from baseline, had already been documented before the self-treatment log began.

## **Significance of the Case**

The significance of this case rests on the convergence of several findings rather than on any one observation.

A measurable and photographed reduction in penile curvature occurred during the practitioner-administered study period. The participant reported better erectile function and described harder and fuller erections. His repeated IIEF assessments changed in the same direction as his subjective reports. The PDQ documented his Peyronie's-specific experience throughout the study. The penis appeared straighter and fuller during treatment. Both participant and practitioner also perceived a substantial change in the physical character of the palpable scar tissue. (Hellstrom et al., 2013; Rosen et al., 1997)

The curvature findings are particularly important because they form a documented progression rather than a single before-and-after observation: approximately 60 degrees at baseline, 50 degrees in February, 45 degrees in March and April, and 40 degrees by May 30. The June 17 and final August 19 measurements remained at 40 degrees.

These findings do not prove that Acutonics caused the changes. They do provide a coherent clinical pattern across physical measurement, photographic

documentation, standardized patient-reported measures, participant reports, practitioner observations, and palpation findings.

That distinction is especially important for an emerging treatment approach. The contribution of a case study does not depend on proving a therapy effective. A well-documented case can identify observations worth testing, expose weaknesses in measurement, help refine a treatment protocol, and point toward questions that can later be examined through more rigorous research. (Yin, 2018)

This case has done each of those things.

## **Contribution to Acutonics Practice**

This study changed my understanding of how Acutonics might be approached in a condition involving localized structural change.

The original treatment plan was broad and included constitutional, energetic, emotional, and local components. As the case developed, direct treatment of the affected tissue became a greater part of the work.

The clinical record documents that direct scar-tissue treatment was planned from the beginning. The treatment process then became more responsive to what I observed, what I could palpate, what the participant reported, and what the repeated assessments documented.

One lesson from the case was the importance of allowing measured outcomes to guide treatment. Another was the need to distinguish the theoretical framework used to select Acutonics treatment from the methods used to assess its outcome.

The language of Qi, Blood, Extraordinary Vessels, planetary frequencies, and energetic patterns belongs within the Acutonics and Traditional Chinese Medicine framework used to design treatment. Curvature measurements, photographs, IIEF scores, PDQ responses, participant reports, practitioner observations, and palpable findings represent different forms of assessment. (Acutonics Institute of Integrative Medicine, n.d.; Carey & de Muynck, 2007; Hellstrom et al., 2013; Rosen et al., 1997)

Keeping these forms of evidence distinct strengthens an Acutonics case study. It allows the treatment to remain true to its theoretical roots while making clear what was measured, what was photographed, what was reported by the participant, what was perceived through palpation, and what remains unknown. (Yin, 2018)

## **Contribution to Peyronie's Disease Research**

The participant entered the study seeking a non-surgical approach. He had not received treatment for his Peyronie's symptoms and expressed concern about the risks he associated with surgery. His stated measure of success was

modest: he would consider any noticeable decrease in curvature or increase in length beneficial.

Against that starting point, the documented reduction from approximately 60 degrees to 40 degrees is meaningful within this individual case.

The study does not show that Acutonics should replace established medical treatment for Peyronie's disease. It does demonstrate that an Acutonics case study can incorporate outcome measures relevant to Peyronie's care. In this study, those measures included photographed curvature in degrees, repeated IIEF assessments, repeated PDQ assessments, the participant's separate erectile dysfunction ratings, sexual-function reports, clinical observation, and palpation of the affected tissue. (EAU, 2026; Hellstrom et al., 2013; Rosen et al., 1997)

The use of the PDQ throughout the study is particularly important because it provided a validated Peyronie's-specific patient-reported measure rather than relying exclusively on general erectile-function scores or informal participant reports. (Hellstrom et al., 2013)

Future research should retain repeated PDQ and IIEF assessments while strengthening objective physical assessment. Standardized photography, blinded or independent curvature assessment, consistent penile length and girth measurements, ultrasound or other appropriate plaque imaging, and vascular

testing when clinically indicated would provide information that this case could not obtain. (EAU, 2026; Hellstrom et al., 2013; Rosen et al., 1997)

A larger study would make it possible to determine whether changes in curvature, erectile function, PDQ responses, and palpable tissue characteristics show a consistent pattern across participants.

Such research could determine whether the pattern observed here can be reproduced.

## **Clinical Integration**

The findings of this case do not support immediate integration of Acutonics into routine urologic treatment for Peyronie's disease. Current clinical guidelines are based on established diagnostic and treatment approaches, and Acutonics has not been clinically established as a Peyronie's disease therapy. (Chierigo et al., 2026; EAU, 2026)

The findings do support further investigation of potential collaboration.

A future research model could bring together an Acutonics practitioner and a urologist. The urologist could confirm diagnosis and disease stage, assess plaque characteristics, document curvature and penile dimensions, evaluate erectile and vascular function, and identify medical concerns. The Acutonics

practitioner could administer a standardized treatment protocol and document the energetic, observational, and tactile aspects of care.

The PDQ and IIEF could be administered at predetermined intervals throughout such a study, as they were repeatedly used in this case. Standardizing the timing of these assessments would make changes easier to compare with physical measurements and treatment milestones. (Hellstrom et al., 2013; Rosen et al., 1997)

Independent outcome assessment would further strengthen the research design. (Yin, 2018)

This kind of collaboration would allow Acutonics to be investigated alongside medical evaluation. It would also provide objective tools that were missing from this case, particularly imaging of plaque structure and assessment of penile vascular function.

## **Reflection on the Research Process**

This study also changed me as a practitioner and researcher.

I began with ideas about what the participant needed and how I expected him to respond. The case repeatedly required me to return to what was actually in front of me: what he said, what the questionnaires recorded,

what I could observe, what I could measure, what I could feel through palpation, and what I could not know.

That became one of the most important lessons of the project.

The participant's emotional response did not always match my expectations. The treatment protocol did not remain as I first designed it. Some outcomes I hoped to measure, such as penile length and girth, were not documented well enough to support conclusions. Medical imaging that could have helped explain the scar-tissue findings was not available.

At the same time, findings emerged that I had not expected to become so important. The photographed curvature changed progressively, reaching 40 degrees by May 30. Erectile-function measures changed. The repeated PDQ and IIEF assessments created a longitudinal record of the participant's experience. He described harder and fuller erections. Both of us perceived a marked physical change in the palpable scar tissue.

The follow-up period also reinforced the importance of defining the boundaries of a case study. Once the participant began self-treatment outside the clinic, I could no longer independently verify the intervention. However, the curvature had already been photographed at 40 degrees before the documented self-treatment period began. A June 17 photograph again documented 40 degrees during self-treatment, and the final August 19

measurement remained at 40 degrees. Keeping these events in their correct chronological order prevents the documented improvement achieved before self-treatment from being mistakenly assigned to the unverified treatment period.

These experiences reinforced the need to remain curious without turning observation into certainty.

## **Final Perspective**

This case cannot answer whether Acutonics is an effective treatment for Peyronie's disease. It can document what happened to one participant during a defined and carefully recorded course of Acutonics treatment. (Yin, 2018)

During the practitioner-administered study period, penile curvature decreased from approximately 60 degrees at baseline to 40 degrees by May 30, 2025. This represents an approximately 20-degree, or 33 percent, reduction in measured curvature.

The participant reported harder and fuller erections and perceived his penis as becoming straighter. His repeated IIEF assessments documented changes in erectile and sexual function, while repeated PDQ assessments documented his experience of Peyronie's disease throughout the study. His IIEF score increased from 56 at baseline to 70 by May 30. Both participant and

practitioner perceived a substantial change in the physical character of the scarred area. (Hellstrom et al., 2013; Rosen et al., 1997)

After the May 30 measurement, the participant began a period of self-treatment that could not be independently verified. A June 17 photograph documented curvature at 40 degrees during this period. On August 19, 2025, after the reported self-treatment period, the final P.D.A.D. assessment again documented curvature at 40 degrees. The later measurements therefore did not show an additional reduction in curvature beyond the 40 degrees already photographed before the documented self-treatment period began.

The study leaves important questions unanswered. The available evidence cannot verify that Acutonics changed plaque size, collagen structure, tissue elasticity, penile blood flow, fibrosis, or any other internal biological process. No imaging was performed that could establish the nature of the palpable tissue changes. A single-participant case also cannot determine whether the observed changes would have occurred without treatment or whether another person would respond in the same way.

Those limits define what can responsibly be concluded from the case.

Within those limits, several findings remain worthy of further study. A photographed and measurable reduction in curvature occurred during the verified practitioner-administered period. Standardized patient-reported

measures documented changes over time. The participant reported changes in erection quality and penile appearance. Both participant and practitioner perceived a substantial physical change in the affected tissue.

The value of this case lies in documenting a pattern that deserves further inquiry. It offers a starting point for a more rigorous study of Acutonics in Peyronie's disease, one that joins the detailed, whole-person approach of Acutonics with standardized patient-reported measures, biomedical assessment, imaging, and independent evaluation. (Yin, 2018)

For a condition that had changed the participant's body, sexual function, and confidence, his original hope was simply to see some improvement. During the practitioner-administered study period, measurable improvement in curvature occurred alongside changes in erectile function, repeated PDQ and IIEF assessments, penile appearance, and the perceived physical character of the affected tissue.

The next question is whether those findings can be reproduced under more controlled conditions. That question provides a clear path for future study and a responsible place for this case to end.

## References

- Acutonics Institute of Integrative Medicine. (n.d.). Acutonics® tuning forks. <https://acutonics.com/sound-tools/tuning-forks>
- Aditya, I., Kwong, J. C. C., Krakowsky, Y., & Grober, E. D. (2020). Non-conventional therapies for Peyronie's disease: What is the evidence for efficacy? *Translational Andrology and Urology*, 9(Suppl 2), S295–S302. <https://doi.org/10.21037/tau.2019.09.36>
- Almsaoud, N. A., Safar, O., Alshahrani, S. T., Alwadai, R., Alkhaldi, S. M., Almurayyi, M., Alrweili, H. H., Assiri, H. M., Al Jubran, A., Hakami, B., & Alzahrani, M. A. (2023). The effect of penile traction device in men with Peyronie's disease on penile curvature, penile length, and erectile dysfunction: A systematic review and meta-analysis. *Translational Andrology and Urology*, 12(11), 1673–1685. <https://doi.org/10.21037/tau-23-310>
- Carey, D., & de Muynck, M. (2007). *Acutonics: There's no place like Ohm: Sound healing, East Asian medicine and the cosmic mysteries*. Devachan Press.
- Chierigo, F., Fallara, G., Tozzi, M., Salonia, A., Ferro, M., Alhajjar, H. M., Muneer, A., & Pang, K. H. (2026). Guideline of guidelines: Peyronie's disease. *BJU International*, 137(5), 770–782. <https://doi.org/10.1111/bju.70201>
- De Berardinis, E., Busetto, G. M., Antonini, G., Giovannone, R., & Gentile, V. (2010). Extracorporeal shock wave therapy in the treatment of Peyronie's

disease: Long-term results. *Archivio Italiano di Urologia e Andrologia*, 82(2), 128–133. <https://pubmed.ncbi.nlm.nih.gov/20812541/>

El-Sakka, A. I. (2021). Medical, non-invasive, and minimally invasive treatment for Peyronie's disease: A systematic review. *Andrology*, 9(2), 511–528. <https://doi.org/10.1111/andr.12927>

European Association of Urology. (2026). Penile curvature. In *EAU guidelines on sexual and reproductive health*. <https://uroweb.org/guidelines/sexual-and-reproductive-health/chapter/penile-curvature>

Hauck, E. W., Altinkilic, B. M., Ludwig, M., Lüdecke, G., Schroeder-Printzen, I., Arens, C., & Weidner, W. (2000). Extracorporeal shock wave therapy in the treatment of Peyronie's disease: First results of a case-controlled approach. *European Urology*, 38(6), 663–670. <https://doi.org/10.1159/000020359>

Hellstrom, W. J. G., Feldman, R., Rosen, R. C., Smith, T., Kaufman, G., & Tursi, J. (2013). Bother and distress associated with Peyronie's disease: Validation of the Peyronie's Disease Questionnaire. *The Journal of Urology*, 190(2), 627–634. <https://doi.org/10.1016/j.juro.2013.01.090>

Kantor, J., Campbell, E. A., Kantorová, L., Marečková, J., Regec, V., Karasová, K., Sedláčková, D., & Klugar, M. (2022). Exploring vibroacoustic

therapy in adults experiencing pain: A scoping review. *BMJ Open*, 12(4), e046591. <https://doi.org/10.1136/bmjopen-2020-046591>

Lee, H. Y., Pyun, J. H., Shim, S. R., & Kim, J. H. (2024). Medical treatment for Peyronie's disease: Systematic review and network Bayesian meta-analysis. *World Journal of Men's Health*, 42(1), 133–147. <https://doi.org/10.5534/wjmh.230016>

Morris, W. (n.d.). *Case study: An approach to knowledge* [Unpublished manuscript].

National Center for Complementary and Integrative Health. (2025). *Mind and body practices*. <https://www.nccih.nih.gov/health/mind-and-body-practices>

National Institute of Diabetes and Digestive and Kidney Diseases. (2019). *Penile curvature (Peyronie's disease)*. U.S. Department of Health and Human Services. <https://www.niddk.nih.gov/health-information/urologic-diseases/penile-curvature-peyronies-disease>

National Museum of American History. (n.d.). *Tuning forks*. Smithsonian Institution. <https://americanhistory.si.edu/acoustics/tuning-forks>

Nelson, C. J., & Mulhall, J. P. (2013). Psychological impact of Peyronie's disease: A review. *The Journal of Sexual Medicine*, 10(3), 653–660.

<https://doi.org/10.1111/j.1743-6109.2012.02999.x>

Ponton, J., & Ponton, P. (Eds.). (2010). *Acutonics: From galaxies to cells: Case study companion guide* (Vol. 1). Devachan Press.

Ponton, J., & Ponton, P. (2019, March 1). *Frequency, resonance and the Tao*. Acutonics Institute of Integrative Medicine.

<https://acutonics.com/news/frequency-resonance-and-the-tao>

Pyrgidis, N., Yafi, F. A., Sokolakis, I., Dimitriadis, F., Mykoniatis, I., Russo, G. I., Verze, P., & Hatzichristodoulou, G. (2022). Assessment of conservative combination therapies for active and stable Peyronie's disease: A systematic review and meta-analysis. *European Urology Focus*, 8(5), 1520–1530.

<https://doi.org/10.1016/j.euf.2021.12.003>

Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick, J., & Mishra, A. (1997). The International Index of Erectile Function (IIEF): A multidimensional scale for assessment of erectile dysfunction. *Urology*, 49(6), 822–830.

[https://doi.org/10.1016/S0090-4295\(97\)00238-0](https://doi.org/10.1016/S0090-4295(97)00238-0)

Sandean, D. P., Leslie, S. W., & Lotfollahzadeh, S. (2024). Peyronie disease. In *StatPearls*. StatPearls Publishing.

<https://www.ncbi.nlm.nih.gov/books/NBK560628/>

Urology Health Store. (n.d.). *P.D.A.D. Peyronie's Disease Assessment Device*. <https://www.urologyhealthstore.com/products/p-d-a-d-peyronie-s-disease-assessment-device>

Wang, X., Liu, H., Tang, G., Wu, G., Chu, Y., Wu, J., & Cui, Y. (2023). Updated recommendations on the therapeutic role of extracorporeal shock wave therapy for Peyronie's disease: Systematic review and meta-analysis. *BMC Urology*, 23, 145. <https://doi.org/10.1186/s12894-023-01320-8>

Yilmaz, M., Karaaslan, M., Şirin, M. E., Aybal, H. Ç., Polat, M. E., Soyturk, S., Toprak, T., Tonyali, S., & Guven, S. (2026). Efficacy of low-intensity pulsed ultrasound (LIPUS) in the treatment of erectile dysfunction: A systematic review. *International Urology and Nephrology*, 58(1), 77–89. <https://doi.org/10.1007/s11255-025-04639-3>

Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). SAGE Publications.