

Jelqz

THE ANATOMY & HISTORY OF THE PENIS & JELQING

An educational companion to The Growth Guide

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INTRODUCTION

Know the Territory

The original guide you started from spent most of its length quoting encyclopedia entries — page after page of anatomy and trivia bolted on to pad a thin booklet. The information was worth having; the presentation buried it. This companion rebuilds that material into something you can actually read: a clear, honest tour of what the penis is, how it works, how human cultures have understood it, and where a practice like jelqing fits into that long story.

It is organised in three parts. **Part I** is pure anatomy and physiology — the structures, the blood supply, and the mechanics of an erection. **Part II** steps back to history and culture: how the organ has been worshipped, feared, dissected, and finally understood. **Part III** turns to jelqing itself — what it is, the colourful origin stories attached to it, how it spread, and, most importantly, what the scientific evidence does and doesn't support.

None of this is medical advice. It is background — the context that makes the training guide make sense, and that lets you separate fact from folklore and marketing.

PART I

Anatomy of the Penis

The penis is one of the more elegantly engineered structures in the body: a hydraulic organ that changes shape and rigidity on demand, serving both the urinary and reproductive systems. To understand any training method, you first have to understand the machine.

External Structure

Seen from the outside, the penis divides into three regions. The **root** is the anchored portion, hidden inside the body, where the organ attaches to the pelvic bones and the perineal muscles. The **body**, or shaft, is the free, visible length. At the end sits the **glans** — the head — a cone of highly sensitive tissue that caps the shaft.

The shaft is wrapped in unusually loose, mobile skin that allows the organ to expand dramatically during an erection. In uncircumcised males, this skin extends forward over the glans as the **foreskin** (prepuce), a retractable double fold tethered to the underside of the glans by a thin band called the **frenulum**. At the very tip, the **meatus** is the external opening of the urethra.

These outer landmarks matter for training because the structures that carry sensation and the structures that carry blood do not run where you might assume — a point that becomes important once pressure is involved.

FIG. 2 · EXTERNAL STRUCTURE (SIDE VIEW)

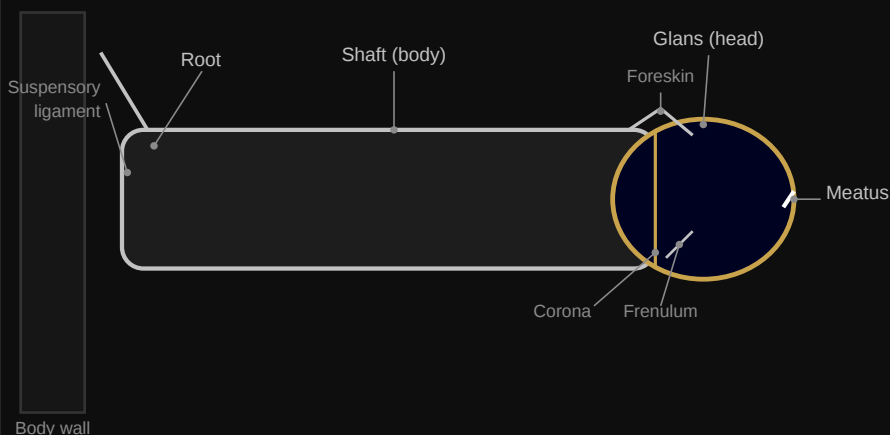


Fig. 2 — External regions of the penis. The sensitive glans and the superficial dorsal nerve and vessels sit exactly where force is most likely to land.

The glans and the foreskin

The glans is densely supplied with nerve endings, which is why it is the most sensitive region. It is also more delicate than the shaft and tolerates far less mechanical force — the reason every credible exercise stops the stroke before reaching it. The foreskin, where present, shares an embryonic origin with the inner labia in females, a clue to how the genitals develop, which we return to later.

The Three Erectile Columns

Inside the shaft, three parallel cylinders of spongy, blood-holding tissue do the real work. Two of them, the paired **corpora cavernosa**, run along the top (dorsal) side. The third, the single **corpus spongiosum**, runs underneath (ventral) and wraps around the urethra, expanding at the end to form the glans.

FIG. 1 · CROSS-SECTION OF THE SHAFT

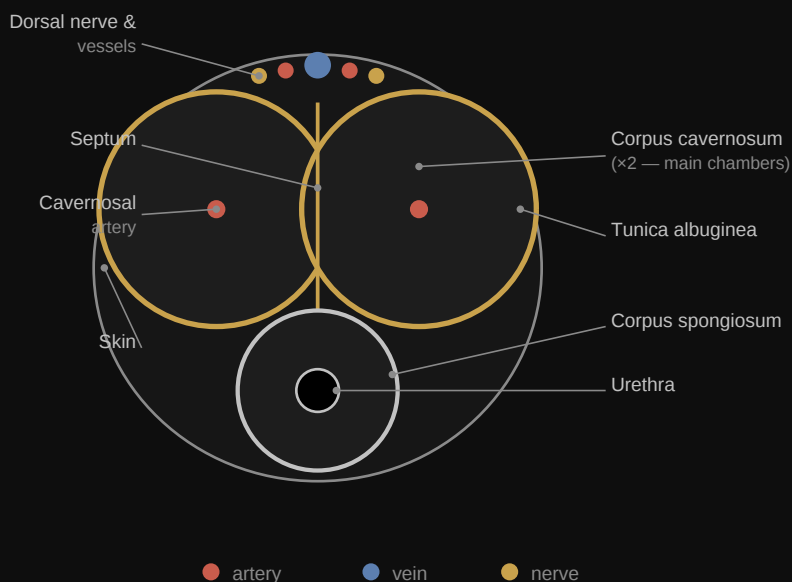


Fig. 1 — Cross-section of the shaft. The paired corpora cavernosa do most of the work; the tunica albuginea around them sets the ceiling on size.

Each column is a lattice of tiny blood spaces called sinusoids, threaded with smooth muscle. At rest the muscle is contracted and the spaces are nearly empty, leaving the penis soft and small. During arousal the muscle relaxes, the spaces flood with blood, and the organ enlarges and stiffens. Roughly nine-tenths of the blood involved in an erection is held in the two corpora

cavernosa — they are the main engine of rigidity and size.

Why this matters for size

Because erect size is set by how much blood the corpora cavernosa can hold, and because their capacity is in turn capped by the fibrous sheath around them, the penis cannot simply will itself larger. Any genuine change in capacity has to come from changes in that surrounding tissue — which is precisely the claim, and the limitation, behind every enlargement method.

The corpus spongiosum is built differently: it stays softer even when erect, so the urethra running through it is never fully compressed. That is deliberate — it keeps the channel open for ejaculation at the one moment it is needed.

The Tunica Albuginea

Wrapped tightly around the corpora cavernosa is a tough, fibrous envelope called the **tunica albuginea**. It is one of the strongest fascial tissues in the body, and it is the single most important structure for understanding both erection and the limits of enlargement.

During an erection the tunica does two jobs at once. As the sinusoids fill and the corpora swell, the tunica stretches only so far and then becomes rigid, giving the erection its firmness. At the same time, its stretching pinches shut the small veins that would otherwise let blood drain away. This trapping effect, called the veno-occlusive mechanism, is what keeps an erection hard once it forms.

The ceiling on size

The tunica's limited distensibility is the natural ceiling on erect size. Enlargement theories propose that very gradual, repeated loading can remodel this tissue over months so that it accommodates slightly more volume — the same logic by which connective tissue adapts elsewhere in the body. The flip side is that the tunica is also what tears in a so-called penile fracture, an injury caused by sudden force on a rigid erection. That is the anatomical reason every responsible method insists on a semi-erect state and gentle pressure: a fully rigid tunica is under tension and far easier to injure.

One Channel, Two Jobs

The **urethra** is the tube that runs the length of the penis inside the corpus spongiosum, opening at the meatus. It is shared infrastructure for two separate systems. Most of the time it carries urine from the bladder. During ejaculation, a valve at the bladder neck closes and the same tube instead carries semen, which arrives via the ejaculatory ducts after passing the prostate.

Because the corpus spongiosum stays compressible, the urethra is never fully crushed even at peak rigidity, keeping the passage open when it counts. This dual-use design is efficient but also explains why irritation or injury in this region can affect both urination and sexual function — and why abrasive substances like soap should never be used as lubricant near the meatus.

The glans, formed by the forward expansion of the corpus spongiosum, is the terminus of this channel. Its softer erectile tissue is why the head engorges visibly but never becomes as hard as the shaft.

The Plumbing of an Erection

An erection is, mechanically, a plumbing event — a controlled imbalance between blood flowing in and blood draining out. Both the inflow and the outflow have a precise anatomy.

Blood arrives through the internal pudendal artery, which branches into the arteries of the penis. The most important of these, the deep (cavernosal) arteries, run inside each corpus cavernosum and feed a network of coiled vessels called **helicine arteries** that open directly into the sinusoids. When these vessels dilate, blood pours into the erectile spaces.

Drainage normally happens through small veins that pierce the tunica albuginea, eventually collecting into the deep dorsal vein on top of the shaft. The trick of a sustained erection is that the swelling corpora press these outflow veins against the stiff tunica and squeeze them nearly shut, so blood is trapped under pressure.

The whole organ also has a rich supply of superficial vessels in the skin. This is why even gentle exercises produce visible flushing and temporary fullness, and why bruising shows so readily if pressure is overdone.

Nerves and Sensation

Two different nerve systems serve the penis, and confusing them is a recipe for injury. The first carries ordinary sensation. The **dorsal nerve of the penis**, a branch of the pudendal nerve, runs in a pair just under the skin along the top of the shaft and supplies most of the organ's touch and the intense sensitivity of the glans.

Because these sensory nerves sit superficially along the dorsal midline, sustained pressure there can cause numbness or tingling. That is exactly why stretching instructions tell you to grip so that force is distributed around the shaft and kept off that thin strip on top.

The autonomic side

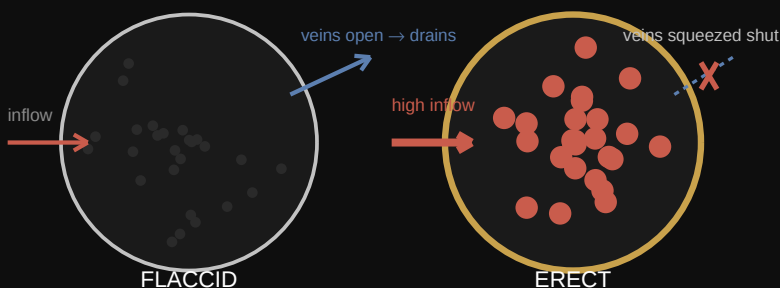
The second system is autonomic and invisible: the **cavernous nerves** control the smooth muscle of the erectile tissue. Parasympathetic fibres trigger and maintain an erection; sympathetic fibres end it. These nerves do not register as 'feeling' in the ordinary sense, but they are the wiring that makes the hydraulic system respond to arousal at all. They run close to the prostate, which is why prostate surgery can affect erectile function.

How an Erection Actually Works

Put the pieces together and the sequence is remarkably orderly. Arousal — physical, psychological, or both — sends signals down the parasympathetic nerves. Nerve endings and the vessel linings release nitric oxide, a tiny signalling molecule that tells the smooth muscle of the arteries and sinusoids to relax.

As the muscle relaxes, the helicine arteries open and blood rushes into the erectile spaces of the corpora cavernosa. They expand against the tunica albuginea, which stiffens and simultaneously clamps the drainage veins shut. Inflow high, outflow blocked: pressure climbs, and the penis becomes both larger and rigid. This is the veno-occlusive mechanism in action.

FIG. 3 · THE VENO-OCCLUSIVE MECHANISM



Relaxed smooth muscle + arterial inflow fills the sinusoids; the swelling presses outflow veins against the tunica and traps blood → rigidity.

Fig. 3 — Inflow fills the sinusoids; the swelling traps the outflow veins against the tunica, holding blood under pressure.

Detumescence — returning to softness — is the reverse. Sympathetic signals after orgasm, or simply the end of arousal, make the smooth muscle contract again. The arteries narrow, the sinusoids empty, the veins reopen, and blood drains away.

The chemistry behind the pill

Nitric oxide works through a second messenger called cGMP, which keeps the muscle relaxed. An enzyme, PDE5, normally breaks cGMP down. Modern erectile drugs such as sildenafil block PDE5, letting cGMP — and therefore the erection — last longer. Understanding this single pathway is what turned erectile dysfunction from a mystery into a treatable condition in the 1990s.

Before Birth: A Shared Blueprint

One of the most striking facts in genital anatomy is that male and female external genitals start from the same embryonic structures. Early in development every fetus has a small bud called the **genital tubercle**, flanked by folds and swellings, with no visible sex difference.

FIG. 4 · A SHARED DEVELOPMENTAL ORIGIN

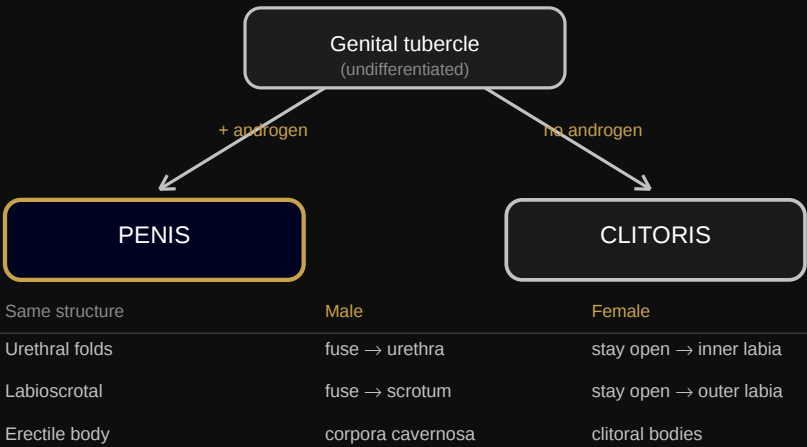


Fig. 4 — The same embryonic structures become male or female genitals depending on androgen signalling.

Under the influence of testosterone — specifically its potent derivative dihydrotestosterone — the tubercle elongates into the penis, the urethral folds fuse to enclose the urethra along the underside, and the labioscrotal swellings fuse into the scrotum. In the absence of that hormonal signal, the same tubercle becomes the clitoris, the folds become the inner labia, and the swellings become the outer labia.

This shared origin is why the penis and clitoris are built from comparable erectile tissue, and why the skin of the penis and the inner labia are embryological cousins. The line of fusion on the underside of the penis, visible as the raphe, is the seam where those folds joined.

Averages, Variation, and Perception

Few numbers are more anxiously sought or more poorly understood than penis size. The most reliable figures come from a large 2015 review that pooled measurements — taken by clinicians, not self-reported — from more than fifteen thousand men. It found an average erect length of about 13.1 cm (5.2 inches), an average flaccid length around 9 cm, and an average erect circumference near 11.7 cm.

FIG. 5 · ERECT LENGTH – DISTRIBUTION

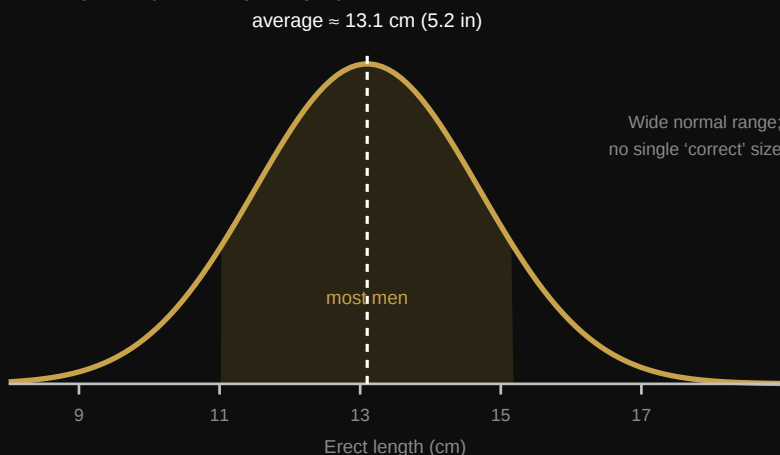


Fig. 5 — Erect length clusters around an average of roughly 13.1 cm, with a wide band of entirely normal variation.

Two themes run through the data. First, the range of normal is wide; there is no single 'correct' size. Second, flaccid length is a poor predictor of erect length — 'growers' gain proportionally more on erection than 'showers' do.

The perception gap

Surveys consistently find that the large majority of men who worry about size fall squarely within the normal range, and that men estimate the average as larger than it is — partly because of pornography, partly because of the foreshortened angle from which a man views his own body. A recognised condition, penile dysmorphic disorder, describes distress about size in men whose anatomy is entirely typical. This is worth stating plainly in a document about enlargement: for most people the gap is between perception and reality, not between their body and the average.

The Foreskin and Circumcision

Circumcision — surgical removal of the foreskin — is one of the oldest and most widely practised procedures in human history, and one of the most debated. It is performed for religious reasons in Judaism and Islam, as a cultural custom in many societies, and electively or medically elsewhere.

The medical picture is genuinely mixed, which is why reasonable authorities disagree. Large studies have linked circumcision to reduced rates of certain infections — including a meaningful reduction in heterosexual HIV transmission in high-prevalence regions, which led the World Health Organization and UNAIDS to endorse it as one part of HIV-prevention programmes in those specific settings. It is also associated with lower rates of some urinary infections in infancy and of penile cancer.

The other side of the ledger

Against this sit the realities of any surgery: bleeding, infection, and removing too much or too little tissue are the common complications, and rates rise when the procedure is done on older children rather than newborns. There is also a live ethical debate about performing a permanent, non-essential operation on a minor who cannot consent. Major medical bodies land in different places, from cautious endorsement to neutrality, reflecting how the risks and benefits are weighed rather than any single settled verdict.

IN SHORT

The foreskin is functional tissue with a real developmental and sensory role; circumcision carries documented benefits in specific contexts and documented risks in all of them. It is a decision shaped by medicine, culture, and ethics together — not a question with one universal answer.

PART II

The Penis in History & Culture

Long before anyone understood the corpora cavernosa, the penis was a symbol — of fertility, power, and protection. The story of how it went from religious icon to dissected specimen to treatable organ is, in miniature, the story of how humans learned to study their own bodies.

Phallus and Symbol

In the ancient world the erect phallus was less an object of embarrassment than a sign of vitality. Prehistoric carvings already use it as shorthand for fertility and life. By the classical era it had become woven into religion and daily ritual.

The Greeks set boundary markers called **herms** — pillars topped with a head and bearing a phallus — at crossroads and doorways for protection and good fortune. The Romans went further: the **fascinus**, a winged phallic charm, was worn and hung as a defence against the evil eye, and the god **Priapus**, perpetually erect, guarded gardens and thresholds. Far to the east, the **lingam** remains a central, revered emblem of the Hindu god Shiva, representing generative cosmic power.

These were not crude jokes. They reflect a worldview in which sexual potency, agricultural fertility, and divine protection were tangled together. The shift toward treating the organ as private and faintly shameful is a later, largely cultural development — useful to remember when modern anxiety presents itself as timeless.

Mapping the Body: Galen to Vesalius

Understanding lagged far behind symbolism. For more than a thousand years European medicine relied on the writings of **Galen**, the Greek physician of the second century, whose anatomy was partly inferred from animals and contained significant errors that no one was permitted to question.

Scholars of the Islamic Golden Age preserved and extended classical medicine; the great physician known in the West as Avicenna compiled encyclopaedic medical texts that dominated teaching for centuries. But the decisive break came with the Renaissance return to direct dissection.

In 1543 the anatomist **Andreas Vesalius** published *On the Fabric of the Human Body*, a lavishly illustrated work based on his own dissections that corrected Galen on point after point and effectively founded modern anatomy. Around the same period, **Leonardo da Vinci** produced remarkably accurate anatomical drawings, including studies of the genitals and of erection, though his notebooks remained unpublished for centuries. For the first time the penis was being mapped as it actually is.

The Discovery of the Erection

Even with accurate maps, the *mechanism* of erection remained mysterious. Early theories imagined the penis filling with air or ‘spirits’ rather than blood. The truth emerged slowly through careful experiment.

In the seventeenth century the Dutch anatomist **Regnier de Graaf** settled the basic question by injecting fluid into the vessels of the penis and producing an artificial erection, demonstrating that the organ fills with blood through its vasculature. This was the conceptual foundation: an erection is a vascular event.

The fine detail — the role of the sinusoids, the veno-occlusive trapping of blood, the smooth-muscle control, and finally the nitric-oxide chemistry — was only fully worked out in the twentieth century. The long gap between knowing *that* the penis fills with blood and understanding *how* the filling is controlled is a reminder that even obvious-seeming questions can take centuries to answer properly.

Taboo, Masculinity, and Anxiety

Alongside the science ran a shifting cultural story. As public attitudes grew more reticent, the penis migrated from temple and marketplace to the private and the unspeakable. With privacy came comparison, and with comparison came anxiety — a thread that runs from ancient ribald graffiti to modern message boards.

Size in particular became loaded with meaning it does not objectively carry, treated as a proxy for masculinity, confidence, and worth. Much of the marketing around enlargement — including in the very booklet this companion is drawn from — works by amplifying that anxiety and then offering to relieve it. It is worth naming the mechanism plainly: a great deal of what is sold as physical enhancement is really aimed at a psychological worry, and that worry is, for most men, out of proportion to the facts of their own bodies.

None of this means the feelings aren't real or that wanting to change your body is illegitimate. It means context matters, and confidence built only on a measurement is fragile by design.

The Birth of Sexual Medicine

The twentieth century turned the penis into a proper subject of clinical science. In the 1960s the researchers **Masters and Johnson** documented the physical stages of sexual response in the laboratory, replacing speculation with observation and giving sexual function a vocabulary.

Treatment advanced in stages. Inflatable penile prostheses arrived in the 1970s for men with severe erectile dysfunction. In the early 1980s the physiologist Giles Brindley dramatically demonstrated — at a medical conference, on himself — that an injected drug could produce an erection, proving the system could be triggered pharmacologically. That insight led to injection therapies and, ultimately, to the discovery that blocking the PDE5 enzyme could do the same thing in pill form.

The approval of **sildenafil** in 1998 was a watershed: a common, embarrassing, long-hidden problem suddenly had a simple oral treatment, and the public conversation about male sexual health changed almost overnight. Modern sexual medicine — the same field that evaluates enlargement claims — grew out of exactly this lineage of careful physiology.

PART III

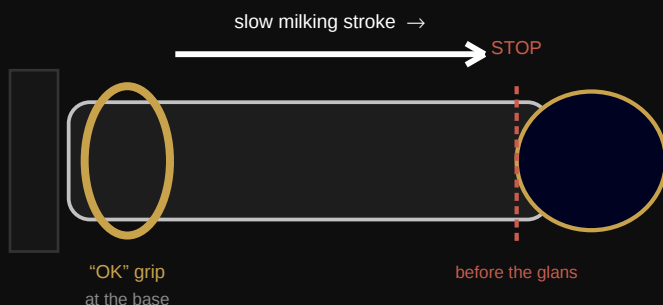
Jelqing: Origins, Claims & Evidence

With the anatomy and history in hand, jelqing comes into focus for what it is: a manual exercise wrapped in a great deal of legend. Here we separate the technique from the mythology and look squarely at what is known, suspected, and unproven.

What Jelqing Is

Jelqing, sometimes called 'milking', is a manual exercise. With the penis lubricated and only partly erect, the practitioner forms a ring with thumb and forefinger at the base and draws it slowly toward the head, stopping short of the glans, then repeats with alternating hands in a steady rhythm. The intent is to push blood into the erectile chambers and apply gentle, repeated stretch to the tissues.

FIG. 6 · THE JELQ STROKE (SCHEMATIC)



Semi-erect ($\frac{1}{2}$ – $\frac{3}{4}$ firm) · lubricated · light pressure · alternate hands
Never at full erection — keep pressure off the dorsal (top) midline.

Fig. 6 — The basic stroke: an “OK” ring drawn slowly from base toward the head, stopping before the glans, performed semi-erect.

It belongs to a broader do-it-yourself category usually labelled **penis enlargement** or ‘PE’, which also includes manual stretching, devices, and pelvic-floor work. Jelqing is the best-known manual technique within it, largely because it requires no equipment beyond lubricant.

The crucial detail, anatomically, is the semi-erect state. As Part I explained, a fully rigid erection puts the tunica albuginea under tension and the veins clamped shut; forcing blood through it manually is how injury happens. The half-to-three-quarters-erect rule exists for that reason.

The Legend of an ‘Ancient’ Practice

Almost every jelqing guide opens with the same origin story: that it is an ancient technique, often said to come from the Arab world or a Middle-Eastern or African tribal tradition, in which fathers taught their sons to ‘milk’ the penis at puberty and continued the practice into adulthood. The word itself is usually claimed to derive from a Persian or Arabic root.

It is a vivid story. It is also, as far as anyone can document, unsubstantiated. There is no solid historical, anthropological, or textual evidence for an organised ancient jelqing tradition. The claim appears in twentieth-century self-help and mail-order material and was then repeated, elaborated, and spread online until sheer repetition lent it a false air of authority. The supposed etymology is likewise unverified.

Why the myth persists

An ‘ancient secret’ sells. Attaching a practice to timeless wisdom makes it feel proven by centuries of use rather than asking it to prove itself now. Recognising this pattern is part of reading any enhancement claim critically: the antiquity of a technique, even if it were real, would say nothing about whether it works. Plenty of genuinely ancient medical practices were simply wrong.

THE HONEST VERSION

Jelqing is best understood as a modern folk-exercise of uncertain origin, popularised in the late twentieth century. Treat the romantic backstory as marketing, and judge the technique on its mechanics and evidence instead.

From Mail-Order to the Internet Era

Whatever its true beginnings, the practice as people know it today took shape in the print era of the mid-twentieth century, when mail-order booklets and the back pages of magazines sold sexual self-improvement by post. These materials packaged manual exercises with bold promises and little accountability — a template the genre never really abandoned.

The real explosion came with the internet. From the late 1990s, dedicated forums gathered men comparing routines, coining terminology, and documenting their own results in measurement logs. This community produced the now-standard vocabulary — ‘newbie routines’, warm-ups, girth versus length work — and an enormous volume of anecdote.

That anecdotal culture is a double-edged thing. It offers peer support, shared caution about injury, and refined technique. But it also propagates unverified claims, survivorship bias — those who feel they gained post enthusiastically; those who didn’t drift away — and commercial interests dressed up as grassroots advice. The same forums that warn about injuries also overflow with results that were never independently measured.

The Proposed Mechanism

The theory behind jelqing borrows directly from how other body tissues adapt to stress. The argument runs like this: repeatedly engorging and gently stretching the erectile tissue and the tunica causes microscopic trauma; the body repairs that trauma during rest; and over many cycles the tissue remodels to hold slightly more blood, yielding a larger erection. Stretching work is similarly said to lengthen the suspensory ligament and tissues over time.

This is a plausible-sounding analogy, and it is not crazy on its face — connective tissue genuinely does remodel under sustained mechanical load, which is the basis of legitimate traction therapy for some medical conditions. The problem is the leap from ‘tissue can remodel’ to ‘this specific manual technique reliably produces permanent enlargement’.

Theory is not evidence

A mechanism that could work is not the same as a mechanism that has been shown to work. The tunica albuginea is extraordinarily strong and resistant to permanent deformation; the forces a hand can safely apply are modest; and the body may simply repair microtrauma back to baseline rather than supercompensating. Whether jelqing crosses the threshold from temporary engorgement to lasting change is exactly the question the evidence has to answer — and largely hasn’t.

A Family of Techniques

Jelqing rarely travels alone. It sits within a cluster of related methods, each with its own history and its own (usually thin) evidence base.

- **Manual stretching** — pulling the flaccid penis in various directions to load the ligaments and tissues. The lowest-tech method and the conceptual basis for traction devices.
- **Traction devices / extenders** — mechanical frames worn for long daily periods. These have the strongest evidence in the whole category, with some clinical use for length and for conditions like Peyronie's disease, precisely because prolonged gentle traction can remodel tissue.
- **Vacuum pumps** — medical devices for erectile dysfunction that draw blood in to produce an erection. They reliably create a temporary engorged state but do not produce durable enlargement, and misuse can bruise or injure.
- **Clamping and 'edging' work** — restricting outflow to maximise engorgement. Higher risk, since it deliberately raises pressure.
- **Pelvic-floor (Kegel) training** — the one item here with solid, uncontroversial benefits, though for erectile strength and continence rather than size.

Set side by side, a pattern appears: the methods with the most evidence are the slow, sustained, low-force ones, and the benefits are usually about function or modest length rather than the dramatic gains the marketing promises.

What the Evidence Actually Shows

Here is the honest summary the original booklet never quite gave you. The scientific literature on non-surgical penis enlargement is thin, and within it jelqing specifically is close to unstudied. There are no good controlled trials demonstrating that manual jelqing produces permanent increases in length or girth.

Reviews of the wider field reach consistent conclusions. Traction devices worn for long periods show the best results, and even those are modest — small average length gains after months of daily use. Vacuum devices produce temporary, not lasting, change. Pills and supplements marketed for enlargement have no credible evidence behind them and are essentially unregulated. Surgery exists but carries real risks and is reserved for specific indications.

Two practical truths follow

First, the most reliably effective ‘treatment’ in the studies is often education and reassurance, because the majority of men seeking enlargement have normal anatomy and a distorted sense of the average. Second, where physical change is achievable at all, it comes from patient, sustained, gentle loading over long timeframes — not intensity, and not quick results. If jelqing helps anyone, it would be through that same slow mechanism, and the realistic ceiling is small.

This is not a reason to feel cheated; it is a reason to train, if you choose to, with clear eyes and modest expectations.

Risks, Injuries, and Caution

Whatever the upside, the downside of getting it wrong is well documented. Because jelqing applies real force to vascular, delicate tissue, careless practice causes predictable harm.

- **Bruising and petechiae** — broken surface vessels from too much pressure; the most common minor injury.
- **Pain, swelling, and skin irritation** — often from inadequate lubrication or excessive duration.
- **Numbness or tingling** — from pressure on the dorsal nerve, a sign to stop and change technique.
- **Tunica or vascular injury** — the serious end of the spectrum, most likely when force is applied at full erection. Repeated microtrauma has also been hypothesised to contribute to scar-tissue (Peyronie's-like) curvature and even erectile difficulty.

The protective rules all trace back to anatomy: stay semi-erect so the tunica isn't under tension, lubricate to protect the skin, keep pressure off the dorsal nerve and away from the glans, start gently and build slowly, and stop immediately at pain, numbness, or discoloration. Anyone with an existing condition, or any new pain that persists, should see a doctor or urologist rather than push through.

THE BOTTOM LINE

The anatomy is well understood, the history is mostly legend, and the evidence is modest at best. Train conservatively, expect little, prioritise function and confidence over centimetres, and treat your body — and the claims made about it — with healthy skepticism.

REFERENCE

Glossary, Timeline & Further Reading

Glossary

Corpora cavernosa	The two upper erectile columns that hold most of the blood during an erection.
Corpus spongiosum	The lower erectile column surrounding the urethra; forms the glans.
Tunica albuginea	The tough fibrous sheath around the corpora cavernosa; sets the limit on size and traps blood.
Veno-occlusive mechanism	The trapping of blood by compressed veins that keeps an erection rigid.
Dorsal nerve	Superficial sensory nerve along the top of the shaft; the structure to keep pressure off.
Detumescence	The return from erection to flaccidity.
PDE5	The enzyme blocked by erectile drugs such as sildenafil to prolong an erection.
Jelqing	A manual 'milking' exercise performed semi-erect with lubricant.

Timeline

Antiquity	Phallic symbols (herms, fascinus, Priapus, lingam) mark fertility, protection, and divine power.
2nd c. CE	Galen's anatomy dominates Western medicine for over a millennium, errors included.
Medieval era	Islamic-world physicians preserve and extend classical medical knowledge.
1543	Vesalius publishes modern anatomy from direct dissection, correcting Galen.
17th c.	De Graaf produces an artificial erection by injection — proof it is a vascular event.
20th c.	Mail-order manuals popularise manual 'enlargement' exercises.
1960s	Masters and Johnson document the physiology of sexual response.
1980s	Injection therapy demonstrates pharmacological erection; sexual medicine matures.
1998	Sildenafil approved; PDE5 chemistry transforms treatment of erectile dysfunction.
Late 1990s+	Internet forums build the modern penis-enlargement community and its lore.

Further reading

For accurate, non-commercial information, look to peer-reviewed sources and professional bodies rather than enthusiast forums or product sites: the 2015 systematic review of penile measurements by Veale and colleagues (for size norms); standard anatomy references such as *Gray's Anatomy* (for structure); World Health Organization and UNAIDS materials (for circumcision and HIV); and urology reviews of penile augmentation (for the evidence on extenders, pumps, and surgery). A urologist remains the best source for anything specific to your own body.

JELQZ

Understand It. Train It. Track It.

This companion exists to put the facts back in front of the folklore. Know the anatomy, respect the history, weigh the evidence — and make your own informed choices from there.

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