Retrograde Ejaculation: Causes, Symptoms, Diagnosis, Male Infertility and Treatment Through Modern Medicine and the Unani System

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Introduction: "Doctor, I Feel the Orgasm but No Semen Comes Out"

A patient may come to me and say:

"Doctor, I have a normal erection and I feel orgasm, but very little or no semen comes out. Afterwards my urine looks cloudy. What is happening?"

One important possibility is **retrograde ejaculation**.

Retrograde ejaculation is an ejaculatory disorder in which all or part of the semen travels **backward into the urinary bladder instead of moving forward through the urethra and out of the penis**. Current European Association of Urology guidance defines it as total or partial absence of normal forward, or antegrade, ejaculation because semen passes backward through the bladder neck into the bladder.

For many men, retrograde ejaculation is not physically dangerous. They may still have normal sexual desire, a satisfactory erection and an orgasm. The major difficulty is usually **fertility**, because little or no semen is deposited in the vagina during intercourse. Mayo Clinic and Cleveland Clinic both emphasize that retrograde ejaculation is generally harmless in itself but can become an important cause of male infertility.

This distinction is very important.

Retrograde ejaculation does not automatically mean erectile dysfunction, impotence, loss of testosterone or absence of sperm production.

A man may be producing sperm normally inside the testes. His reproductive tract may also be producing semen normally. The problem may simply be that the ejaculate is travelling in the wrong direction.

In my practice at **Saira Health Care**, I therefore do not treat every patient who says, "No semen is coming out," with the same medicine. First, I determine whether the problem is

truly retrograde ejaculation, **anejaculation, very low semen volume, obstruction, reduced semen production or another condition**.

The current EAU Sexual and Reproductive Health Guidelines are in their **2026 edition**, which includes updated evidence in the section on disorders of ejaculation.

What Is Retrograde Ejaculation?

During normal ejaculation, semen should move in one direction:

from the reproductive organs → into the urethra → out through the penis.

At the same time, the muscle at the opening of the bladder—the **bladder neck or internal urinary sphincter**—closes.

This closure is extremely important.

It works like a temporary valve. It prevents semen from travelling upward into the bladder while ejaculation is taking place.

In retrograde ejaculation, this valve does not close properly.

As a result:

semen enters the bladder instead of coming out through the penis.

The semen is later passed out of the body when the man urinates.

This is why one of the characteristic complaints is:

“My urine becomes cloudy after orgasm.”

Cleveland Clinic explains that semen entering the bladder is subsequently eliminated during urination.

How Does Normal Ejaculation Occur?

Understanding the normal mechanism makes retrograde ejaculation much easier to understand.

Ejaculation is not one simple muscular action.

It involves a coordinated interaction between:

- the epididymis;
- vas deferens;
- seminal vesicles;

- prostate;
- ejaculatory ducts;
- bladder neck;
- urethra;
- pelvic-floor muscles;
- sympathetic and parasympathetic nerves.

Current EAU guidance describes ejaculation as a complex neurological, hormonal and anatomical process involving both **emission and expulsion**.

Phase 1: Emission

Sperm move from the epididymis through the vas deferens.

Secretions from the seminal vesicles and prostate are added.

Together they form semen.

This semen enters the posterior urethra.

Phase 2: Bladder-Neck Closure

At approximately the same time, the bladder neck contracts.

This prevents semen from entering the bladder.

Phase 3: Expulsion

Rhythmic contractions of the pelvic and periurethral muscles propel semen forward through the urethra and out through the penis.

EAU guidance explains that bladder-neck closure and seminal emission are primarily coordinated through sympathetic neurological pathways, while additional pelvic and muscular mechanisms participate in ejaculation.

If the bladder-neck closure mechanism fails, semen can travel backward.

Complete and Partial Retrograde Ejaculation

Retrograde ejaculation does not always mean that absolutely no semen appears outside the body.

There are two practical patterns.

Complete Retrograde Ejaculation

Almost all semen passes into the bladder.

The man may experience what is commonly called a **dry orgasm**.

He feels orgasm but sees little or no semen.

Partial Retrograde Ejaculation

Part of the semen comes out normally while another portion enters the bladder.

The patient may simply notice that semen volume has become unusually low.

The AUA/ASRM male-infertility guideline recognizes that partial retrograde ejaculation may coexist with some normal antegrade ejaculation. If the forward ejaculate contains enough usable sperm, spontaneous pregnancy or assisted reproduction may sometimes remain possible without additional sperm-retrieval procedures.

Retrograde Ejaculation Is Not the Same as Anejaculation

This difference is essential.

Retrograde Ejaculation

Semen is produced and ejaculation occurs, but semen goes **into the bladder**.

Anejaculation

There is failure of semen emission or ejaculation, and semen is not being expelled either forward or backward.

EAU guidance defines true anejaculation as complete absence of both antegrade and retrograde ejaculation.

A post-orgasm urine test can help distinguish the two.

If significant sperm are found in urine after orgasm, retrograde ejaculation becomes much more likely.

If no sperm are found despite a dry orgasm, another cause such as anejaculation, failure of seminal emission or reduced/absent seminal fluid production must be considered.

Retrograde Ejaculation Is Also Not Azoospermia

Patients often confuse these conditions.

Azoospermia

Semen comes out of the penis, but laboratory examination finds **no sperm in the ejaculate**.

Retrograde Ejaculation

Little or no semen may emerge because the semen—including sperm—has travelled into the bladder.

Therefore, a man with retrograde ejaculation may actually be producing sperm.

This distinction is extremely important in infertility treatment.

What Are the Main Symptoms?

The most typical symptoms are surprisingly simple.

1. Little or No Semen During Orgasm

The man has a normal sexual climax but produces very little semen or none.

2. Cloudy Urine After Orgasm

This happens because semen has mixed with urine in the bladder.

3. Difficulty Achieving Pregnancy

The man may have normal erection, libido and intercourse but the couple cannot conceive because sufficient sperm-containing semen is not deposited in the vagina.

Mayo Clinic lists these three features—dry or very low-volume orgasm, cloudy post-orgasm urine and infertility—as the major clinical clues.

Does Retrograde Ejaculation Cause Pain?

Usually, **no**.

Retrograde ejaculation itself is typically painless.

The semen entering the bladder does not normally damage the bladder.

It is later eliminated during urination.

Cleveland Clinic describes the condition as generally non-painful and not harmful, although it can create significant emotional and fertility-related distress.

Does It Affect Erection?

Usually, retrograde ejaculation does **not directly prevent erection**.

A man may have:

normal desire, normal erection, normal intercourse and normal sensation of orgasm.

Cleveland Clinic specifically notes that retrograde ejaculation does not inherently prevent erection or orgasm.

However, psychological distress caused by seeing no semen can eventually create secondary sexual anxiety.

A patient may start thinking:

“Something is seriously wrong with my masculinity.”

That anxiety can subsequently affect confidence and sexual satisfaction.

Therefore, counselling and proper explanation are also important.

Does Retrograde Ejaculation Mean That Sperm Are Being Destroyed?

No.

The sperm are simply travelling into the bladder.

The urinary environment is not ideal for sperm survival, so sperm collected from post-ejaculatory urine for fertility treatment often require specialized laboratory preparation.

But retrograde ejaculation does not automatically mean that sperm production inside the testes has stopped.

How Common Is Retrograde Ejaculation?

It is less common than erectile dysfunction or premature ejaculation.

Current EAU epidemiological guidance states that retrograde ejaculation is reported in approximately **0.3%–2% of men attending fertility clinics**, although rates are considerably higher in certain groups, particularly men with diabetes and men who have undergone procedures affecting the bladder neck or prostate.

The exact prevalence in the general population is difficult to determine because many men do not seek treatment unless fertility becomes important.

Main Causes of Retrograde Ejaculation

I find it useful to divide the causes into four main groups:

1. **Neurological causes**

2. **Surgery or structural causes**
3. **Medication-related causes**
4. **Endocrine and medical causes**

Current EAU guidance uses a similar framework and lists neurological, anatomical/bladder-neck, pharmacological and endocrine causes.

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1. Diabetes and Autonomic Neuropathy

Diabetes is one of the most important medical causes.

Longstanding high blood glucose can damage the **autonomic nerves** that control internal organs.

These nerves are involved in bladder-neck closure during ejaculation.

If diabetic autonomic neuropathy affects these pathways, the bladder neck may fail to contract adequately.

Semen then passes backward.

EAU epidemiological data note substantially higher rates of retrograde ejaculation in men with diabetes than in general fertility-clinic populations.

This is why a diabetic patient with a new dry orgasm deserves proper evaluation rather than being told:

“Your semen has simply become weak.”

The underlying issue may be neurological.

Good Diabetes Control Matters

If diabetic neuropathy is contributing, improving blood-glucose control remains important for overall neurological and reproductive health.

However, once advanced nerve damage has occurred, glucose control does not guarantee complete reversal.

Therefore, diabetes treatment and ejaculation-specific treatment often have to proceed together.

Unani supportive treatment should **never replace insulin, metformin or other necessary diabetes treatment**.

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2. Multiple Sclerosis, Spinal Cord Disease and Other Neurological Conditions

The nervous system coordinates both ejaculation and bladder-neck closure.

Conditions that damage neurological pathways can therefore cause retrograde ejaculation.

EAU guidance lists neurological causes including:

- spinal cord injury;
- cauda equina lesions;
- multiple sclerosis;
- autonomic neuropathy;
- Parkinson's disease;
- certain pelvic and retroperitoneal operations that damage autonomic nerves.

In neurological patients, erectile dysfunction, ejaculatory dysfunction and abnormal fertility may occur individually or together.

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3. Prostate and Bladder-Neck Surgery

Surgery is one of the classic causes of retrograde ejaculation.

Procedures involving the bladder neck or prostate can alter the valve mechanism that normally closes during ejaculation.

Examples include:

- transurethral resection of the prostate (TURP);
- certain prostate operations;
- bladder-neck surgery;
- retroperitoneal lymph-node surgery;
- selected pelvic, colorectal or urinary procedures.

Mayo Clinic and EAU both recognize prostate and bladder-neck procedures as important causes.

When the anatomy has been permanently altered by surgery, medicines intended to tighten the bladder neck may be much less effective than when the problem is primarily neurological or medication-related. Mayo Clinic specifically makes this distinction.

Fertility Counselling Before Surgery Is Important

A younger man who still wishes to father children should discuss possible ejaculatory side effects **before** prostate, bladder-neck, retroperitoneal or certain pelvic surgeries.

Where clinically appropriate, sperm banking may be worth discussing before procedures carrying a substantial risk of ejaculatory dysfunction.

Cleveland Clinic similarly recommends discussing fertility preservation before surgery when retrograde ejaculation is a known possible consequence.

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4. Medicines Can Cause Retrograde Ejaculation

Medication history is one of the first things I review.

Certain medicines interfere with bladder-neck contraction.

Particularly important are some **alpha-1 adrenergic blockers**, commonly used for benign prostate enlargement and sometimes hypertension.

Certain antidepressants, antipsychotics and other medicines can also contribute.

EAU guidance lists alpha-1 blockers, some antihypertensive agents, thiazide diuretics, antidepressants and antipsychotics among pharmacological causes.

ASRM also emphasizes alpha blockers as an important reversible medication-related cause.

Never Stop a Prescribed Medicine Yourself

If retrograde ejaculation begins after starting a prostate, blood-pressure or psychiatric medicine, do not simply discontinue it.

The prescribing clinician should first determine:

- whether the drug is truly responsible;
- why it was prescribed;
- whether another medicine can safely replace it;
- whether fertility goals justify modification.

When an alpha blocker is responsible, antegrade ejaculation may return after an appropriate medication change.

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5. Endocrine Conditions

EAU guidance also lists some endocrine disorders as possible contributors, including:

- hypothyroidism;
- hypogonadism;
- hyperprolactinaemia.

These are not the commonest causes, but they remind us that a dry or low-volume ejaculation should not automatically be diagnosed from symptoms alone.

Appropriate hormonal testing may be necessary in selected patients.

Retrograde Ejaculation and Male Infertility

This is the area where the condition becomes most clinically important.

To achieve natural pregnancy through intercourse, sperm-containing semen needs to reach the female reproductive tract.

If most semen repeatedly enters the bladder, the number of sperm deposited in the vagina can become insufficient.

Therefore:

A man can produce sperm normally and still experience infertility because the sperm are being delivered in the wrong direction.

This is a very different problem from severely impaired spermatogenesis.

It also means that fertility may sometimes be possible by **recovering the sperm rather than trying to increase sperm production**.

Why Semen Analysis Alone Can Be Misleading

Imagine a patient who produces almost no visible semen.

The laboratory may receive no usable sample.

It would be incorrect simply to label him azoospermic.

First, we have to ask:

Where did the semen go?

A post-ejaculatory urine test can reveal sperm inside the bladder.

The WHO sixth-edition semen laboratory manual specifically includes procedures related to spermatozoa recovered from urine in retrograde ejaculation.

How I Diagnose Retrograde Ejaculation

Step 1: Detailed History

I ask:

- Was ejaculation normal previously?
- Is the problem complete or partial?
- Is orgasm preserved?
- Does urine become cloudy afterwards?
- Is the patient diabetic?
- Has prostate, bladder, pelvic or spinal surgery occurred?
- Is there spinal cord disease or multiple sclerosis?
- Which medicines are being taken?
- Is fertility currently desired?

Often, the medical history provides the strongest clue.

Step 2: Examination

A focused examination may assess:

- penis and testes;
- prostate where appropriate;
- neurological status;
- signs of diabetes or endocrine disease;
- possible structural genital abnormalities.

The extent of examination depends on the patient's history.

Step 3: Semen Examination

If the patient can produce some antegrade ejaculate, semen volume and sperm parameters can be measured.

The WHO sixth edition provides standardized laboratory procedures for human semen examination and processing.

A low-volume ejaculate is a clue—but not proof—of retrograde ejaculation.

Other causes of low semen volume include incomplete sample collection, ejaculatory-duct obstruction, hormonal disorders and congenital reproductive-tract abnormalities.

Step 4: Post-Ejaculatory Urinalysis

This is the key investigation.

Mayo Clinic describes a practical diagnostic procedure:

the patient empties his bladder, reaches orgasm and then supplies a urine sample for laboratory analysis. Finding a significant amount of sperm in the post-orgasm urine supports retrograde ejaculation.

This is particularly important when the patient has:

dry orgasm + normal orgasmic sensation + fertility concerns.

What If No Sperm Are Found in Post-Orgasm Urine?

Then the diagnosis should be reconsidered.

Mayo Clinic notes that a man with a dry orgasm but no semen/sperm in the bladder may have another problem, such as reduced seminal production following prostate surgery, radiation or other damage to semen-producing structures.

True anejaculation is another possibility.

This is why the terms **dry orgasm, anejaculation and retrograde ejaculation should not be used interchangeably**.

Does Every Patient Need Treatment?

No.

If a patient:

- has no discomfort;
- is not concerned about the absence of visible semen;
- does not wish to father children;

then treatment may not be necessary.

Both Mayo Clinic and Cleveland Clinic emphasize that retrograde ejaculation itself is generally harmless and treatment is primarily needed when fertility or significant personal distress is involved.

This is an important principle:

We should treat the patient's medical need, not merely an abnormality because it exists.

Modern Treatment: Correct the Cause First

Treatment should begin with the underlying cause whenever possible.

For example:

Medication-related retrograde ejaculation

Review the responsible medicine and consider a safe alternative.

Poorly controlled diabetes

Improve metabolic control and evaluate diabetic neuropathy.

Hormonal disease

Treat the genuine endocrine disorder.

Structural post-surgical retrograde ejaculation

Recognize that medical reversal may be difficult and consider fertility-oriented sperm retrieval when needed.

This cause-based approach is more rational than giving every patient an ejaculation stimulant.

Medicines Used for Retrograde Ejaculation

Modern treatment sometimes uses medicines that increase sympathetic tone and help the bladder neck remain closed during ejaculation.

Commonly described agents include:

- pseudoephedrine;
- ephedrine;
- midodrine;
- phenylpropanolamine in some literature;

- imipramine;
- selected antihistaminic/antimuscarinic agents.

EAU guidance describes sympathomimetics as agents that can increase adrenergic activity and help restore bladder-neck closure.

However, the evidence is not as strong as it is for many common modern medicines.

EAU notes that much of the evidence comes from small studies or case reports. A systematic review cited by the guideline found an approximate **28% response rate for sympathomimetics**, while reported effectiveness for antimuscarinic-type therapy was around 22% and approximately 39% when combined with sympathomimetics; the guideline stresses that limited sample sizes prevent firm conclusions.

These numbers are population-level observations, **not guaranteed individual success rates**.

These Medicines Are Not Harmless

Sympathomimetic drugs can raise:

blood pressure and heart rate.

EAU specifically lists hypertension among possible adverse effects.

Mayo Clinic similarly warns that some medicines used for retrograde ejaculation may increase blood pressure and heart rate and can be dangerous for patients with hypertension or heart disease.

Therefore, a patient should not self-treat with large doses of pseudoephedrine merely because it is sometimes available as a cold medicine.

Surgery Is Not a Routine Treatment for Retrograde Ejaculation

The statement that a **TURP might be performed to correct retrograde ejaculation** requires correction.

TURP is actually a recognized **cause** of retrograde ejaculation because it can alter bladder-neck integrity.

There is no routine operation in which standard TURP is performed simply to make semen flow forward again.

Treatment instead focuses on:

- correcting reversible causes;

- medication when appropriate;
- fertility-oriented sperm recovery;
- assisted reproductive treatment when necessary.

This is an important medical distinction.

Pelvic-Floor Exercises: Can Kegels Reverse Retrograde Ejaculation?

Pelvic-floor exercise can be useful for several urological and sexual problems.

But it should not be promoted as a proven method of forcing semen out of the penis in true retrograde ejaculation.

Cleveland Clinic specifically notes that Kegel exercises do **not** correct the underlying backward flow through an inadequately closed bladder neck.

This is another example of why the anatomical mechanism matters.

Fertility Treatment When Medicines Do Not Restore Normal Ejaculation

A man with persistent retrograde ejaculation can still have realistic fertility options.

The fundamental question is:

Can we obtain viable sperm?

Often, the answer is yes.

Recovering Sperm From Post-Ejaculatory Urine

Sperm can sometimes be collected from urine immediately after orgasm.

However, ordinary urine can damage sperm because of its acidity and osmotic environment.

Therefore, specialized preparation may be used.

EAU describes approaches involving:

- increased fluid intake;
- alkalinization of urine, sometimes using sodium bicarbonate under clinical protocols;
- collection of post-orgasm urine;
- centrifugation;
- resuspension of recovered sperm in an appropriate laboratory medium.

These prepared sperm can then potentially be used in assisted reproduction.

This should be managed by an experienced fertility laboratory rather than attempted casually at home.

The Modified Hotchkiss Technique

Another laboratory method is the **Hotchkiss or modified Hotchkiss technique**.

In simplified terms, the bladder is prepared and sperm-containing fluid is recovered under more favourable laboratory conditions.

EAU includes the Hotchkiss technique among established sperm-acquisition strategies for infertility associated with retrograde ejaculation.

This is a specialized fertility procedure and requires an andrology or assisted-reproduction laboratory.

IUI, IVF and ICSI

Once suitable sperm are recovered, the reproductive strategy depends on:

- sperm number;
- motility;
- sperm quality;
- female partner's age;
- ovarian reserve;
- duration of infertility;
- other male or female factors.

Possible treatments include:

IUI — intrauterine insemination
IVF — in vitro fertilization
ICSI — intracytoplasmic sperm injection

ASRM confirms that sperm obtained from post-ejaculatory urine can be used for assisted reproductive treatment when medication does not restore adequate antegrade ejaculation.

Surgical Sperm Retrieval

If suitable sperm cannot be recovered from urine, sperm may sometimes be obtained directly from the male reproductive system.

AUA/ASRM guidance recognizes surgical sperm retrieval as one possible option for infertility associated with retrograde ejaculation or aspermia.

Depending on the individual situation, procedures may include techniques such as:

TESA or TESE.

This is particularly relevant because the testes may still be producing sperm normally.

Neurological Patients and Assisted Ejaculation

Patients with spinal cord injury or other neurogenic conditions may require additional methods.

EAU neuro-urology guidance describes options including:

- penile vibratory stimulation;
- electroejaculation;
- post-ejaculatory urinary sperm recovery;
- sperm retrieval techniques when required.

Again, the choice depends on the neurological lesion and fertility goals.

Pregnancy Is a Couple's Outcome

I always remind infertility patients that fertility should not be judged from the man alone.

The WHO emphasizes that fertility is ultimately a **couple-level outcome**, and semen analysis should not be interpreted as an absolute fertile-versus-infertile test for one individual.

Therefore, when retrograde ejaculation is causing infertility, the female partner should also receive appropriate reproductive assessment.

This becomes especially important when:

- female age is increasing;
- ovarian reserve is reduced;
- infertility has lasted several years;
- another female reproductive factor is present.

The choice between continued medical treatment, IUI, IVF or ICSI should consider **both partners**.

Emotional Effects of Retrograde Ejaculation

Although physically harmless in most cases, the condition can be psychologically distressing.

Some men associate visible ejaculation with masculinity or fertility.

They may think:

“No semen means I have lost my sexual power.”

That is incorrect.

A man may have completely normal:

- libido;
- erection;
- orgasm;
- testosterone;
- sperm production.

The problem may be only the direction in which semen travels.

Clear explanation often reduces anxiety considerably.

If infertility has been prolonged, counselling may also help both partners cope with emotional stress.

The Unani Perspective: An Important Academic Clarification

The phrase **retrograde ejaculation** describes a very specific modern anatomical and neurological mechanism involving failure of bladder-neck closure.

I do **not** consider it scientifically accurate to claim that every case corresponds directly to one single classical Unani disease name.

Likewise, statements that retrograde ejaculation is simply caused by an excess of “phlegm and bile” should not be presented as if they were established modern pathophysiology.

Classical Unani medicine uses a traditional framework based on:

- **Mizaj** or temperament;

- **Akhlat** or humours;
- functional strength of organs;
- diet;
- sleep;
- activity;
- psychological state;
- retention and evacuation.

These concepts form part of a historical medical system. They are not identical to modern concepts such as **diabetic autonomic neuropathy, bladder-neck incompetence or alpha-blocker pharmacology**.

I believe the best approach is to respect the Unani framework **without forcing an artificial one-to-one equivalence**.

Why Unani Medicine Can Still Be Useful

Although Unani theory and modern urological physiology use different explanatory models, Unani medicine can contribute meaningfully to **supportive and individualized care**.

For example, a patient with retrograde ejaculation may simultaneously have:

- diabetes;
- general debility;
- disturbed digestion;
- poor sleep;
- obesity;
- anxiety;
- urinary complaints;
- medication-related symptoms;
- fertility stress.

Treating the whole patient can improve overall health even when a mechanical bladder-neck problem requires modern urological or fertility treatment.

This is where I find an **integrative Unani approach** most valuable.

The Four Major Unani Treatment Modes

CCRUM, under the Ministry of AYUSH, officially describes four broad therapeutic approaches in Unani medicine:

Ilaj-bil-Tadbir — regimental therapy
Ilaj-bil-Ghiza — dietotherapy
Ilaj-bil-Dawa — pharmacotherapy
Ilaj-bil-Yad — surgery.

This broad framework is relevant because retrograde ejaculation cannot always be managed with medicine alone.

A diabetic patient needs metabolic treatment.

A medication-related case may need drug adjustment.

A post-surgical case may require fertility procedures.

A psychologically distressed couple may need counselling.

An infertility case may ultimately need assisted reproduction.

A truly holistic approach should acknowledge all these pathways.

Asbab Sitta Daruriyya: Lifestyle as Part of Unani Care

Unani medicine emphasizes the **Six Essential Factors**, or Asbab Sitta Daruriyya:

1. Air/environment
2. Food and drink
3. Physical movement and rest
4. Mental activity and psychological peace
5. Retention and evacuation
6. Sleep and wakefulness.

These factors provide a useful traditional structure for improving general health.

For example, a man with diabetic retrograde ejaculation may benefit from:

healthy nutrition, appropriate physical activity, adequate sleep, stress reduction and proper management of metabolic disease.

These measures do not mechanically close a surgically damaged bladder neck, but they may support the patient's overall neurological, metabolic and reproductive health.

Ilaj-bil-Ghiza: Dietotherapy

Diet should be designed according to the patient's actual health.

For a diabetic patient, excessive sugar, honey or calorie-dense “sexual tonics” may worsen glucose control.

For an overweight man, weight management may improve metabolic and hormonal health.

For a patient with kidney disease, diet and medicine need even greater caution.

Therefore, I do not prescribe the same high-calorie fertility diet to every man with retrograde ejaculation.

Unani dietotherapy should be individualized—not stereotyped.

Ilaj-bil-Tadbir: Regimental and Lifestyle Care

Appropriate regimental management may involve:

- regular physical activity suited to the patient's health;
- sleep correction;
- stress management;
- control of unhealthy habits;
- counselling regarding fertility and sexual confidence.

CCRUM describes regimental therapy as one of the fundamental therapeutic modes of Unani medicine.

However, procedures such as massage or cupping should not be presented as proven methods for reversing bladder-neck incompetence.

If used, they should remain supportive and appropriate to the patient's general condition.

Ilaj-bil-Dawa: Unani Pharmacotherapy

Physician-selected Unani medicines may be used to support:

general strength, urinary function, digestive health, nervous-system wellness or other associated symptoms.

However, a distinction is essential:

A supportive traditional formulation is not automatically a proven drug for restoring antegrade ejaculation.

The evidence supporting sympathomimetic medicines for true retrograde ejaculation is already limited; the evidence for finished Unani formulations specifically reversing retrograde ejaculation is considerably more limited.

Therefore, I prefer transparent language.

Dr. Qasmi's Nuskha No. 108: Where Does It Fit?

The material provided for this article specifically mentions **Dr. Qasmi's Nuskha No. 108**.

The current Saira Health Care Pharmacy page describes Nuskha No. 108 as a **Majoon-style Unani formulation** used for supportive purposes including general weakness, kidney and urinary health, urinary incontinence, excessive urination, appetite and general stamina. The page also describes it as a nervine tonic.

Its currently published indications do **not specifically list retrograde ejaculation**.

For this reason, I would not professionally describe Nuskha No. 108 as a scientifically established or universally effective “cure for retrograde ejaculation.”

At Saira Health Care, when considered in a patient with ejaculatory or reproductive concerns, it should be understood as part of an **individualized supportive Unani programme**, not as a replacement for:

- post-ejaculatory urine testing;
- medication review;
- diabetes management;
- urological assessment;
- sympathomimetic therapy when appropriate;
- sperm recovery or ART when fertility is the priority.

This distinction is important for responsible Unani practice.

What Is Present in Nuskha No. 108?

The current pharmacy listing includes ingredients such as:

pine-nut kernel, chamomile, amla, long pepper, black pepper, coconut-related ingredients, Salab Misri, ginger, raisins, honey and additional traditional substances.

Because it is a multi-ingredient formulation, suitability may vary according to:

- diabetes;
- allergy;
- gastrointestinal health;
- kidney function;
- concurrent medication;
- individual constitutional assessment.

The pharmacy itself states that the product is intended to be used after physician consultation rather than through self-medication.

An Important Safety Point About the Current Ingredient Listing

The current Nuskha No. 108 page also lists an ingredient identified as **"Zaravand Mudharij / Aristolochia…"**.

This requires particular pharmaceutical-safety attention.

Plants containing **aristolochic acids** have been classified as carcinogenic to humans, and exposure has been associated with severe kidney injury and upper urinary-tract cancers. The International Agency for Research on Cancer describes aristolochic acid and plants containing it as human carcinogenic hazards.

Therefore, any formulation whose ingredient list refers to an *Aristolochia* species should undergo appropriate botanical authentication, regulatory review and confirmation regarding aristolochic-acid safety.

I would not recommend describing such an ingredient as automatically harmless simply because it is traditional.

This is especially important in an article about a condition involving the **urinary and reproductive systems**.

"No Side Effects" Is Not a Scientifically Appropriate Universal Claim

The current pharmacy page states that no side effects or absolute contraindications have been observed.

For professional medical publication, I recommend more cautious wording.

Every biologically active medicine—traditional or modern—can potentially produce:

- individual intolerance;
- allergy;
- drug interactions;
- dose-related effects;
- problems in patients with kidney or liver disease.

Therefore:

Natural does not mean universally risk-free.

Unani medicine gains credibility when safety is discussed openly.

What Is My Treatment Approach at Saira Health Care?

When a patient comes to me with suspected retrograde ejaculation, I prefer a structured approach.

Step 1: Confirm What the Patient Means

Is there:

- absolutely no semen?
- very little semen?
- cloudy urine afterwards?
- normal orgasm?
- infertility?
- pain?
- erectile dysfunction?

Many patients use the word “ejaculation problem” for completely different disorders.

Step 2: Distinguish Retrograde Ejaculation From Other Conditions

I consider:

- anejaculation;

- azoospermia;
- low semen volume;
- ejaculatory-duct obstruction;
- reduced seminal fluid production;
- hormonal disease;
- incomplete semen collection.

This avoids treating the wrong condition.

Step 3: Look for the Cause

I ask specifically about:

diabetes, neurological disease, spinal injury, prostate or bladder surgery, pelvic surgery and current medicines.

This is one of the most important steps.

Step 4: Confirm the Diagnosis

When necessary, I advise:

semen assessment and post-ejaculatory urine examination.

The presence of sperm in post-orgasm urine supports the diagnosis.

Step 5: Ask About Fertility Goals

This completely changes treatment.

If the patient does not want children and is otherwise comfortable, treatment may not even be required.

If the couple wants pregnancy, preserving and recovering sperm becomes a major priority.

Step 6: Correct Reversible Causes

This can include:

- adjusting responsible medication through the prescribing doctor;
- controlling diabetes;

- treating genuine endocrine abnormalities;
- improving metabolic health.

Step 7: Consider Appropriate Medical Treatment

When medically suitable, sympathomimetic or related therapy may be considered according to the underlying cause.

Patients with hypertension, heart disease or certain medications need particular caution because some of these drugs increase heart rate or blood pressure.

Step 8: Add Individualized Unani Support

I assess:

- Mizaj;
- general vitality;
- diet;
- sleep;
- psychological state;
- urinary complaints;
- digestive health;
- chronic disease.

Traditional medicines, including supportive formulations, are selected only when they make sense for that individual.

Step 9: Protect Fertility

If normal antegrade ejaculation cannot be restored, I do not consider treatment a failure.

The next question becomes:

Can we recover viable sperm for conception?

Post-ejaculatory urinary sperm recovery, IUI, IVF, ICSI or direct sperm retrieval can be considered depending on the couple.

Why This Integrative Approach Is Important

Consider four different patients.

Patient A

A young man starts an alpha blocker and suddenly notices very little semen.

The primary intervention may be medication review.

Patient B

A man with poorly controlled diabetes gradually develops dry orgasm.

The problem may be diabetic autonomic neuropathy.

Patient C

A man develops retrograde ejaculation after bladder-neck or prostate surgery.

Medication may be less likely to restore normal anatomy, so fertility-oriented sperm retrieval may become more important.

Patient D

A man says no semen comes out, but his post-ejaculatory urine also contains no sperm.

He may not have retrograde ejaculation at all.

Giving all four men the same Nuskha would not represent individualized medicine.

Dr. Nizamuddin Qasmi and My Work in Sexual Disorders & Infertility

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

My professional education and training for this article include:

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

Saira Health Care's public professional profile lists **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK**, and describes my focused clinical work in sexual disorders and infertility.

MasterHealthPro currently publicly lists a **six-month Male Infertility Masters programme**, together with advanced courses addressing semen analysis, male infertility, azoospermia, erectile dysfunction and ejaculatory dysfunction.

This combined sexual-health and male-infertility perspective is particularly relevant to retrograde ejaculation because the patient's major concern is often **not sexual performance itself, but the ability to father a child**.

Contribution of Saira Health Care to Sexual Disorders and Infertility

Saira Health Care describes itself as a registered Unani clinic focused on **sexual disorders and infertility**, with a patient-centered approach that combines traditional knowledge, individualized treatment planning, lifestyle guidance and contemporary medical understanding.

In a condition such as retrograde ejaculation, I believe one of our most important contributions is **accurate education**.

Patients frequently arrive with misconceptions such as:

“No semen means no sperm.”

“Dry orgasm means impotence.”

“If semen goes into the bladder it will damage my kidneys.”

“I need more sperm-producing medicine.”

“Pelvic exercise will force the semen out.”

“One herbal medicine can correct every cause.”

These are not reliable medical conclusions.

Patient education prevents unnecessary anxiety and helps couples reach the correct fertility treatment sooner.

Common Myths About Retrograde Ejaculation

“No visible semen means I have azoospermia.”

No.

Sperm may be entering the bladder.

A post-ejaculatory urine test can help distinguish retrograde ejaculation from azoospermia or anejaculation.

“Retrograde ejaculation causes erectile dysfunction.”

Not necessarily.

Erection and orgasm can remain completely normal.

“Semen stored in the bladder is dangerous.”

Usually no.

It is generally eliminated during subsequent urination.

“Cloudy urine after sex always means retrograde ejaculation.”

No.

Urine can be cloudy for several reasons. The diagnosis should be confirmed rather than assumed.

“Kegel exercises can push semen forward.”

There is no good evidence that pelvic-floor exercise corrects true bladder-neck failure, and Cleveland Clinic specifically notes that Kegels will not force retrograde semen through the urethra.

“Retrograde ejaculation means natural sperm production has stopped.”

No.

Many patients produce sperm normally.

The problem is semen direction.

“Every patient needs medicine.”

No.

Treatment may not be necessary unless fertility or significant distress is involved.

“TURP can be performed to correct retrograde ejaculation.”

No.

TURP is actually one of the recognized procedures that can cause retrograde ejaculation.

Frequently Asked Questions

Can retrograde ejaculation be cured?

It depends on the cause.

Medication-related cases may improve after an appropriate drug change.

Some neurologically mediated cases may respond to medication.

Permanent anatomical alteration after certain surgeries may be difficult to reverse.

Even when normal ejaculation cannot be restored, fertility may still be possible through sperm recovery and assisted reproduction.

Can a man with retrograde ejaculation become a father?

Yes, in many cases.

Sperm may be recovered from post-ejaculatory urine or directly from the reproductive tract and used for IUI, IVF or ICSI where appropriate.

Does retrograde ejaculation lower testosterone?

Not necessarily.

It is primarily a disorder of ejaculation direction.

Testosterone deficiency can coexist in some patients but is not an inevitable consequence.

Can diabetes cause retrograde ejaculation?

Yes.

Diabetic autonomic neuropathy can interfere with bladder-neck closure and ejaculation.

Can prostate medicines cause it?

Yes.

Alpha-1 adrenergic blockers are among the recognized medication causes.

Can antidepressants cause ejaculation problems?

Yes.

Some antidepressants can contribute to retrograde, delayed or absent ejaculation depending on their mechanism. EAU includes antidepressants among pharmacological contributors to retrograde ejaculation.

Is cloudy urine after orgasm dangerous?

Usually not when it is caused by semen.

But persistent cloudy urine at other times may have different causes and should not automatically be attributed to ejaculation.

Does retrograde ejaculation reduce sexual pleasure?

Many men experience a normal orgasm.

Some report reduced orgasmic sensation, and psychological distress can reduce sexual satisfaction. EAU notes that orgasmic sensation may be normal or decreased.

Can Unani medicine help?

Unani medicine can be useful as an **individualized supportive system** addressing diet, metabolic health, general vitality, psychological well-being, urinary complaints and associated chronic disease.

However, a surgically damaged bladder neck, severe diabetic neuropathy or medication-induced retrograde ejaculation must be recognized for what it is. Appropriate urological and fertility treatments should not be delayed.

Is Dr. Qasmi's Nuskha No. 108 a proven cure for retrograde ejaculation?

No high-quality clinical evidence currently establishes Nuskha No. 108 as a universal cure for true retrograde ejaculation.

Its current Saira Health Care Pharmacy listing positions it mainly for general strength, urinary/kidney support and related complaints rather than specifically listing retrograde ejaculation.

If used, it should be part of an individualized physician-supervised programme rather than a substitute for diagnosis.

Prognosis

The prognosis depends strongly on the cause.

Medication-Induced Retrograde Ejaculation

Often one of the more reversible forms when the responsible medicine can safely be changed.

Neurological Retrograde Ejaculation

Response varies according to the severity of nerve damage.

Diabetic Retrograde Ejaculation

Improvement may be possible, but advanced autonomic neuropathy can make restoration more difficult.

Post-Surgical Retrograde Ejaculation

May be permanent when the bladder neck has been structurally altered.

Fertility Prognosis

Even permanent retrograde ejaculation does not necessarily eliminate the possibility of biological fatherhood because sperm can often be recovered for assisted reproduction.

This is an important message of hope—but it should be realistic rather than guaranteed.

When Should You Consult a Doctor?

I recommend evaluation when:

- ejaculation suddenly becomes dry;
- semen volume becomes markedly reduced;
- urine repeatedly becomes cloudy after orgasm;
- the problem begins after starting a new medicine;
- symptoms begin after prostate, bladder or pelvic surgery;
- diabetes or neurological disease is present;
- the couple is trying to conceive;
- the condition causes significant anxiety.

You should not wait for years if fertility is important.

Conclusion

Retrograde ejaculation is an important but often misunderstood male reproductive disorder.

It occurs when all or part of the semen moves **backward through the bladder neck into the urinary bladder instead of being ejaculated forward through the penis**.

The man may still have:

normal sexual desire, normal erection and normal orgasm.

The characteristic clues are:

little or no visible semen, cloudy urine after orgasm and difficulty achieving pregnancy.

The causes are diverse.

They include:

diabetic autonomic neuropathy, spinal or neurological disease, prostate or bladder-neck surgery, alpha-blocker and other medications, and selected hormonal conditions.

This is why diagnosis matters so much.

A dry orgasm is not automatically retrograde ejaculation, and retrograde ejaculation is not the same as azoospermia or anejaculation.

A **post-ejaculatory urine examination for sperm** is one of the most useful diagnostic tools.

Modern treatment first targets the cause.

Sympathomimetic and related medicines may help some patients by improving bladder-neck closure, although current EAU evidence shows that response rates are moderate and the supporting studies are relatively small.

When fertility is the major concern, one of the most important advances is that **normal forward ejaculation does not always have to be restored in order to achieve biological fatherhood**.

Sperm can sometimes be recovered from post-ejaculatory urine, processed in an andrology laboratory and used for assisted reproduction. Other sperm-retrieval techniques are available when necessary.

The **Unani system of medicine** can add value through an individualized whole-person approach based on Mizaj, diet, lifestyle, general strength, psychological state and associated chronic disease. CCRUM formally recognizes dietotherapy, regimental therapy, pharmacotherapy and surgery as the principal therapeutic modes of Unani medicine.

However, responsible Unani practice must remain clear about its limits.

A traditional formulation cannot be assumed to mechanically correct a bladder neck altered by prostate surgery. Nor should diabetic neuropathy, medication effects or infertility be treated without proper diagnostic evaluation.

At **Saira Health Care**, my approach as **Dr. Nizamuddin Qasmi** is therefore based on one principle:

First identify exactly why the semen is not coming forward. Determine whether the patient has true retrograde ejaculation, anejaculation, obstruction or another problem. Then identify the cause, review medicines and medical conditions, assess fertility goals, and combine appropriate modern urological and reproductive treatment with individualized Unani supportive care where suitable.

My focused practice in **sexual disorders and infertility**, together with my training in Unani medicine, infertility, urology, male infertility and integrated sexual and reproductive health, allows me to look at these patients from both the sexual-health and fertility perspectives.

The most important message I want patients to remember is:

A dry orgasm does not automatically mean that you are impotent or that your body has stopped producing sperm. Retrograde ejaculation is often primarily a problem of semen direction. Once the diagnosis and cause are correctly identified, there are treatment options—and even when normal ejaculation cannot be completely restored, modern fertility techniques may still make biological fatherhood possible.

About Saira Health Care

Saira Health Care is a registered Unani clinic with a focused practice in **sexual disorders, male and female infertility and reproductive health**. Its published approach emphasizes individualized history-taking, Mizaj assessment, traditional treatment, lifestyle guidance and appropriate contemporary diagnostic understanding.

Medical Disclaimer

This article is intended for **general medical education and sexual- and reproductive-health awareness**. It does not replace individual examination, semen analysis, post-ejaculatory urine testing, urological assessment or fertility consultation.

Do not stop alpha blockers, antidepressants, blood-pressure medicines, diabetes treatment or any other prescribed medicine because of an ejaculation problem without consulting the prescribing clinician.

Medicines such as pseudoephedrine, midodrine, ephedrine or imipramine should not be self-prescribed for retrograde ejaculation. Some can increase blood pressure and heart rate and may be unsuitable for patients with cardiovascular disease.

Traditional and Unani formulations contain biologically active ingredients and should not be assumed to be universally free from side effects or interactions.

The current Nuskha No. 108 ingredient listing includes an *Aristolochia*-identified ingredient; because aristolochic acids are associated with severe nephrotoxicity and are recognized human carcinogenic hazards, botanical identity and pharmaceutical safety should be carefully verified before use of any preparation containing an *Aristolochia* species.

No modern medicine, Unani formulation, supplement, procedure or fertility technique can responsibly guarantee restoration of normal ejaculation, sperm recovery or pregnancy in every patient.