Sexual Problems in People With Diabetes: Causes, Symptoms, Diagnosis, Treatment and the Unani Approach

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Introduction

One of the questions I hear from people living with diabetes is:

"Doctor, my diabetes is under treatment, but my sexual health is getting worse. Are the two problems connected?"

In many cases, the answer is **yes**.

Diabetes is not only a disorder of blood sugar. When high blood glucose persists over time, it can affect the **blood vessels, peripheral nerves, autonomic nerves, hormones, kidneys, heart, psychological health and general energy levels**. All of these systems are important for healthy sexual function.

For men, diabetes may contribute to **erectile dysfunction, reduced sexual desire, ejaculatory problems, retrograde ejaculation and orgasmic difficulties**. For women, it may contribute to **reduced desire, difficulty becoming aroused, vaginal dryness, painful intercourse and difficulty reaching orgasm**.

The subject is important enough that the **American Diabetes Association Standards of Care in Diabetes—2026** specifically recommends screening men with diabetes or prediabetes for erectile dysfunction and asking about low libido. The same guideline recommends that women with diabetes should be asked about desire, arousal and orgasm difficulties, while postmenopausal women should be assessed for vaginal dryness and painful intercourse.

I want patients to understand one point from the beginning:

Sexual dysfunction in diabetes is a medical complication—not a failure of masculinity, femininity or personal worth.

It deserves proper assessment and treatment just like diabetic neuropathy, kidney disease, hypertension or an eye complication.

The **Unani system of medicine** can be particularly useful in this area because it traditionally views health as a whole. In Unani practice, I consider not only the sexual complaint but also the patient's **Mizaj, diet, body weight, sleep, digestion, physical strength, psychological state, lifestyle, diabetes control and reproductive goals**.

My approach at Saira Health Care is therefore integrative: **identify the exact sexual disorder, investigate the underlying cause, improve diabetes and general health, and then select individualized modern and/or Unani treatment according to the patient's condition.**

What Does Diabetes Do to Sexual Function?

Sexual function depends on a surprisingly complex interaction between the brain, nerves, hormones, blood vessels and sexual organs.

For example, a normal male erection requires sexual stimulation to activate nerve pathways. The penile arteries must then dilate, allowing a large increase in blood flow. The erectile tissues must trap that blood efficiently, and the patient's psychological state must allow normal arousal.

In women, normal arousal also depends on healthy genital circulation, nerve sensation, lubrication, hormonal status and psychological responsiveness.

Diabetes can interfere with several parts of these systems at the same time.

NIDDK explains that chronic high blood glucose can damage **blood vessels and nerves**, leading to sexual and bladder problems in both men and women.

This is one reason diabetes-related sexual dysfunction can sometimes be more difficult to treat than a temporary sexual problem caused only by stress or fatigue.

Why Diabetes Can Cause Sexual Problems

1. Damage to Blood Vessels

Healthy sexual function requires healthy circulation.

In a man, sexual stimulation causes the arteries of the penis to relax and carry more blood into the erectile chambers.

Diabetes can damage the delicate inner lining of blood vessels, known as the **endothelium**, and contribute to atherosclerosis. If penile blood flow becomes inadequate, erections may become weaker, take longer to develop or disappear before intercourse is completed.

The 2026 ADA Standards of Care states that vascular disease is probably the most important underlying factor in many men with diabetes and erectile dysfunction.

This is why I often tell patients:

"If diabetes has affected your erection, we must think about your circulation—not only your penis."

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2. Diabetic Nerve Damage

The second major pathway is **neuropathy**.

Sexual function depends on autonomic and sensory nerves. Diabetes can gradually damage these nerves.

In men, autonomic neuropathy can contribute to erectile dysfunction and **retrograde ejaculation**, where semen passes backward into the bladder rather than mainly leaving through the penis.

The ADA's 2026 neuropathy guidance specifically recognizes both erectile dysfunction and retrograde ejaculation as possible manifestations of diabetic autonomic neuropathy.

In women, diabetic neuropathy may contribute to reduced sexual sensation, reduced arousal and inadequate lubrication.

Therefore, sexual dysfunction in a diabetic patient is sometimes a sign of broader nerve involvement.

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3. Impaired Nitric Oxide Pathway

Nitric oxide is essential for erection.

It causes smooth muscle in the penis to relax so that the erectile tissues can fill with blood.

Diabetes can impair endothelial function and reduce the effectiveness of the nitric-oxide pathway. This is one reason some men with longstanding diabetes respond less strongly to erection medicines than men without severe vascular disease.

It does not mean treatment will necessarily fail.

It means I also need to consider the severity of the underlying diabetes, vascular disease and neuropathy rather than simply increasing medication.

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4. Obesity, Metabolic Syndrome and Testosterone

Type 2 diabetes frequently occurs with obesity and metabolic syndrome.

These conditions are strongly associated with reduced testosterone in some men.

The current EAU guideline notes that hypogonadism frequently occurs alongside metabolic syndrome and type 2 diabetes. At the same time, it emphasizes that erectile dysfunction in diabetes is often predominantly **vascular and neuropathic**, so correcting testosterone alone does not necessarily restore normal erections.

Therefore, when a diabetic patient has low desire and ED, I do not automatically say:

"Your testosterone must be low."

We test when clinically indicated.

How Common Is Erectile Dysfunction in Diabetes?

Erectile dysfunction is very common in men with diabetes.

The **American Diabetes Association Standards of Care—2026** cites an estimated prevalence of approximately **52.5%** among men with diabetes.

Risk increases particularly with age, longer diabetes duration, poor glycaemic control, hypertension, cardiovascular disease, obesity, dyslipidaemia, metabolic syndrome, smoking, diabetic neuropathy, kidney disease, depression and hypogonadism.

NIDDK also notes that men with diabetes can develop erectile dysfunction roughly **10–15 years earlier** than men without diabetes.

This is why ED in a diabetic man should not simply be dismissed as "normal ageing."

Erectile Dysfunction in Diabetic Men

A patient may notice that his erection has gradually become less reliable.

He may tell me:

"I get an erection, but it is not as hard as before."

Another says:

"The erection comes but disappears during intercourse."

Another:

"I need much more stimulation now."

These are typical patterns.

Erectile dysfunction means persistent difficulty achieving or maintaining an erection sufficiently firm for satisfactory sexual activity.

Current EAU guidance recognizes diabetes, hypertension, metabolic syndrome, chronic kidney disease, cardiovascular disease and several other systemic conditions among important causes of ED.

Erectile Dysfunction Can Be a Cardiovascular Warning

This is something every diabetic man should understand.

The arteries supplying the penis are small.

Vascular dysfunction may therefore become noticeable as erection difficulty before a more obvious cardiovascular problem develops.

The 2026 ADA guideline highlights that men with diabetes are at increased risk for both cardiovascular disease and ED and that ED can predict future cardiovascular events.

Therefore, when a diabetic man develops persistent ED, I consider whether his blood pressure, lipids, smoking status, body weight and cardiovascular risk also need assessment.

Treating an erection without treating the vascular disease is incomplete care.

Psychological Erectile Dysfunction Can Exist Alongside Diabetes

Not every sexual problem in a diabetic man is caused entirely by nerve or blood-vessel damage.

Suppose a man develops a mild erection difficulty because of diabetes.

After one or two unsuccessful encounters, he becomes frightened:

“My diabetes has made me permanently impotent.”

The next time he has sexual contact, he begins monitoring the erection continuously.

Anxiety rises.

The erection becomes weaker.

Now a partly physical condition has acquired a significant psychological component.

This combination is extremely important.

A patient may require improved diabetes care and ED treatment **plus counselling or psychosexual support**.

Modern ED guidance recognizes performance anxiety, relationship factors, depression and other psychological contributors and recommends cognitive-behavioural or psychological treatment in appropriate patients.

Reduced Sexual Desire in Diabetic Men

Some patients do not primarily complain of erection difficulty.

They say:

“Doctor, I simply don't feel interested anymore.”

Reduced libido can have several causes in diabetes.

These include low testosterone, obesity, chronic fatigue, depression, poor sleep, relationship stress, medications and anxiety related to ED.

The 2026 ADA guideline recommends asking men with diabetes about both libido and erectile function. If clinical features suggest hypogonadism, morning serum total testosterone should be measured.

This is much better than blindly prescribing a testosterone booster.

Low Testosterone in Diabetes

Men with type 2 diabetes and obesity have a higher likelihood of functional testosterone deficiency.

Symptoms may include reduced libido, fewer spontaneous erections, fatigue and reduced physical vitality.

But low testosterone must be diagnosed properly.

The EAU notes that low testosterone is common in obesity and metabolic syndrome/type 2 diabetes and recommends improving lifestyle, reducing excess weight and treating associated illness before testosterone treatment when appropriate.

Testosterone treatment may improve libido and sexual satisfaction in genuinely hypogonadal men, but in diabetes its effect on erection can be limited when major vascular and neurological damage is present.

Important Fertility Warning About Testosterone

This is one of the most important messages I give reproductive-age men.

A man may think:

“Testosterone is the male hormone, so taking testosterone must make me more fertile.”

That is incorrect.

External testosterone suppresses pituitary gonadotropins and can significantly reduce sperm production.

The EAU strongly recommends **not using testosterone therapy for male infertility or in men actively wishing to father children**.

Therefore, if a diabetic man has low testosterone and is also trying for pregnancy, fertility goals must be discussed before treatment.

This is one area where specialist knowledge of both sexual medicine and male infertility is particularly important.

Diabetes and Ejaculatory Disorders

Diabetes can affect ejaculation as well as erection.

Some men notice that ejaculation becomes weak or delayed.

Others experience orgasm but release very little semen.

A smaller group develops **retrograde ejaculation**.

The ADA specifically recognizes retrograde ejaculation as a possible consequence of diabetic autonomic neuropathy.

NIDDK explains that in retrograde ejaculation, part or all of the semen enters the bladder instead of leaving through the penis and can later be passed harmlessly with urine.

For a man trying to conceive, this becomes particularly important because the problem is not simply “weak semen”—the direction of ejaculation itself may be abnormal.

Diabetes and Fertility Are Related but Not Identical

I regularly remind patients:

Erection quality and sperm quality are not the same thing.

A diabetic man can have significant ED and entirely satisfactory sperm production.

Another may have normal erections but abnormal sperm count, motility or morphology.

A third may have normal sperm production but retrograde ejaculation.

Therefore, fertility should be assessed separately when pregnancy is the goal.

A semen analysis may be required, and further investigations depend on the result.

Premature Ejaculation in Diabetic Patients

Premature ejaculation is not usually considered a direct classical complication of diabetes in the same way as ED or retrograde ejaculation.

However, it can coexist.

For example, a patient with diabetic ED may start rushing intercourse because he fears losing his erection. This can contribute to acquired premature ejaculation.

Prostatitis, anxiety, thyroid problems and relationship stress can also contribute.

Therefore, if a diabetic man has PE, I assess PE as its own condition rather than assuming that diabetes is automatically the direct cause.

Female Sexual Problems in Diabetes

For many years, medical discussion of diabetic sexual dysfunction focused almost entirely on men.

That is no longer acceptable.

The 2026 ADA Standards of Care specifically recommends asking women with diabetes about **sexual desire, arousal and orgasm**, and recommends screening postmenopausal women for vaginal dryness and painful intercourse.

Research summarized by the ADA indicates that female sexual dysfunction is more common in women with both type 1 and type 2 diabetes than in women without diabetes. A meta-analysis cited in the 2026 guideline reported odds ratios of about **2.27 for type 1 diabetes and 2.49 for type 2 diabetes**.

Women deserve the same opportunity to discuss sexual-health concerns without embarrassment.

Reduced Sexual Desire in Women

Women with diabetes may experience lower desire for several reasons.

These include depression, anxiety, chronic fatigue, poor glucose control, hormonal changes around menopause, relationship problems and diabetes-related emotional burden.

The ADA emphasizes that psychological and social factors play a particularly important role in female sexual dysfunction.

Therefore, treatment should not always begin with medicine.

Sometimes psychological support, better diabetes control or treatment of menopausal symptoms may be more important.

Vaginal Dryness and Painful Intercourse

Vaginal lubrication is partly controlled by nerves and genital blood flow.

Diabetic nerve and vascular damage can interfere with this response.

NIDDK notes that diabetic nerve damage may reduce lubrication and contribute to uncomfortable or painful sexual intercourse.

Vaginal dryness can also become more important after menopause.

The ADA therefore specifically recommends assessing postmenopausal women with diabetes for **genitourinary syndrome of menopause, vaginal dryness and dyspareunia**.

Treatment can include appropriate lubricants or moisturizers, management of menopause-related changes where medically suitable and treatment of infection when present.

Difficulty With Arousal or Orgasm in Women

Some women with diabetes report reduced genital sensitivity or difficulty becoming fully aroused.

Others experience difficulty reaching orgasm.

NIDDK recognizes reduced sensation, reduced lubrication, arousal difficulty and orgasmic problems among possible diabetes-related sexual complications.

These are medical concerns and should not be interpreted as lack of love or attraction toward the partner.

Recurrent Yeast and Urinary Infections

Diabetes can increase susceptibility to genital yeast infection, particularly when blood glucose remains elevated.

Infection may cause itching, burning, discharge or pain during intercourse.

NIDDK notes that yeast can grow more readily when blood glucose is high.

Repeatedly treating discomfort without improving diabetes control may lead to recurrence.

Psychological and Relationship Effects

Sexual dysfunction often affects more than sexual activity.

It can influence self-esteem, confidence and the relationship.

A man may believe that ED means he has lost masculinity.

A woman with vaginal dryness may worry that her partner will think she has lost interest.

One partner may interpret reduced sexual activity as rejection.

This can produce anxiety, arguments, guilt and avoidance of intimacy.

The ADA notes strong associations between female sexual dysfunction and depression, anxiety and diabetes-related distress.

The same holistic principle applies in men.

Sexual treatment should therefore sometimes involve the couple, not only the individual patient.

How I Assess Sexual Problems in Diabetic Patients

When a diabetic patient consults me, I first determine **what the actual sexual problem is**.

I do not treat “sexual weakness” as a diagnosis.

For a male patient, I ask about desire, morning erections, erection rigidity, ability to maintain erection, ejaculation, orgasm, penile sensation and fertility plans.

I also ask about diabetes duration, current glucose control, hypertension, obesity, cholesterol, kidney disease, cardiovascular history, neuropathy, medications, smoking, alcohol, sleep and psychological stress.

For women, I ask about desire, arousal, lubrication, orgasm, pain, menopausal symptoms, recurrent infections, depression and relationship circumstances.

NIDDK emphasizes that patient-reported symptoms and careful history-taking are central to diagnosing sexual dysfunction in diabetes.

Investigations

Not every patient needs every available test.

The investigation should follow the clinical question.

In an appropriate male patient, testing may include **HbA1c, fasting or other glucose assessment, lipid profile, kidney function and morning total testosterone**.

LH, FSH, prolactin or thyroid investigations may be required when endocrine disease is suspected.

The 2026 ADA guideline specifically advises morning total testosterone testing in men with symptoms or signs of hypogonadism and notes that LH, FSH and prolactin may be required for further evaluation.

For suspected vascular ED, penile Doppler ultrasound may be useful in selected patients.

For fertility concerns, semen analysis is assessed separately.

The goal is not to order the longest laboratory package—it is to find the cause.

Why Good Diabetes Control Is Part of Sexual Treatment

One message I repeat frequently is:

"We cannot protect sexual health while allowing diabetes to remain uncontrolled."

NIDDK recommends maintaining glucose within individualized target ranges, controlling blood pressure and cholesterol, maintaining physical activity and healthy weight, and stopping smoking to help prevent or manage diabetes-related sexual and bladder problems.

Improving diabetes control cannot guarantee that longstanding severe neuropathy or vascular disease will completely disappear.

But it can reduce ongoing injury and improve overall health.

Weight Management

Obesity contributes to insulin resistance, cardiovascular disease, low testosterone and ED.

Weight reduction may therefore improve several contributing factors simultaneously.

Current EAU guidance recommends lifestyle improvement and weight reduction before or alongside testosterone treatment in men with functional hypogonadism.

For me, this is one of the areas where modern endocrine medicine and traditional Unani lifestyle principles complement one another particularly well.

Exercise

Exercise improves cardiovascular fitness, insulin sensitivity, weight control and psychological health.

The ADA's 2026 discussion of female sexual health also identifies lifestyle measures—including nutrition, walking and smoking cessation—as potentially beneficial to overall sexual well-being.

A sexual-treatment plan therefore should not consist only of tablets.

Smoking and Alcohol

Smoking damages blood vessels.

When diabetes is already putting vascular health under pressure, smoking adds further risk.

Excessive alcohol can also impair erection and sexual response.

Smoking cessation and moderation of alcohol are therefore part of treatment.

Modern Treatment of Diabetic Erectile Dysfunction

PDE5 Inhibitors

Medicines such as **sildenafil and tadalafil** are established treatments for erectile dysfunction.

Current EAU guidance recommends PDE5 inhibitors as **first-line pharmacological treatment for ED** in appropriate patients.

These medicines strengthen the normal nitric-oxide/cGMP erection pathway.

They do not automatically create sexual desire, and sexual stimulation is still required.

They also do not cure diabetes.

Why Tablets Sometimes Work Less Well in Diabetes

If a man has significant arterial disease or diabetic neuropathy, the erection pathway may be more severely impaired.

Before saying a tablet has failed, I review correct dose, timing, sexual stimulation, progression of diabetes, hormonal status and psychological factors.

This is much more sensible than continuously increasing the dose without reassessment.

A Critical Safety Point: Nitrate Medicines

Sildenafil, tadalafil and other PDE5 inhibitors must **not** be used together with nitrate medicines used for angina or certain cardiovascular conditions because the combination can produce dangerous hypotension.

This is particularly important for diabetic men because cardiovascular disease is common.

A patient should always tell the treating clinician about heart medicines before starting ED treatment.

Vacuum Erection Devices

Vacuum erection devices mechanically draw blood into the penis.

They can be useful when tablets are unsuitable or insufficient.

EAU guidance recommends vacuum devices for appropriately informed men seeking non-invasive, drug-free ED management.

They may be particularly useful in selected diabetic patients.

Penile Injection Treatment

Intracavernosal treatment uses medicine injected directly into erectile tissue.

It can produce an erection even when oral therapy is inadequate.

Current EAU guidance allows intracavernosal injections as an alternative first-line option in well-informed patients or as a second-line treatment.

Because excessive dosing may lead to a prolonged erection or other complications, proper training and medical supervision are necessary.

Penile Prosthesis

For severe ED that does not respond satisfactorily to less-invasive treatment, a penile prosthesis may be considered.

Surgery is normally reserved for carefully selected patients after discussion of alternatives, risks and expected outcomes.

Diabetes should also be appropriately controlled because poorly controlled diabetes may increase surgical and infection risks.

Testosterone Treatment

Testosterone therapy may be useful when a diabetic man has **properly confirmed hypogonadism**, particularly when libido is reduced.

The EAU concludes that testosterone can improve libido and milder sexual symptoms in hypogonadal men.

But it is not a universal diabetic-ED medicine.

And, most importantly, it should not be used as male infertility treatment because it can suppress sperm production.

Psychological and Couple Therapy

A diabetic patient may have genuine vascular disease and severe performance anxiety at the same time.

These conditions should both be treated.

Counselling can help reduce fear, performance pressure, depression and relationship conflict.

Modern sexual medicine recognizes psychological and couple factors as important parts of ED management, rather than assuming that every problem should be solved only through pharmacological treatment.

The Unani Understanding of Diabetes and Sexual Health

The Unani system is rooted historically in Greco-Arabic medicine and developed through generations of physicians who considered health in relation to **Mizaj, Akhlat, organ function, lifestyle and the six essential factors of health**.

Traditional concepts should, however, be described accurately.

A classical Unani explanation involving Mizaj or humoral imbalance is **not scientifically identical** to today's understanding of insulin resistance, endothelial dysfunction or diabetic neuropathy.

Modern medicine tells us how diabetes damages blood vessels and nerves.

Unani medicine provides an additional individualized framework for thinking about the person's constitution, diet, lifestyle and general vitality.

I prefer using these perspectives together rather than pretending that one is simply another name for the other.

Why Unani Medicine Can Be Useful in Diabetic Sexual Dysfunction

The strength of Unani medicine is its **whole-person approach**.

A patient with diabetes and ED may simultaneously have obesity, poor digestion, disturbed sleep, stress, physical inactivity and poor dietary habits.

If I treat only the erection, I may temporarily improve one symptom while leaving the rest of the patient unchanged.

The Unani approach provides a framework to consider diet, exercise, sleep, psychological health and individualized traditional treatment alongside the patient's modern medical needs.

CCRUM, under the Ministry of AYUSH, officially describes four broad modes of Unani treatment: **Ilaj-bil-Tadbir (regimental therapy), Ilaj-bil-Ghiza (dietotherapy), Ilaj-bil-Dawa (pharmacotherapy) and Ilaj-bil-Yad (surgery)**.

This is why Unani treatment should never be reduced to the simple idea of “taking herbs.”

Ilaj-bil-Ghiza: Dietotherapy

Diet is fundamental in a diabetic patient.

In Unani practice, diet is adjusted according to Mizaj and disease condition.

Modern diabetes care additionally requires attention to glucose control, calories, carbohydrates, cardiovascular risk and body weight.

These two approaches can be intelligently combined.

I do not advise diabetic patients to consume unlimited honey, sweets, dried fruits or calorie-rich sexual tonics simply because they are traditionally considered strengthening.

A diet that worsens blood glucose will ultimately work against sexual health.

The correct diet should support both **metabolic control and general vitality**.

Ilaj-bil-Tadbir: Lifestyle and Regimental Therapy

Regimental care can include appropriate exercise and other lifestyle measures.

For diabetic sexual-health patients, I place particular emphasis on regular physical activity, adequate sleep, stress reduction, healthy body weight and avoidance of tobacco.

Massage may sometimes be used within traditional regimental care for relaxation and general well-being.

Cupping is also a recognized Unani regimental practice in some clinical contexts.

However, I do not tell patients that massage or cupping has been proven to reverse diabetic neuropathy or severe arterial ED.

Their role should be viewed as **supportive and individualized**, not as substitutes for glycaemic control or evidence-based treatment.

Ilaj-bil-Dawa: Unani Pharmacotherapy

Unani medicines may be selected according to the patient's constitution, symptoms, associated disease and reproductive goals.

Traditional herbs used in male-wellness formulations may include **Safed Musli, Ashwagandha and Akarkara**, among others.

Some individual herbal ingredients have been investigated for effects on stress, sexual well-being or reproductive parameters, but evidence specifically demonstrating reversal of severe diabetes-related vascular or neuropathic sexual dysfunction remains limited.

I therefore consider these medicines as potential components of **physician-guided supportive treatment**, not universal replacements for PDE5 inhibitors, diabetes control, hormone treatment or surgical options.

This is a more responsible way to represent the strengths of Unani medicine.

Herbal Does Not Mean Completely Risk-Free

This point is particularly important in diabetes.

Herbal and traditional medicines are biologically active.

They may affect glucose levels or interact with insulin, oral diabetes medicines, blood-pressure drugs and cardiovascular treatment.

Therefore, every diabetic patient should inform the treating doctor about all herbal supplements and traditional formulations being used.

“Natural” does not mean “take any dose without supervision.”

Should Diabetes Medicines Be Stopped When Starting Unani Treatment?

No.

A patient should never stop insulin, metformin or another prescribed diabetes treatment simply because Unani medicine has been added.

Any change to conventional diabetes medication should be made by an appropriately qualified clinician using glucose monitoring and the patient's overall medical condition.

Poorly controlled diabetes can progressively damage blood vessels and nerves.

An integrative treatment plan should protect the patient from this damage—not increase it.

My Approach at Saira Health Care

When a diabetic patient comes to me with a sexual complaint, I prefer to follow a clear clinical sequence.

First, I identify whether the main problem is **erection, libido, ejaculation, orgasm, genital discomfort or fertility**.

Second, I assess diabetes itself—its duration, control and complications.

Third, I look for contributing factors such as obesity, hypertension, smoking, poor sleep, medications and psychological stress.

Fourth, I investigate hormones or reproductive health when indicated.

Fifth, I evaluate the patient according to the Unani concept of Mizaj and overall constitution.

Finally, I design an individualized treatment plan rather than using the same medicine for every diabetic patient.

This approach is consistent with Saira Health Care's published ED treatment model, which emphasizes correcting smoking, obesity, poor physical activity, uncontrolled diabetes, hypertension, sleep problems and stress before or alongside individualized treatment.

Special Treatment by Dr. Nizamuddin Qasmi

My clinical focus at Saira Health Care is not simply on giving a medicine for erection.

The aim is to understand **why the sexual problem has developed**.

A patient with mild vascular ED and normal testosterone may need a different treatment from a patient with severe neuropathy.

A diabetic man with low testosterone who wants children requires a different strategy from one who has completed his family.

A patient with retrograde ejaculation requires different management from one whose primary problem is premature ejaculation.

A woman with recurrent vaginal dryness and menopausal symptoms requires different care from a woman whose principal problem is depression-related loss of desire.

This diagnosis-based approach allows both modern medical treatments and Unani principles to be used more intelligently.

Fertility Assessment in Diabetic Men

Because my work also focuses on male infertility, I pay particular attention to whether a diabetic man wishes to father a child.

If fertility is a concern, semen analysis may be required.

Ejaculatory problems such as retrograde ejaculation must be recognized.

Hormonal treatment must be selected carefully.

External testosterone is particularly important to avoid when a man is actively trying to conceive because of its sperm-suppressing effect.

MasterHealthPro's male-infertility programmes publicly include training in semen analysis, hormonal evaluation, hypogonadism, azoospermia, ejaculatory dysfunction and male reproductive diagnostics.

This type of reproductive-health knowledge becomes useful when diabetes affects sexual function and fertility at the same time.

Can Unani Medicine Reverse Diabetic Nerve Damage?

I do not promise this.

Once severe diabetic neuropathy has become established, complete reversal cannot be guaranteed by an herbal medicine, massage or any other single treatment.

Unani treatment can be valuable in improving lifestyle, general health, metabolic discipline, psychological well-being and selected sexual symptoms.

But significant vascular or neurological damage may require long-term medical treatment.

The correct objective is therefore to **prevent further damage, improve the reversible components and manage established dysfunction effectively**.

Can Better Diabetes Control Restore Sexual Function?

It can help, particularly when metabolic problems are still reversible or only partially established.

Better glucose control reduces the risk of continued nerve and vascular damage.

Weight reduction, exercise and treatment of hypertension and cholesterol can also improve overall cardiovascular function.

However, I do not promise that normal HbA1c will automatically reverse severe longstanding ED.

Treatment outcome depends on how much structural vascular or nerve damage has already occurred.

Why Early Treatment Is Better

A man may ignore mild ED for several years.

During those years, diabetes may remain uncontrolled.

Neuropathy progresses.

Cardiovascular disease worsens.

Confidence falls.

Sexual anxiety develops.

By the time he seeks professional care, his sexual problem may involve several mechanisms simultaneously.

This is why I encourage patients to discuss sexual symptoms early.

The 2026 ADA guidelines themselves recommend active screening rather than waiting for every patient to raise the subject.

Common Myths About Diabetes and Sexual Health

“Every diabetic man eventually becomes impotent.”

No.

Diabetes increases risk, but severe ED is not inevitable for every patient.

“If tadalafil works, my diabetes no longer matters.”

Incorrect.

Tadalafil helps erection physiology. It does not prevent diabetic vascular and nerve damage.

“If ED tablets do not work, there is no treatment.”

Incorrect.

Vacuum devices, injection therapy, correction of genuine hormone deficiency and penile prosthesis are additional options for selected patients.

“Every diabetic man needs testosterone.”

No.

Testosterone treatment is for properly diagnosed hypogonadism—not simply diabetes or tiredness.

“Testosterone improves fertility.”

External testosterone can reduce sperm production.

“Women with diabetes do not have sexual complications.”

Incorrect.

The ADA recognizes reduced desire, arousal problems, orgasm difficulty, vaginal dryness and painful intercourse in women with diabetes.

“Herbal treatment has no side effects.”

Incorrect.

Herbal and traditional preparations can interact with diabetes and cardiovascular medicines and should be supervised professionally.

When Should You Seek Medical Advice?

I encourage diabetic patients to seek professional sexual-health assessment when an erection problem becomes persistent, libido decreases significantly, ejaculation changes, orgasm becomes difficult, very little semen is released, intercourse becomes painful, vaginal dryness is persistent, recurrent genital infections develop or sexual problems begin to affect emotional health or the relationship.

A diabetic man with new ED should also consider whether his cardiovascular risk needs reassessment.

These problems should not be hidden because of embarrassment.

Emergency Situations

Most sexual problems are not emergencies.

However, urgent medical care is needed for an erection lasting about four hours or longer, serious penile injury, sudden severe testicular pain or symptoms of a major cardiovascular event.

Routine sexual medicines or traditional treatments should never delay emergency medical attention.

About Me: Dr. Nizamuddin Qasmi

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

My professional education and training include:

BUMS – Hamdard University, Delhi
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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 official professional profile publicly lists qualifications including **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK** and describes my clinical focus as sexual disorders and infertility.

MasterHealthPro publicly offers its **Male Infertility Masters** programme and advanced male reproductive and sexual-health training covering areas including fertility evaluation, semen analysis, hypogonadism, azoospermia and sexual dysfunction.

This combination of Unani medical training, infertility-oriented education and urological and sexual-health knowledge is particularly relevant to diabetes because diabetes can affect **erection, libido, ejaculation, reproductive hormones, fertility and psychological health simultaneously**.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, our work is not limited to prescribing sexual medicines.

One important contribution is helping patients understand the difference between symptoms and diagnoses.

A diabetic patient who says:

“I have sexual weakness”

may actually have vascular ED.

Another may have hypogonadism.

Another may have performance anxiety.

Another may have retrograde ejaculation.

Another may have normal sexual function but a fertility problem.

Saira Health Care's published treatment approach emphasizes correcting reversible factors, individualized diagnosis, lifestyle improvement, guideline-supported medication where appropriate, traditional Unani treatment under supervision and surgical referral in selected severe cases.

This is the kind of patient-centered approach I consider most useful.

Modern Medicine and Unani Medicine Do Not Need to Compete

I do not believe patients should be forced into thinking:

“Either I choose Unani medicine or I choose modern medicine.”

Modern medicine gives us excellent diagnostic tools, blood tests, cardiovascular assessment, effective ED medicines, hormone treatment, vacuum devices, injection treatment and surgical options.

Unani medicine contributes individualized assessment of Mizaj, diet, lifestyle, physical vitality and traditional therapeutics.

Used responsibly, the two approaches can complement each other.

The important boundary is that **traditional therapy should not delay proper treatment of uncontrolled diabetes, cardiovascular disease, severe neuropathy, hormonal disease or infection**.

Frequently Asked Questions

Can diabetes cause erectile dysfunction?

Yes. Diabetes can impair penile blood vessels and nerves, and ED is substantially more common in men with diabetes.

Can ED appear before diabetes is diagnosed?

Yes, in some patients sexual or urinary problems can contribute to the discovery of previously unrecognized diabetes or metabolic disease.

Can diabetic ED be treated successfully?

Often yes. Treatment depends on severity and may include metabolic improvement, PDE5 inhibitors, psychological care, hormone treatment where appropriate, vacuum devices, injections or surgery.

Can sildenafil or tadalafil be used in diabetes?

They are established ED medicines for many appropriate men. Cardiovascular status and interacting medicines must be considered, particularly nitrate use.

Does diabetes lower testosterone?

Type 2 diabetes, obesity and metabolic syndrome are commonly associated with reduced testosterone, but proper testing is required.

Can diabetes affect ejaculation?

Yes. Diabetic autonomic neuropathy can contribute to retrograde ejaculation and other ejaculatory difficulties.

Can diabetes affect female sexual health?

Yes. Reduced desire, arousal difficulty, dryness, pain and orgasmic problems are recognized.

Can Unani medicine help?

Unani medicine can provide valuable individualized supportive treatment through diet, lifestyle, Mizaj assessment and professionally selected traditional medicines. It should be integrated with appropriate diabetes and sexual-health evaluation rather than replacing necessary medical care.

Can I stop my diabetes medicine while using Unani treatment?

No. Prescription diabetes treatment should not be stopped or changed without medical supervision.

Prognosis

The outlook varies according to the underlying problem.

A patient with early vascular dysfunction, obesity and mild ED may improve considerably through weight reduction, exercise, better diabetes control and appropriate sexual treatment.

A man with low testosterone may benefit when genuine hypogonadism is identified and treated correctly.

A patient with performance anxiety may improve substantially through counselling and confidence restoration.

More advanced diabetic neuropathy or severe vascular disease may require longer-term treatment or devices.

Women with dryness, infection or menopausal symptoms may also achieve significant relief when the correct cause is treated.

The prognosis therefore depends less on the word **“diabetes”** and more on **which mechanisms diabetes has affected in that particular patient**.

Conclusion

Sexual problems in people with diabetes are common, medically important and often under-treated.

The **American Diabetes Association Standards of Care in Diabetes—2026** specifically recommends screening men with diabetes for erectile dysfunction and asking about sexual desire, especially when cardiovascular disease, neuropathy, chronic kidney disease, retinopathy, depression, hypogonadism or poor glycaemic control are present. It also recommends sexual-health assessment in women, including desire, arousal, orgasm, vaginal dryness and painful intercourse.

The biological explanation is now well understood.

Diabetes can damage **blood vessels and autonomic and sensory nerves** required for sexual function. In men this commonly produces erectile dysfunction and can also contribute to retrograde ejaculation. In women it can contribute to reduced desire, arousal difficulty, impaired lubrication, pain and orgasmic problems.

Treatment therefore needs to be comprehensive.

Improving glucose management, cardiovascular health, body weight, physical activity and smoking status forms the foundation.

Modern therapies such as sildenafil and tadalafil are effective first-line treatments for many men with ED, while vacuum devices, injections and penile prosthesis provide additional options when necessary.

Testosterone can help selected men with genuine hypogonadism, but it is not a general treatment for every diabetic man's ED and should not be used as male-infertility therapy because it suppresses sperm production.

The **Unani system of medicine** can add significant value through its individualized whole-person approach. Its recognized modes of treatment include dietotherapy, regimental therapy, pharmacotherapy and surgery, and its focus on Mizaj, lifestyle, physical health and psychological condition can complement modern diabetes and sexual-medicine care.

At **Saira Health Care**, my goal as **Dr. Nizamuddin Qasmi** is to identify the exact reason for the sexual problem before treatment. My practice is particularly focused on sexual disorders and infertility, supported by training in Unani medicine, infertility, urology, male infertility and integrated sexual and reproductive health.

The most important message I want to leave with every patient is:

Do not accept diabetes-related sexual dysfunction as an unavoidable loss of sexual life. Do not self-medicate out of embarrassment. Identify whether the problem is vascular, neurological, hormonal, psychological, reproductive or mixed; improve diabetes and overall health; and follow a treatment plan designed specifically for your condition. Modern medicine and responsibly practiced Unani medicine can work together to support sexual function, reproductive health and quality of life.

About Saira Health Care

Saira Health Care focuses on male and female **sexual disorders, infertility and reproductive health**, with individualized Unani assessment, lifestyle guidance and appropriate contemporary diagnostic understanding. The clinic's published approach emphasizes reversible-risk-factor management, appropriate investigation and individualized modern and traditional treatment.

Website: www.sairahealthcare.com

Medical Disclaimer

This article is intended for **general medical education and sexual- and reproductive-health awareness**. It does not replace an individualized medical consultation, physical examination, diabetes assessment, cardiovascular evaluation or laboratory investigation.

Persistent sexual dysfunction in diabetes may reflect vascular disease, autonomic neuropathy, hormonal abnormalities, medication effects, depression or other medical conditions requiring professional assessment.

Do not discontinue insulin, oral diabetes medicines, blood-pressure medicines or other prescribed treatment in order to begin Unani or herbal therapy without appropriate medical supervision.

Men using nitrate medicines for cardiac disease must obtain professional advice before using sildenafil, tadalafil or other PDE5 inhibitors because potentially dangerous hypotension can occur.

Men who want current or future fertility should discuss this before beginning testosterone therapy because external testosterone can suppress sperm production.

Unani, herbal and traditional medicines contain biologically active substances. “Natural” does not mean completely free from potential side effects or interactions.

No conventional medicine, Unani formulation, herbal medicine, procedure or treatment programme can responsibly guarantee restoration of sexual function, fertility or identical results in every patient.