Sexual Problems in Older Age: Understanding Age-Related Changes, Erectile Dysfunction, Low Libido, Menopause and Treatment Through Modern Medicine and the Unani System

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Introduction: Sexual Health Does Not End With Age

One of the misconceptions I frequently hear from patients is:

"Doctor, I am getting older. Is it normal that my sexual life should completely finish?"

My answer is **no**.

Ageing changes the body, and these changes can affect sexual desire, erection, arousal, lubrication, ejaculation and physical comfort. But sexual interest, intimacy and the desire for emotional and physical closeness do not automatically disappear after the age of 50, 60 or 70.

The National Institute on Aging emphasizes that many older adults continue to value sexuality and intimacy, and some couples even report greater satisfaction in later life because they have more privacy, fewer distractions and better communication about their needs. At the same time, age-related physical changes, illness, medication and emotional factors may make sexual activity different from what it was in younger adulthood.

This is the first message I want older patients and their partners to understand:

A change in sexual function with age is common, but persistent sexual dysfunction should not simply be dismissed as "old age."

An older man who develops erectile dysfunction may have vascular disease, diabetes, medication-related effects, low testosterone or psychological stress that deserves proper assessment.

An older woman who develops painful intercourse may have **genitourinary syndrome of menopause**, a treatable condition associated with declining estrogen.

A couple who has stopped being intimate may actually be dealing with arthritis, chronic pain, depression, fear after heart disease, loss of privacy or poor communication rather than a complete loss of sexual capacity.

Sexual health in later life therefore deserves the same respectful and scientific approach as sexual health at any other age.

The **Unani system of medicine** can make an important contribution because its traditional geriatric philosophy considers ageing through the whole person—**Mizaj, diet, sleep, physical activity, psychological state, general vitality, chronic disease and the balance between activity and rest**. CCRUM's geriatric-care material specifically incorporates age-related physiological and psychological changes, Mizaj, lifestyle management, dietotherapy and Ilaj-bil-Tadbir into elderly healthcare.

In my practice at Saira Health Care, I believe the strongest approach is an **integrative one**: distinguish normal ageing from disease, identify the exact sexual problem, evaluate underlying medical causes and then combine appropriate modern treatment with individualized Unani diet, lifestyle and physician-selected supportive therapy where suitable.

What Do We Mean by Sexual Problems in Older Age?

Sexual dysfunction in older adults is not a single disease.

It can involve **desire, arousal, erection, ejaculation, orgasm, genital comfort, physical ability or relationship satisfaction**.

In men, common concerns include erectile dysfunction, reduced libido, reduced confidence, delayed ejaculation, ejaculation difficulties and sexual problems associated with chronic illness.

In women, common concerns include reduced desire, slower arousal, vaginal dryness, painful intercourse and difficulty reaching orgasm, particularly after menopause.

Both men and women may also experience problems related to chronic pain, arthritis, diabetes, heart disease, urinary incontinence, depression, anxiety, bereavement, medication or relationship changes.

The important question is therefore not simply:

“Is the patient old?”

The important question is:

“Which part of sexual function has changed, and why?”

Ageing Is Not a Disease

Growing older produces biological changes, but ageing itself should not be treated as a disease.

Current European Association of Urology evidence is particularly informative regarding testosterone. In healthy ageing men, testosterone does decline gradually, but the EAU notes that **age itself accounts for a relatively small proportion of clinically significant hypogonadism up to around age 80**. Obesity, diabetes, chronic illness and overall poor health often contribute much more strongly to low testosterone in older men.

This is why I do not accept statements such as:

“You are 65, so weak erections and very low testosterone are simply normal. Nothing can be done.”

Nor do I accept the opposite extreme:

“Every 65-year-old man needs testosterone.”

Both are oversimplifications.

The patient requires individual assessment.

Normal Sexual Changes That May Occur With Age

Ageing can change the way sexual response occurs without eliminating healthy sexuality.

An older man may require more direct or prolonged stimulation to achieve an erection. Erections may not feel exactly the same as they did decades earlier, and the recovery period after ejaculation may become longer.

Older women may notice that genital arousal and lubrication take more time. After menopause, declining estrogen may cause the vaginal tissues to become thinner, less elastic and drier, making intercourse uncomfortable for some women.

These changes do not automatically indicate disease.

The problem becomes clinically important when the change causes persistent difficulty, pain, distress, avoidance of intimacy or dissatisfaction for the individual or couple.

Sexuality and Intimacy Are Not the Same as Intercourse

This is particularly important in older age.

Sexual well-being should not be defined only by vaginal penetration or the ability to maintain an erection for a certain number of minutes.

Intimacy can include affection, touch, kissing, emotional closeness, sexual stimulation and many other forms of physical connection.

The National Institute on Aging specifically distinguishes sexuality from intimacy and notes that older adults may value one or both in different ways.

When illness or physical limitation changes how intercourse is performed, the couple may need to adapt rather than assume that intimacy is over.

This is where good sexual counselling can sometimes be as important as medication.

Erectile Dysfunction in Older Men

What Is Erectile Dysfunction?

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

It becomes increasingly common with age, but it is **not an inevitable consequence of ageing**.

The EAU reports a strong age-related rise in ED prevalence. For example, one large epidemiological study found ED prevalence increasing from around 2.3% in younger adult men to more than 50% in the oldest age group studied.

But age often acts through associated disease.

Current EAU guidance identifies important ED risk factors including **diabetes, cardiovascular disease, hypertension, high cholesterol, obesity, metabolic syndrome, physical inactivity, smoking, neurological disease and psychological factors**.

Therefore, when an older man tells me:

“Doctor, my erection has become weak,”

I do not immediately answer:

“This is because you are old.”

I want to know whether his arteries, nerves, hormones, medicines, psychological health or general medical condition are contributing.

How a Normal Erection Occurs

An erection is mainly a **neurovascular event**.

Sexual stimulation activates nerve pathways. Nitric oxide is released inside the erectile tissues, causing smooth muscle to relax. Blood enters the erectile chambers and is temporarily trapped, producing rigidity.

This system requires:

healthy blood vessels, intact nerves, responsive erectile tissue, appropriate hormonal function and adequate sexual arousal.

Anything that interferes with these mechanisms can cause ED.

This explains why diseases affecting the whole body may first become noticeable to a patient through sexual symptoms.

Cardiovascular Disease and Erectile Dysfunction

One of the most important things I explain to older men is that the penis and heart share a common dependence on healthy arteries.

Current EAU guidance states that ED is associated with cardiovascular disease and can sometimes precede clinically apparent cardiovascular problems. The guideline now incorporates the Princeton Consensus IV approach to cardiovascular evaluation in men with predominantly vascular ED.

Therefore, new persistent ED—especially in a man with hypertension, diabetes, obesity, smoking or high cholesterol—can provide an opportunity to evaluate broader vascular health.

I sometimes tell patients:

“Do not think only about the erection. We should also think about the arteries producing that erection.”

This is particularly important in older adults because cardiovascular risk increases with age.

Is Sexual Activity Safe for an Older Person With Heart Disease?

For many patients with **stable, appropriately treated cardiovascular disease**, sexual activity can remain safe.

However, men with unstable angina, uncontrolled hypertension, very recent myocardial infarction, severe heart failure or certain dangerous arrhythmias may require cardiovascular assessment before resuming sexual activity or using ED medicines.

The current EAU cardiovascular framework specifically recommends further evaluation in patients whose cardiovascular status makes the safety of sexual activity uncertain.

A patient should not avoid all intimacy forever simply because he once had a heart problem, but neither should a high-risk cardiac condition be ignored.

The correct approach is individualized cardiovascular advice.

Diabetes and Sexual Problems in Older Age

Diabetes is one of the major causes of sexual dysfunction in older adults.

Over time, diabetes can affect both the **blood vessels and nerves** required for normal erection and genital sensation.

A diabetic man may therefore develop ED through a combination of vascular and neurological damage.

Older adults may additionally have hypertension, obesity, kidney disease or low testosterone, making the problem more complex.

This is why an erection tablet alone may sometimes provide only partial benefit if the underlying diabetes and cardiovascular risk factors remain poorly controlled.

Good diabetes management is part of sexual-health treatment.

High Blood Pressure and Cholesterol

Hypertension and abnormal cholesterol contribute to vascular disease.

Both are common in older adults.

In addition, older patients often take several medicines, making medication review particularly important.

Patients should never stop blood-pressure or cardiac medicines on their own because they suspect that a tablet is affecting their sexual function.

Sometimes an alternative medicine may be possible, but that decision should be made safely with the prescribing clinician.

Medication-Related Sexual Problems in Older Adults

Medication effects become particularly important as people age because **polypharmacy**—taking several medicines at the same time—becomes more common.

The National Institute on Aging notes that some medicines used for blood pressure, depression, mental-health conditions, Parkinson's disease, cancer and other disorders may interfere with erection, desire, ejaculation, arousal or orgasm.

For this reason, one of the most useful questions during a sexual-health consultation is:

“Which medicines are you currently taking?”

The problem may sometimes be modified without compromising treatment of the underlying disease.

But patients should never discontinue essential medication themselves.

Reduced Libido in Older Men

Sexual desire naturally varies throughout life.

An older man may notice less frequent spontaneous sexual interest without necessarily having a disease.

However, a marked or persistent loss of libido deserves assessment when it causes distress.

Possible causes include:

low testosterone, depression, chronic disease, fatigue, sleep disturbance, medications, relationship problems and anxiety about sexual performance.

Sexual desire is not controlled by testosterone alone.

That is why I do not prescribe hormone treatment simply because a patient says:

“My interest is less than it was 20 years ago.”

Testosterone and Ageing

Testosterone is an important male sex hormone, but discussions about “low T” have become heavily commercialized.

The latest 2026 EAU guideline emphasizes that the diagnosis of late-onset hypogonadism requires **both compatible symptoms and consistently low morning testosterone measurements**. It uses around 12 nmol/L as a practical biochemical threshold in symptomatic men, while recognizing that clinical interpretation remains essential.

Older age alone is **not** an indication for testosterone.

In fact, the EAU specifically advises against using testosterone simply to improve cognition, vitality or physical strength in ageing men who do not have an appropriate clinical indication.

This is a very important point.

Testosterone replacement is a medical treatment for properly diagnosed hypogonadism—not a general anti-ageing tonic.

Can Testosterone Improve Sexual Function in Older Men?

In appropriately selected hypogonadal men, testosterone treatment can improve sexual desire and some sexual symptoms.

The EAU notes that older men with genuine hypogonadism may experience improvements in sexual activity, desire and overall sexual satisfaction. However, testosterone does not necessarily correct significant ED when severe vascular disease is present.

For example, the TRAVERSE data summarized by EAU found improvements in sexual activity and desire in middle-aged and older hypogonadal men but did not demonstrate a comparable restoration of erectile function itself.

Therefore, an older man may sometimes require treatment for both hypogonadism and vascular ED.

A Fertility Warning About Testosterone

Although fertility is less frequently the primary concern in advanced age, some older men still wish to father children.

External testosterone can suppress LH and FSH from the pituitary gland and interfere with sperm production.

The EAU explicitly states that testosterone treatment is contraindicated in men seeking fertility treatment.

Therefore, age should never be used to assume that fertility goals are irrelevant.

I ask the patient.

Premature Ejaculation in Older Men

Premature ejaculation can occur at any adult age.

A man who did not have PE earlier in life but develops it later should be evaluated for **acquired premature ejaculation**.

For example, some older men begin ejaculating rapidly because they are frightened their erection will disappear.

In that situation, ED and performance anxiety may be more important than penile sensitivity.

Other associated conditions can also contribute.

The correct treatment is therefore different from treating lifelong premature ejaculation in a younger man.

Older age does not make every ejaculation problem the same.

Delayed Ejaculation and Difficulty Reaching Orgasm

Some older men experience the opposite problem.

Erection may be adequate, but ejaculation takes much longer or does not occur.

Possible causes include:

medication effects, diabetic or other neuropathy, reduced genital sensation, psychological factors and hormonal problems.

Antidepressants are particularly relevant because some can significantly delay ejaculation or orgasm.

In these patients, a general “sexual-strength” medicine may not address the cause.

The medication history and neurological and hormonal context matter.

Changes in Ejaculatory Volume

Some men notice that the force or quantity of ejaculate appears different with age.

This does not automatically indicate infertility or loss of masculinity.

If the change is marked—particularly if almost no semen is produced—conditions such as medication effects, previous prostate or bladder surgery, retrograde ejaculation or other reproductive issues may require evaluation.

Appearance alone cannot tell us sperm count or fertility.

Menopause and Sexual Health in Older Women

For women, one of the most important biological transitions affecting sexual health is menopause.

Menopause is associated with declining ovarian estrogen production.

The vagina and vulva are responsive to estrogen. When estrogen levels decline, the vaginal lining may become **thinner, drier and less elastic**, and lubrication may decrease.

These changes are now described collectively as part of **genitourinary syndrome of menopause**, or GSM.

GSM may cause:

vaginal dryness, burning, itching, irritation, painful intercourse, urinary symptoms and recurrent urinary infections.

These symptoms are common and treatable.

An older woman should not simply be told:

“Painful intercourse is normal after menopause, so tolerate it.”

Vaginal Dryness

Vaginal dryness is one of the most frequent sexual complaints after menopause.

Some women experience only mild discomfort.

Others develop sufficient dryness that penetration becomes painful and sexual activity is avoided.

ACOG explains that reduced estrogen can decrease lubrication and cause thinning, drying and inflammation of vaginal tissues.

The problem may then become psychological as well.

If intercourse hurts repeatedly, a woman may understandably become fearful of penetration.

A cycle develops:

dryness → pain → fear → reduced arousal → greater discomfort.

This requires compassionate treatment rather than blame.

Treatment of Vaginal Dryness and Pain

For mild dryness, non-prescription **vaginal moisturizers and lubricants** can provide substantial relief.

Lubricants are used during sexual activity to reduce friction, while vaginal moisturizers can be used regularly to improve ongoing dryness.

When symptoms remain significant, **local vaginal estrogen** may be appropriate for many women.

ACOG notes that vaginal estrogen creams, rings and tablets can help restore vaginal tissue and reduce dryness and irritation. Other prescription options—including certain selective estrogen receptor modulators—may also be considered in selected patients.

Treatment should be individualized, particularly in women with a history of hormone-sensitive cancer or other complex medical conditions.

Is Hormone Replacement Therapy Necessary for Every Older Woman?

No.

Systemic menopausal hormone therapy can be very useful for selected women with significant menopausal symptoms, but it is **not a universal sexual-health treatment**.

A woman whose only complaint is vaginal dryness may sometimes obtain sufficient benefit from local treatment.

Another woman with hot flashes, sleep problems and broader menopausal symptoms may need a different discussion.

The choice depends on age, time since menopause, symptoms, uterus status, cardiovascular risk, cancer history and personal preference.

This is why hormone treatment should be individualized rather than prescribed solely because a woman has reached menopause.

Reduced Sexual Desire in Older Women

Menopause does not automatically remove sexual desire.

Some women experience reduced desire.

Others experience no major change.

Some may even feel more sexually comfortable in later life because pregnancy is no longer a concern.

The National Institute on Aging notes that desire during and after the menopausal transition may increase or decrease.

Loss of libido in an older woman may also involve:

depression, fatigue, painful intercourse, relationship difficulties, medication effects, poor sleep, chronic disease or emotional stress.

Therefore, libido should not be reduced to an estrogen level alone.

Difficulty With Orgasm in Older Women

Some women find that arousal requires more time or that orgasm becomes more difficult.

This can involve changes in genital sensation, medications, psychological factors, relationship circumstances or discomfort caused by GSM.

Treatment should be directed at the specific cause.

Sometimes improved lubrication and freedom from pain considerably improve sexual response.

Other patients may benefit from sex therapy, pelvic-floor treatment or medication review.

Arthritis, Pain and Physical Limitations

Sexual problems in older age are not always diseases of the reproductive organs.

A patient with severe knee, hip or back pain may avoid intercourse because the position is uncomfortable.

NIA specifically recognizes arthritis and chronic pain as potential barriers to sexual activity and suggests that treatment of pain, changing position and timing sexual activity can help.

This sounds simple, but it is clinically important.

Sometimes adapting the sexual activity is more useful than prescribing another sexual medicine.

Urinary Incontinence and Sexual Confidence

Urinary leakage is more common in older adults and can create embarrassment during intimacy.

Some patients stop sexual activity because they fear leaking urine.

NIA notes that bladder emptying before and after intercourse, adapting positions and treating the underlying incontinence may help.

Sexual-health treatment in older adults therefore often overlaps with urology, gynecology and pelvic-floor care.

Depression, Anxiety and Loneliness

Sexual desire depends strongly on emotional health.

Older adulthood may involve bereavement, retirement, illness, body-image changes, financial stress or loss of independence.

Depression can considerably reduce libido.

Anxiety about sexual performance can interfere with erection and arousal.

Another important issue is that older adults may feel embarrassed discussing sexuality because society sometimes wrongly assumes that they should no longer be sexually active.

This stigma can delay diagnosis and treatment.

As a physician, I believe the consultation should provide a **private, respectful and non-judgmental environment**.

Saira Health Care similarly describes its model as providing a safe setting where people can discuss sensitive sexual-health and infertility concerns without fear of judgment.

Relationship Changes in Later Life

Sexual health often depends on the relationship as much as on biology.

Partners may have different levels of desire.

One partner may become a caregiver for the other.

Illness can change body image.

A widowed older adult may begin a new relationship after many years.

Open communication becomes extremely important.

A partner should not automatically interpret reduced erection, vaginal dryness or slower arousal as lack of attraction.

Sometimes understanding the physiological reason for the change can relieve considerable relationship tension.

Older Adults and Sexually Transmitted Infections

Older age does not provide immunity from sexually transmitted infections.

Pregnancy may no longer be a concern after menopause, but STI transmission remains possible.

The National Institute on Aging specifically reminds older adults that they are **not too old to be at risk**.

When a person has a new or multiple sexual partners, appropriate condom use, testing and sexual-health discussion remain important.

Sexual-health education should therefore continue throughout life.

How I Evaluate Sexual Problems in Older Adults

When an older patient comes to me, I begin by listening rather than assuming.

I want to understand what has actually changed.

For a man, I ask about desire, erection rigidity, morning erections, ejaculation, orgasm, penile pain, urinary symptoms and medication use.

For a woman, I ask about desire, arousal, lubrication, discomfort, menopause-related symptoms and orgasm.

For both, I ask about diabetes, hypertension, heart disease, neurological conditions, chronic pain, sleep, depression, relationship circumstances, tobacco, alcohol and current medicines.

If necessary, I also discuss whether sexual activity itself is physically comfortable and safe.

This allows me to distinguish **normal age-related adaptation from treatable disease**.

Physical Examination

An older man with ED may require focused evaluation of the cardiovascular, genital, endocrine and neurological systems.

Current EAU guidance strongly recommends a focused physical examination and appropriate metabolic and hormonal assessment in men presenting with ED.

Depending on circumstances, examination may identify:

Peyronie's disease, testicular changes, obesity, signs of vascular disease or another underlying condition.

For women with pain or dryness, gynecological assessment may be necessary to distinguish menopause-related GSM from infection, skin disease or other pelvic conditions.

Persistent pain should never automatically be assumed to be “just menopause.”

Laboratory Tests

Tests should be selected according to the clinical problem.

In an older man with ED, useful investigations may include glucose or HbA1c, lipids and morning testosterone.

The EAU strongly recommends glucose, lipid and testosterone assessment to identify reversible ED risk factors when appropriate.

If testosterone is low, the result should be confirmed appropriately and further hormonal testing may be needed.

I do not believe in ordering every possible hormone simply because a patient is over 60.

Tests should answer a clinical question.

Cardiovascular Assessment Before ED Treatment

Older men are more likely to have heart disease.

Before prescribing ED therapy, the patient's cardiovascular status and medication list are therefore particularly important.

A man with stable controlled disease may often continue sexual activity safely.

A man with unstable cardiovascular disease may first require cardiology evaluation.

The current EAU/Princeton framework recognizes this distinction rather than treating every cardiac patient as either completely safe or completely prohibited from sexual activity.

Modern Treatment of Erectile Dysfunction in Older Men

The modern treatment of ED has become highly effective.

The first step is to improve reversible risk factors.

Exercise, weight management, smoking cessation and control of diabetes, hypertension and cardiovascular risk can contribute to better sexual function. The EAU recommends lifestyle and risk-factor modification before or alongside specific ED therapy.

For many men, **PDE5 inhibitors** such as sildenafil and tadalafil remain first-line pharmacological treatment.

The treatment should still be individualized according to the patient's medical status, sexual frequency, preference and other medicines.

Sildenafil and Tadalafil

Sildenafil and tadalafil enhance the normal nitric oxide–cGMP erection pathway.

They help the erectile response to sexual stimulation.

They are not automatic aphrodisiacs and do not create sexual desire by themselves.

Tadalafil has a longer duration of action and can also be prescribed in a low daily dose in selected men, including some with both ED and lower urinary-tract symptoms. Current EAU guidance lists tadalafil as on-demand 10 or 20 mg or 5 mg once daily in appropriate patients.

The correct medicine and dose should be selected according to the patient rather than copied from another person's prescription.

The Most Important Safety Warning: Nitrates

This is particularly important in older adults.

Many older men take nitrate medicines for angina or coronary disease.

PDE5 inhibitors must not be combined with nitrate medicines, because the combination can produce a dangerous drop in blood pressure.

An older patient should therefore always provide a complete cardiac medication list before using sildenafil, tadalafil or related medicines.

Self-medication can be dangerous.

What If ED Tablets Do Not Work?

A poor response to sildenafil or tadalafil does not mean there are no further options.

I first check whether the medicine was used correctly.

Was the dose appropriate?

Was there sufficient sexual stimulation?

Is diabetes progressing?

Is testosterone genuinely low?

Is performance anxiety interfering?

Current EAU guidance emphasizes patient education because incorrect use is an important reason for apparent PDE5-inhibitor failure.

Additional treatment can include vacuum erection devices, intracavernosal injections or penile prosthesis surgery in appropriately selected patients.

Vacuum Erection Devices in Older Men

Vacuum erection devices are especially relevant in older adults because they provide a **non-drug, non-surgical option**.

A vacuum device draws blood into the penis, and a constriction ring helps maintain erection.

The EAU reports high short-term efficacy and specifically notes that vacuum devices may be particularly suitable for **well-informed older men with comorbidities who prefer non-invasive, drug-free management**.

However, they require correct instruction, and men with significant bleeding disorders or anticoagulation require particular caution.

Penile Injection Therapy

For men who do not respond adequately to tablets, intracavernosal medicines such as alprostadil can be highly effective.

These medicines act directly on penile erectile tissue.

Current EAU guidance allows injection therapy as an alternative first-line treatment in informed patients or as a later-line option.

The patient requires professional training because incorrect dosage can cause pain, bleeding or a prolonged erection.

Penile Prosthesis

When severe ED persists despite appropriate conservative treatment, a penile implant can provide reliable mechanical rigidity.

This is generally considered after less-invasive options have failed or when a patient prefers a definitive surgical solution.

Age itself is not necessarily a contraindication.

Overall health, surgical fitness, infection risk and patient expectations matter more.

Testosterone Therapy in Older Men: Use It Carefully

I believe testosterone is one of the areas in which older patients are most vulnerable to misleading advertising.

The current EAU guideline says clearly:

Do not use testosterone in men with normal testosterone, and do not use it simply to improve cognition, vitality or physical strength in ageing males.

Before starting treatment, genuine hypogonadism should be confirmed through compatible symptoms and appropriately repeated morning testosterone testing.

When genuine deficiency exists, treatment may improve libido and some sexual symptoms.

But testosterone is not a universal "youth injection."

Psychological and Sex Therapy

Medication is not always enough.

Older couples may need counselling regarding:

changes in arousal, erection expectations, menopause, body image, chronic illness and fear of sexual failure.

The National Institute on Aging specifically notes that individual or couple therapy can be useful for older adults experiencing sexual problems.

The objective should not be to make the patient behave like a 25-year-old.

The objective is to achieve **comfortable, satisfying and realistic sexual well-being appropriate to that individual and relationship**.

The Unani Concept of Ageing

The Unani system has a long tradition of **Tadabir-i-Mashayikh—care of older people**.

According to a CCRUM review of elderly care, classical Unani literature describes the ageing body as progressively moving toward a **Barid wa Yabis, or cold and dry, Mizaj**, associated traditionally with reduction in Hararat-i-Ghariziyya and Rutubat-i-Ghariziyya.

This should be understood as a **traditional Unani physiological model**.

It is not scientifically identical to modern concepts such as endothelial ageing, testosterone decline, menopause or vascular disease.

Today, we can respect the classical framework while also using contemporary diagnostic knowledge.

That combination is far more useful than pretending that the two systems describe exactly the same mechanism.

Sexual Debility: Zu'f-i-Bah in Unani Medicine

Traditional Unani literature discusses reduced sexual desire and capacity under the concept of **Zu'f-i-Bah**, or sexual debility.

CCRUM's Standard Unani Treatment Guidelines describe Zu'f-i-Bah as reduced sexual desire and reduced capacity for sexual activity. Traditional contributing factors include general weakness, penile flaccidity and psychological factors.

The traditional treatment principles include strengthening penile and general functional capacity and addressing psychological contributors.

This is particularly interesting in older-age sexual medicine because modern science likewise recognizes that older sexual problems often involve **physical disease plus psychological and relationship factors**.

The explanatory language differs, but the need to assess the whole patient remains highly relevant.

Asbab Sitta Daruriyya: The Six Essential Factors

A valuable part of Unani geriatric care is attention to the **Asbab Sitta Daruriyya**, the six essential factors traditionally considered important for maintaining health.

CCRUM's geriatric training module includes factors relating to the environment, food and drink, **physical activity and rest, psychological activity and repose, sleep and wakefulness, and elimination and retention** in elderly lifestyle management.

For sexual health, these principles can be very practical.

An older man who is physically inactive, sleeps poorly, has uncontrolled diabetes and lives under constant stress will not obtain optimal sexual health simply from taking a sexual tonic.

A postmenopausal woman with chronic pain, poor sleep and relationship stress also requires more than one medicine.

This is where the broad Unani approach can add real value.

Ilaj-bil-Ghiza: Dietotherapy in Older Adults

Diet must be individualized in older age.

CCRUM's geriatric-care material emphasizes age-appropriate, nutritious and relatively easy-to-digest dietary planning as part of elderly care.

From a modern perspective, the diet should also reflect the patient's medical condition.

An older person with diabetes needs appropriate glucose control.

A patient with chronic kidney disease may have dietary restrictions.

Someone with cardiovascular disease needs attention to vascular risk.

An underweight frail patient has completely different nutritional needs from an obese patient with metabolic syndrome.

Therefore, I do not believe that every older patient should simply be told to consume large quantities of milk, honey, nuts or sweet traditional tonics in the name of sexual strength.

A diet that worsens diabetes or obesity can ultimately worsen sexual function.

Ilaj-bil-Tadbir: Regimental and Lifestyle Therapy

CCRUM recognizes **Ilaj-bil-Tadbir** as one of the major modes of Unani therapy and specifically incorporates regimental therapy into geriatric healthcare.

For older sexual-health patients, I focus particularly on safe physical activity, adequate rest, sleep quality, stress management and maintenance of mobility.

Regular exercise supports cardiovascular health, blood pressure, glucose regulation and psychological well-being.

For a man with vascular ED, these benefits can support erection health.

For an older woman, maintaining mobility and general strength can support confidence and comfort during intimacy.

Massage and Other Unani Regimens

Massage may be used in Unani regimental care for selected patients to promote relaxation and general physical well-being.

However, I do not tell older patients that massage can reverse severe arterial ED or permanently restore hormone levels.

Similarly, procedures such as cupping should not be represented as established treatments for erectile dysfunction or menopausal sexual dysfunction.

An older patient may be taking anticoagulants or have fragile skin, diabetes or vascular disease, so any physical regimen must be selected carefully.

A traditional treatment becomes safer when it is adapted to the patient's actual geriatric condition.

Ilaj-bil-Dawa: Unani Pharmacotherapy

Unani medicine includes a long tradition of physician-selected formulations used for **Zu'f-i-Bah and general debility**.

CCRUM's standardized guideline lists several classical formulations historically used for sexual debility, including Labub Kabir, Labub Saghir and other compound preparations.

However, older adults require particular caution.

A 70-year-old patient may already be taking:

diabetes medicines, blood-pressure medicines, blood thinners, cholesterol medicines, prostate medicines and antidepressants.

Adding multiple traditional medicines without reviewing this complete list can create unnecessary risk.

Therefore, the correct Unani principle in older adults is **individualization**, not simply prescribing the strongest aphrodisiac.

Natural Does Not Mean Risk-Free

Older patients are particularly vulnerable to the misconception that natural medicines cannot cause adverse effects.

Herbal, mineral and traditional preparations are biologically active.

They may interact with prescription medicines or need dose adjustment in kidney or liver disease.

A medicine appropriate for a healthy 30-year-old man may not be equally appropriate for an 80-year-old man with heart disease and several medications.

This is why professional supervision matters.

Unani Medicine Should Complement Diagnosis, Not Replace It

I believe strongly in the usefulness of Unani medicine, but I also believe that its credibility increases when its limits are described accurately.

If an older man's ED is the first sign of serious coronary artery disease, he needs cardiovascular evaluation.

If testosterone is genuinely deficient, proper hormonal investigation is required.

If a woman has postmenopausal bleeding, she needs gynecological assessment rather than simply an herbal tonic.

If vaginal pain is caused by severe GSM, evidence-based local therapy can be very effective.

If a patient has severe medication-resistant ED, an implant may eventually be the best treatment.

Unani medicine should support comprehensive care—not delay necessary treatment.

My Special Approach at Saira Health Care

When an older patient consults me for a sexual problem, I prefer to work through the problem systematically.

First, I identify **the patient's actual goal**. Some want intercourse to become possible again. Others mainly want greater intimacy or relief from pain. Some are concerned about libido, erection, ejaculation or fertility.

Second, I distinguish **normal ageing from disease**.

Third, I evaluate reversible factors such as diabetes, obesity, smoking, medication effects, poor sleep, hypertension, cardiovascular disease and psychological stress.

Fourth, when necessary, I assess hormones, cardiovascular status, genital or reproductive health and other appropriate investigations.

Fifth, I perform an individualized Unani assessment including Mizaj, diet, general vitality and lifestyle.

Sixth, I select treatment according to the cause. This may involve counselling, lifestyle management, evidence-based ED medication, menopausal treatment, physician-selected Unani therapy, vacuum treatment or specialist referral.

Finally, I review the response rather than assuming that the first prescription must be continued indefinitely.

Saira Health Care's published ED treatment pathway similarly emphasizes correction of reversible factors such as smoking, obesity, physical inactivity, poorly controlled diabetes, hypertension, sleep problems and stress, followed by individualized treatment that may include counselling, guideline-supported medication, vacuum devices, injection therapy, hormonal treatment, supervised Unani medicine or surgery when needed.

Why I Do Not Treat Every Older Man With the Same "Power Medicine"

Consider three men who are all 68 years old.

The first has diabetes and vascular ED.

The second has completely satisfactory arteries and testosterone but has developed severe performance anxiety after the death of his previous partner and beginning a new relationship.

The third has genuine symptomatic hypogonadism confirmed on repeated testing.

All three may say:

"Doctor, I am weak because of age."

But they do not have the same disease.

The first needs cardiovascular and metabolic treatment alongside ED care.

The second may benefit greatly from counselling.

The third may require proper endocrine treatment.

Giving all three the same aphrodisiac would not be individualized medicine.

Why I Do Not Treat Every Older Woman With Hormones

The same principle applies to women.

One postmenopausal woman may have mild dryness that improves with lubricant.

Another may have significant GSM requiring local vaginal estrogen or another prescription treatment.

A third may have normal vaginal tissues but low desire caused by depression.

A fourth may have pelvic-floor pain.

A fifth may have relationship difficulties.

The symptoms may sound similar, but the treatment is different.

The Role of the Partner

I often encourage partner involvement when the patient is comfortable with it.

Sexual problems are rarely experienced by only one person in a relationship.

A partner can help reduce pressure.

For example, an older man with ED may feel that every intimate encounter must immediately end in penetration. That pressure itself can worsen erection.

An older woman with painful intercourse may need her partner to understand that reduced lubrication is physiological and not a sign of rejection.

Good communication can sometimes transform the treatment outcome.

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 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 current public professional profile lists my **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK**, and describes my clinical work as focused on sexual disorders and infertility.

MasterHealthPro publicly lists a six-month **Male Infertility Masters** programme and advanced training in male infertility and sexual medicine, including evaluation and management of male reproductive and sexual disorders.

In older-age sexual medicine, this combined reproductive and sexual-health perspective is valuable because an older patient's problem may involve **vascular health, hormones, erection, ejaculation, prostate-related treatment, psychological health or reproductive concerns simultaneously**.

Contribution of Saira Health Care to Sexual Disorders and Infertility

A major problem in sexual healthcare is not merely lack of medicines.

It is lack of **accurate information and comfortable communication**.

Many older adults grew up in environments where sexual health was almost never discussed openly.

Some therefore tolerate treatable ED for years.

Some women tolerate painful intercourse because they think menopause means sex must become painful.

Some older men use unregulated erection medicines despite significant heart disease.

Others take testosterone simply because they feel tired.

Saira Health Care describes its philosophy as treating sexual and infertility concerns in a **safe, compassionate and non-judgmental environment**, combining traditional knowledge with individualized treatment and contemporary research.

I believe patient education is one of the most important contributions we can make.

An informed patient is less likely to be frightened by normal ageing, less likely to self-medicate dangerously and more likely to seek appropriate treatment when genuine disease exists.

Common Myths About Sexual Health in Old Age

“People over 60 should not be interested in sex.”

Incorrect.

Sexuality and intimacy can remain important throughout later life.

“Every older man develops impotence.”

No.

ED becomes more common with age, but diabetes, cardiovascular disease, medications, obesity, neurological disease and psychological factors are major contributors.

“Every older man needs testosterone.”

No.

The EAU specifically recommends against testosterone treatment in men with normal testosterone and against using it simply to improve vitality or physical strength in ageing men.

“Painful intercourse is simply normal after menopause.”

No.

Vaginal dryness and GSM are common, but effective treatment options include lubricants, moisturizers and, in appropriate patients, local estrogen and other therapies.

“Heart patients cannot have sex.”

Not necessarily.

Many people with stable cardiovascular disease can remain sexually active, but high-risk or unstable cardiac disease requires professional evaluation.

“Herbal medicines cannot interact with prescription medicines.”

Incorrect.

Older adults commonly take several medicines, so traditional treatment should be professionally reviewed.

“Sex is only intercourse.”

No.

Intimacy and sexuality can include many forms of physical and emotional connection.

When Should an Older Man Seek Medical Advice?

I recommend evaluation when erection difficulty becomes persistent, sexual desire changes substantially, morning erections disappear along with other symptoms, ejaculation becomes markedly different, sexual activity becomes painful or there is significant distress.

New ED in an older man also provides an opportunity to evaluate cardiovascular and metabolic risk.

A man should not continue self-medicating for years without understanding the cause.

When Should an Older Woman Seek Medical Advice?

Persistent vaginal dryness, frequent painful intercourse, vaginal bleeding after intercourse, recurrent urinary or vaginal problems or major changes in sexual desire deserve assessment.

ACOG specifically advises professional evaluation when vaginal irritation or painful sex does not improve with appropriate initial measures or when other concerning symptoms occur.

Any **postmenopausal vaginal bleeding** should be medically evaluated rather than assumed to be caused by sexual activity or dryness.

When Is Urgent Medical Attention Needed?

Most sexual problems in older adults are not emergencies.

However, urgent medical care is required for severe chest pain or cardiovascular symptoms during sexual activity, sudden severe genital trauma, sudden severe testicular pain or an erection lasting approximately four hours or longer.

Routine Unani or sexual-health treatment should never delay emergency care.

Frequently Asked Questions

Is it normal for sex drive to decrease with age?

Some change can occur, but marked loss of libido may also be caused by hormones, chronic disease, depression, medication or relationship factors. It should be assessed when it causes concern.

Is erectile dysfunction curable in old age?

Many men can achieve substantial improvement. Outcome depends on the cause. Treatments include lifestyle measures, PDE5 inhibitors, vacuum devices, injection therapy, appropriate hormone treatment and implants in selected cases.

Can a 70-year-old man take sildenafil or tadalafil?

Age alone does not prohibit these medicines, but cardiovascular status and other medications must be reviewed. Nitrates are an important contraindication.

Should every older man get a testosterone test?

No. Testing is most useful when symptoms suggest hypogonadism. Diagnosis should be based on symptoms plus consistently low morning testosterone.

Does testosterone make an older man younger?

No. Testosterone is not a general anti-ageing therapy. Current EAU guidance specifically recommends against using it simply to improve vitality, cognition or strength in ageing men.

Can an older woman continue sexual activity after menopause?

Yes. Menopause does not end sexual life. Dryness or discomfort can often be treated.

Can Unani medicine help sexual problems in older age?

Yes, particularly through an individualized approach involving Mizaj, diet, lifestyle, general vitality, psychological well-being and physician-selected traditional treatment. However, Unani care should be integrated with appropriate cardiovascular, hormonal, urological or gynecological evaluation when required.

Can Unani medicines replace ED tablets or menopause treatment in everyone?

No. Treatment should be selected according to the cause and severity. Severe vascular ED, genuine hypogonadism or significant GSM may require established medical treatment.

Prognosis

Older age does not automatically mean that sexual dysfunction is permanent.

A man whose ED is associated with poor physical fitness, obesity, medication effects or performance anxiety may improve considerably when those factors are addressed.

A patient with vascular disease may obtain meaningful benefit from appropriate ED treatment.

A hypogonadal man may improve when genuine hormone deficiency is correctly managed.

An older woman with vaginal dryness may experience substantial improvement with moisturizers, lubricants or appropriate local therapy.

A couple affected mainly by fear or communication problems may benefit significantly from counselling.

More severe neurological or vascular disease may require longer-term management.

The most important predictor of treatment strategy is therefore **the cause of the problem—not the patient's age alone**.

Conclusion

When an older patient asks me about sexual health, I want him or her to understand that **ageing changes sexuality but does not automatically end it**.

Sexuality and intimacy can remain meaningful throughout later life. The National Institute on Aging specifically emphasizes that older adults continue to experience sexual desire, intimacy and relationships, although physical illness, medication and normal age-related changes can alter sexual response.

In men, erectile dysfunction becomes more common with age, but current EAU evidence shows that it is strongly associated with cardiovascular disease, diabetes, hypertension, obesity, metabolic disease, neurological conditions and psychological factors. Persistent ED therefore deserves proper evaluation rather than being dismissed as a normal consequence of becoming older.

Testosterone requires equal caution. Healthy ageing produces only a gradual decline, while obesity and chronic disease account for much of clinically important late-onset hypogonadism. Diagnosis requires symptoms and consistently low morning testosterone,

and current EAU guidance explicitly advises against using testosterone simply as an anti-ageing treatment for vitality or physical strength.

In women, menopause may lead to genitourinary syndrome of menopause, including vaginal dryness, reduced lubrication and painful intercourse. These problems should not simply be tolerated. Moisturizers, lubricants, local vaginal estrogen and other individualized treatments can provide meaningful relief.

The **Unani system of medicine** provides a valuable additional perspective because it has long recognized ageing as a stage requiring individualized geriatric care. CCRUM's geriatric framework addresses age-related physiological and psychological changes, Mizaj, Asbab Sitta Daruriyya, diet and Ilaj-bil-Tadbir. Traditional Unani literature also recognizes **Zu'f-i-Bah**, or sexual debility, as involving reduced sexual desire or capacity together with physical and psychological contributors.

At **Saira Health Care**, my approach as **Dr. Nizamuddin Qasmi** is therefore not to prescribe a generic “old-age sex tonic.”

I prefer to determine whether the patient's concern is caused by normal ageing, cardiovascular disease, diabetes, hormone deficiency, medication, menopause, pain, neurological disease, psychological stress or a combination of factors.

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, supports this individualized approach. Saira Health Care's public profile confirms my listed BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK, while MasterHealthPro publicly lists its Male Infertility Masters programme.

The message I want every older patient and every family to remember is simple:

Growing older does not mean losing the right to intimacy or sexual well-being. Do not accept every sexual problem as an unavoidable consequence of age, and do not self-medicate because of embarrassment. Identify the real cause, improve general health, discuss the problem openly and follow an individualized treatment plan. Modern sexual medicine and responsibly practiced Unani medicine can complement one another to support a safer, more comfortable and more satisfying quality of life in older age.

About Saira Health Care

Saira Health Care focuses on **male and female sexual disorders, infertility and reproductive health**, with an approach based on individualized Unani assessment, lifestyle guidance, patient education and appropriate contemporary diagnostic understanding.

Visit Saira Health Care

Medical Disclaimer

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

Older adults frequently have multiple medical conditions and use several prescription medicines. Sexual-health treatment—including herbal, Unani, hormonal and conventional medicines—should therefore be individualized.

Do not discontinue blood-pressure medicines, heart medicines, diabetes treatment, antidepressants or other prescribed drugs because of sexual side effects without consulting the prescribing clinician.

Men using **nitrate medicines** for angina or cardiovascular disease should not take sildenafil, tadalafil or similar PDE5 inhibitors without appropriate medical guidance because the combination can cause dangerous hypotension.

Testosterone should not be used simply as an anti-ageing or sexual-performance treatment. It should be considered only when genuine hypogonadism is appropriately diagnosed.

Unani, herbal and traditional medicines contain biologically active ingredients. “Natural” does not mean universally free from adverse effects or interactions, particularly in older adults with diabetes, cardiovascular disease, kidney disease or polypharmacy.

No conventional medicine, hormone, Unani formulation, supplement, device or procedure can responsibly guarantee complete restoration of sexual function or identical results in every older patient.