Male Sexual Problems: Causes, Diagnosis, Modern Treatment and the Unani Approach

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Introduction

When a man comes to me and says, **"Doctor, I have a sexual problem"** or **"I feel sexually weak,"** my first responsibility is to understand exactly what he means.

Male sexual problems are not one disease.

One patient may be unable to achieve a sufficiently firm erection. Another may obtain an erection normally but ejaculate much sooner than he wishes. A third man may have good erections but almost no sexual desire. Another may have difficulty reaching ejaculation or orgasm. Some men have satisfactory sexual function but are worried about fertility, sperm quality, penile size or sexual performance because of misinformation.

For this reason, I always tell my patients:

Do not treat the words "sexual weakness." First identify which sexual function is actually affected.

Modern sexual medicine recognizes different disorders involving **sexual desire, erection, ejaculation, orgasm, penile structure and psychological sexual well-being**. The current European Association of Urology (EAU) Sexual and Reproductive Health guideline addresses erectile dysfunction, disorders of ejaculation, low sexual desire, male hypogonadism, penile curvature and male infertility as separate clinical areas. Its 2026 update incorporated new evidence particularly in hypogonadism and ejaculation disorders and reorganized recommendations for ED management.

The **Unani system of medicine** adds another valuable dimension. In Unani practice, we do not look only at a symptom. We consider the person's **Mizaj, Akhlat, diet, sleep, digestion, physical strength, psychological condition, lifestyle, reproductive health and associated medical problems**.

My preferred approach at Saira Health Care is therefore an **integrative, diagnosis-based model**: understand the exact sexual problem, investigate its underlying cause, correct

reversible health factors, and then select individualized modern and/or Unani treatment according to the patient.

What Do We Mean by Male Sexual Problems?

Male sexual function is a coordinated biological and psychological process.

Healthy sexual activity requires the brain to experience desire and arousal, the nervous system to transmit appropriate signals, healthy blood vessels to supply the penis, adequate hormonal function, normal penile anatomy, coordinated ejaculation and orgasm, and a psychological environment in which the individual can feel comfortable and sexually responsive.

A problem in any one of these areas can disturb sexual function.

This is why a patient with diabetes may experience ED because of vascular and nerve damage, while another patient with completely healthy blood vessels may develop erection difficulty because of severe performance anxiety.

Another man may have low testosterone and reduced libido but no major erection problem.

Another may have premature ejaculation but completely normal testosterone, erection and fertility.

We should never assume that one medicine will solve all of these conditions.

The Most Common Male Sexual Problems

The major problems I commonly evaluate in clinical practice include erectile dysfunction, premature ejaculation, reduced sexual desire, delayed ejaculation, anejaculation, orgasmic difficulty, painful ejaculation, penile hypersensitivity and sexual-performance anxiety.

The following comparison helps explain why accurate diagnosis matters:

Sexual Problem	Main Complaint	Important Possible Causes
Erectile dysfunction	Difficulty obtaining or maintaining an erection	Diabetes, vascular disease, hormones, nerves, medicines, anxiety
Premature ejaculation	Ejaculation earlier than desired with poor control	Lifelong biological factors, anxiety, ED, prostatitis, relationship issues

Sexual Problem	Main Complaint	Important Possible Causes
Low libido	Reduced interest in sexual activity	Testosterone deficiency, prolactin, depression, stress, relationship problems
Delayed ejaculation	Takes unusually long to ejaculate or cannot ejaculate	Medicines, diabetes, nerve disease, psychological factors
Anejaculation	No semen expelled despite sexual stimulation/orgasm	Neurological disease, surgery, medications, spinal injury
Anorgasmia	Difficulty or inability to reach orgasm	Psychological factors, medicines, hormonal or neurological causes
Painful ejaculation	Pain during or after ejaculation	Prostatitis, infection, pelvic disorders, medications
Penile curvature	Abnormal acquired or congenital bend	Peyronie's disease or congenital curvature
Performance anxiety	Sexual function worsens because of fear and excessive monitoring	Stress, previous sexual difficulty, relationship pressure

These conditions can occur alone or together.

Erectile Dysfunction

What Is Erectile Dysfunction?

Erectile dysfunction, commonly called **ED**, means a persistent difficulty obtaining or maintaining an erection firm enough for satisfactory sexual activity.

The EAU defines ED as the persistent inability to attain and maintain an erection sufficient for satisfactory sexual performance. Importantly, the guideline also emphasizes that most cases involve a mixture of causes rather than being purely physical or purely psychological.

I often explain to patients that one unsuccessful sexual encounter does not automatically mean they have ED.

Fatigue, stress, lack of privacy, excessive alcohol intake, illness or relationship tension can temporarily affect erection.

It becomes more important when the problem is recurring or persistent.

How Does a Normal Erection Occur?

A normal erection requires cooperation between the brain, nerves, blood vessels, hormones and erectile tissue.

During sexual stimulation, nerve signals promote the release of nitric oxide inside the penis. This causes relaxation of smooth muscle in the erectile tissues and allows increased arterial blood flow.

As the erectile chambers fill, the veins carrying blood away become compressed, helping maintain rigidity.

Therefore, anything that damages vascular supply, nerve function, hormonal regulation or psychological arousal may interfere with erection.

This is why ED should not simply be called “penile weakness.”

It is often a sign involving the whole body.

Physical Causes of Erectile Dysfunction

Current EAU guidance recognizes vascular, hormonal, neurological, anatomical, medication-related and psychological pathways. Important risk factors include diabetes, hypertension, cardiovascular disease, obesity, metabolic syndrome, smoking, lack of exercise, high cholesterol and various chronic illnesses.

When I see a patient with new persistent ED, particularly in middle age, I am interested not only in sexual performance but also in his general health.

Does he have diabetes?

Is his blood pressure controlled?

Does he smoke?

Is he overweight?

Does he exercise?

Does he have cholesterol problems?

Could a medication be affecting sexual function?

These questions are sometimes more important than immediately asking which erection tablet he wants.

Erectile Dysfunction and Heart Health

One of the most important lessons in modern sexual medicine is that ED can sometimes act as an early sign of vascular disease.

The EAU notes that men seeking treatment for ED have a higher prevalence of cardiovascular disease and that ED can precede clinically apparent cardiovascular problems in some individuals.

This does not mean every man with ED has heart disease.

It means that persistent ED should provide an opportunity to assess cardiovascular risk, particularly when diabetes, smoking, obesity, hypertension or high cholesterol are present.

I therefore tell patients:

Do not treat your erection while ignoring your circulation.

Diabetes and Erectile Dysfunction

Diabetes is one of the most important causes of difficult-to-treat ED.

Over time, high blood glucose can damage blood vessels and peripheral and autonomic nerves.

A diabetic man may therefore have reduced penile blood flow, impaired nerve signalling or both.

If diabetes remains uncontrolled, taking sexual medicine alone may provide only partial or temporary benefit.

Good diabetic management is part of sexual-health treatment.

This principle also fits very naturally with Unani medicine's holistic emphasis on treating the patient's overall health rather than focusing only on one organ.

Psychological Erectile Dysfunction

Some men have excellent physical erectile capacity but struggle during intercourse because of anxiety.

A common pattern is:

A man experiences erection loss once.

He becomes frightened.

At the next sexual encounter, he constantly checks whether the erection is hard enough.

Instead of focusing on pleasure, intimacy and stimulation, his attention shifts toward fear.

That fear activates a stress response and further interferes with erection.

The cycle becomes:

one difficulty → anxiety → another difficulty → greater anxiety.

The EAU recognizes anxiety, depression, relationship dissatisfaction, poor self-esteem and dysfunctional expectations about sexual performance as relevant to ED, and it recommends cognitive-behavioural approaches when appropriate.

In these cases, simply increasing medication may not solve the main problem.

Premature Ejaculation

What Is Premature Ejaculation?

Premature ejaculation, or PE, does not simply mean that intercourse lasted fewer minutes than someone expected.

Modern sexual medicine considers several aspects together:

the timing of ejaculation, the man's ability to control or delay it, the distress it causes and the effect on sexual satisfaction and the relationship.

A patient who occasionally ejaculates earlier than expected does not necessarily have a disorder.

The EAU distinguishes lifelong and acquired PE and also recognizes variable PE and subjective PE.

This distinction is very useful clinically.

Lifelong Premature Ejaculation

Lifelong PE usually begins from a man's earliest sexual experiences.

Current research suggests that lifelong PE may involve complex biological factors involving central and peripheral neurotransmitter pathways, sensitivity and genetic or neurobiological influences.

It should not simply be blamed on masturbation, “weak nerves” or semen loss.

Acquired Premature Ejaculation

Acquired PE develops after a period in which ejaculation was previously satisfactory.

In these patients, I look particularly carefully for an underlying problem.

The current EAU guideline identifies possible associations with erectile dysfunction, prostatitis, hyperthyroidism, poor sleep quality, sexual-performance anxiety and relationship problems.

For acquired PE, treating the underlying cause is particularly important.

A man who rushes intercourse because he fears losing his erection may improve when the erectile problem is addressed.

Another patient may need treatment for prostatitis.

Another may primarily need psychosexual therapy.

Penile Hypersensitivity and Premature Ejaculation

Some men tell me:

“Doctor, my penis is too sensitive, so I cannot control ejaculation.”

Increased peripheral sensitivity may contribute in a subgroup of men, but it is not the universal cause of premature ejaculation.

We should therefore avoid treating every PE patient only by numbing the penis.

Reducing sensation excessively can itself reduce pleasure and sometimes affect erection.

Treatment needs to balance sensation, control and satisfaction.

Low Libido or Reduced Sexual Desire

What Is Libido?

Libido means sexual desire or interest.

Some men have perfectly adequate erections but simply do not feel interested in sexual activity.

This is a different problem from ED.

The current EAU guideline explains sexual desire as involving biological drive, psychological motivation and cultural or relational influences. Testosterone is important, but desire does not directly correspond to one testosterone number in every man.

This is why I never diagnose low testosterone simply because a patient says:

“My desire has decreased.”

Causes of Low Libido

Reduced sexual desire may occur with testosterone deficiency, high prolactin, thyroid disease, diabetes, depression, anxiety, relationship conflict, chronic illness or medication effects.

Some antidepressants can reduce desire.

Chronic stress may reduce sexual interest.

A man worried constantly about erectile failure may gradually lose interest because sexual activity itself has become stressful.

The EAU recommends medical and sexual history, physical assessment and endocrine investigations when indicated, including testosterone, prolactin and thyroid evaluation.

Therefore, low libido should be investigated according to the individual cause.

Low Testosterone and Male Sexual Problems

Testosterone plays an important role in sexual desire and contributes to sexual function.

But low testosterone is frequently overdiagnosed.

A man should not be diagnosed with hypogonadism merely because he feels tired or sexually weak.

Proper diagnosis requires compatible symptoms together with reliably low testosterone.

Current EAU evidence indicates that testosterone therapy can improve libido and milder ED in genuinely hypogonadal men, but it should not be prescribed to men with normal testosterone simply to improve sexual performance.

A Very Important Fertility Warning About Testosterone

This is particularly important in my infertility practice.

Many men assume:

“Testosterone is the male hormone, so testosterone injections must increase sperm.”

In reality, external testosterone can suppress LH and FSH from the pituitary gland, lower intratesticular testosterone and **reduce sperm production**.

The EAU specifically states that testosterone therapy suppresses spermatogenesis and is contraindicated when a man actively wishes to father children.

Therefore, a young man planning pregnancy should never start testosterone injections, gels or bodybuilding hormones without appropriate reproductive advice.

Increasing blood testosterone and improving fertility are not the same objective.

Delayed Ejaculation

Some men have the opposite problem from premature ejaculation.

They can maintain sexual activity for a prolonged period but are unable to ejaculate or require unusually intense stimulation.

Delayed ejaculation can result from antidepressants, neurological disease, diabetes, psychological factors, alcohol, reduced penile sensation and other conditions.

The EAU lists endocrine, neurological, inflammatory, medication-related and psychological factors among possible causes.

Treatment therefore depends on identifying why ejaculation is delayed.

Simply prescribing an aphrodisiac may not solve a medication-induced or neurological problem.

Anejaculation

Anejaculation means semen is not expelled despite sexual stimulation, and sometimes despite orgasm.

This may occur after spinal cord injury, pelvic or retroperitoneal surgery, neurological disease, certain medicines or severe ejaculatory dysfunction.

For men planning fertility, this becomes a reproductive as well as a sexual problem.

Depending on the cause, specialized ejaculation techniques, sperm retrieval or assisted reproductive methods may be considered.

Anorgasmia

Orgasm and ejaculation are closely related but not identical.

A man may occasionally ejaculate without a strong orgasmic sensation, or may experience orgasmic difficulty even when erection is normal.

The EAU recognizes medication effects, testosterone deficiency, hypothyroidism, psychological factors and reduced penile sensitivity among potential contributors to delayed orgasm or anorgasmia.

Again, diagnosis matters more than labeling the patient as sexually weak.

Painful Ejaculation

Pain during or after ejaculation should not be ignored.

Possible causes include prostatitis, inflammatory pelvic conditions, infections, certain medications or disorders affecting the reproductive tract.

If pain occurs repeatedly, especially with urinary burning, pelvic discomfort, fever, discharge or blood in semen, medical evaluation is advisable.

Taking a general sexual tonic without investigating persistent painful ejaculation may delay diagnosis.

Penile Curvature and Peyronie's Disease

Some male sexual complaints are structural rather than hormonal or psychological.

A man may develop a new bend, plaque or hourglass deformity of the penis due to Peyronie's disease.

Severe curvature may interfere with intercourse and may coexist with ED.

This requires specific urological evaluation and should not be managed as general "weakness."

Likewise, congenital penile curvature is a different structural condition and may require surgical correction when severe.

Male Sexual Problems Are Not the Same as Infertility

This distinction is very important.

A man can have excellent erection, desire and ejaculation but severe oligozoospermia or azoospermia.

Another man can have significant erectile dysfunction but completely normal sperm production.

Premature ejaculation does not automatically mean poor sperm.

Semen thickness does not determine erection quality.

Sexual stamina does not tell us sperm motility.

At Saira Health Care, where my work includes both sexual disorders and infertility, I make this distinction very clearly.

Sexual performance and reproductive capacity overlap, but they are not identical.

Causes of Male Sexual Problems

When I evaluate a patient, I generally think in several broad categories rather than looking for one universal cause.

Cardiovascular and Metabolic Causes

Diabetes, high blood pressure, obesity, metabolic syndrome, high cholesterol and vascular disease are among the most important physical contributors to erectile dysfunction.

These conditions may also affect testosterone, energy and general sexual well-being.

The current EAU guideline strongly links ED with several cardiovascular and metabolic risk factors and emphasizes lifestyle and risk-factor modification as part of treatment.

Hormonal Causes

Low testosterone is important, but it is not the only hormone involved.

Elevated prolactin can reduce sexual desire.

Thyroid disorders can influence desire and ejaculation.

Pituitary disorders may affect several reproductive hormones.

Diabetes can affect both hormonal and neurological pathways.

The correct hormonal investigation therefore depends on the symptoms.

Neurological Causes

Normal sexual function requires intact nerve pathways.

Possible causes include:

spinal injury, multiple sclerosis, Parkinson's disease, diabetic neuropathy, stroke, pelvic surgery and neurological disorders.

These may affect erection, ejaculation, orgasm or sensation in different ways.

Medication-Related Sexual Problems

Patients should always tell me which medicines they take.

Some antidepressants may reduce libido, delay ejaculation or interfere with orgasm.

Some antihypertensive medicines may influence erectile function in selected patients.

Antiandrogen treatments and certain prostate medicines can affect sexual function.

Opioids may suppress hormonal function.

However, prescribed medicine should **never be stopped without consulting the clinician who prescribed it**.

Often, the treatment can be adjusted safely when sexual adverse effects are recognized.

Smoking, Alcohol and Recreational Drugs

Smoking damages vascular health and can contribute to ED.

Excessive alcohol may impair erection and ejaculation.

Recreational drugs can have unpredictable sexual effects.

Anabolic steroids are particularly problematic because they may disturb natural testosterone production and suppress fertility.

I therefore consider substance use part of the sexual-health history.

Obesity and Physical Inactivity

Obesity can contribute to ED, low testosterone, diabetes and cardiovascular disease.

Regular exercise supports vascular health, body weight and psychological well-being.

The EAU reports evidence that lifestyle changes can improve erectile function in selected populations and recommends initiating lifestyle modification alongside ED treatment.

This is one of the clearest areas where modern medicine and Unani holistic principles agree.

Sleep and Sexual Function

Poor sleep can influence hormones, mood, metabolic health and sexual desire.

Sleep disorders such as obstructive sleep apnea may coexist with obesity, fatigue, low testosterone symptoms and erectile problems.

If a man sleeps poorly every night, treating only his sexual symptom is incomplete care.

Stress, Anxiety and Depression

Sexual activity is strongly affected by emotional state.

Depression can reduce desire.

Performance anxiety may disturb erection or ejaculation.

Chronic stress can reduce interest in intimacy.

Relationship conflict may make sexual activity emotionally difficult.

Modern guidelines recognize psychosexual factors in ED, PE and low desire, and behavioural, cognitive and couple-focused approaches can be useful when appropriately selected.

Pornography, Unrealistic Expectations and Performance Pressure

One issue I increasingly discuss with patients is unrealistic comparison.

Some men believe an erection must remain maximally hard continuously.

Some believe penetration must last 30, 45 or 60 minutes to be normal.

Others compare their penis or sexual performance with pornography.

These comparisons can produce anxiety in men whose sexual function is actually within a healthy range.

Treatment sometimes begins with correcting the expectation rather than increasing medicine.

Does Masturbation Cause Permanent Sexual Weakness?

Normal masturbation has not been shown to permanently destroy erections, testosterone, sperm or masculinity.

However, habits can influence sexual response.

Very specific, unusually intense or compulsive stimulation may make partnered sexual stimulation feel different for some men.

If masturbation is compulsive, interfering with relationships or creating psychological distress, it deserves attention.

But creating fear about normal masturbation can itself worsen sexual anxiety.

Does Nightfall Cause Sexual Weakness?

Nocturnal emission, commonly called nightfall, can be a normal physiological event.

It does not automatically cause permanent weakness, infertility or testosterone deficiency.

Men who repeatedly worry about semen loss can sometimes develop significant anxiety.

Persistent abnormal discharge or associated urinary symptoms should be investigated separately.

How I Diagnose Male Sexual Problems

When a patient visits me, I first ask him to describe the problem in his own words.

I want to know:

When did it begin?

Is the problem present every time or only occasionally?

Are morning erections present?

Is sexual desire normal?

Is erection adequate during masturbation?

How quickly does ejaculation occur?

Is control over ejaculation reduced?

Is orgasm normal?

Is there pain?

Are diabetes, blood pressure, thyroid or other diseases present?

Which medicines are being used?

Is there psychological or relationship stress?

Is the patient planning fertility?

The latest EAU ED guideline states that the first step in evaluation is a detailed medical and sexual history, including assessment of erection rigidity and duration as well as desire, arousal, ejaculation and orgasm.

This is exactly why I say:

The consultation is not just a formality; it is part of the diagnosis.

Physical Examination

Where clinically appropriate, examination may assess blood pressure, body weight, genital anatomy, testes, signs of hormonal deficiency, Peyronie's disease and vascular or neurological findings.

The EAU recommends focused genitourinary, endocrine, vascular and neurological examination in ED assessment.

Not every sexual complaint requires an extensive physical examination, but we should not ignore it when the history suggests a physical cause.

Laboratory Testing

For ED, current EAU recommendations include glucose or HbA1c, lipid assessment and early-morning testosterone in appropriate patients, with additional prolactin, LH or other tests selected according to symptoms.

For low sexual desire, endocrine assessment may include testosterone, prolactin and thyroid tests when indicated.

For premature ejaculation, routine laboratory testing is **not required for every man**; tests should be directed by specific findings in the history or examination.

This is an important principle:

More tests do not automatically mean better care. The correct tests are those that answer a clinical question.

Role of Penile Doppler Ultrasound

Penile Doppler ultrasound is useful in selected ED patients when vascular dysfunction is suspected, such as in diabetes, multiple cardiovascular risk factors or poor response to oral treatment.

It is not necessary for every man complaining of sexual weakness.

The EAU describes dynamic duplex ultrasound as a second-level investigation used particularly when vasculogenic ED is suspected.

Modern Treatment of Erectile Dysfunction

Modern ED treatment has become highly effective.

Current EAU guidance recommends lifestyle and risk-factor modification and identifies **PDE5 inhibitors as first-line treatment**.

These include medicines such as sildenafil and tadalafil.

They work by enhancing the natural nitric-oxide/cGMP erection pathway.

They do not automatically increase libido, and sexual stimulation remains necessary.

Safety of Sildenafil and Tadalafil

These medicines are effective for many men but should not be taken casually.

The most important safety warning is the combination with **nitrate medicines or nitric-oxide donors**, which can cause a dangerous fall in blood pressure.

The EAU describes concomitant nitrate use as an absolute contraindication to PDE5 inhibitors.

Patients with significant heart disease should therefore discuss ED treatment professionally.

When ED Tablets Seem to Stop Working

A poor response does not necessarily mean the medicine has permanently failed.

Incorrect dose, incorrect timing, inadequate stimulation, progression of diabetes or vascular disease, testosterone deficiency and psychological factors can all influence response.

Current EAU recommendations specifically emphasize educating patients about the correct use of PDE5 inhibitors because incorrect use or inadequate information is an important reason for apparent failure.

I therefore do not recommend simply increasing dose repeatedly without reassessment.

Other Modern ED Treatments

When oral medication is unsuitable or ineffective, options can include vacuum erection devices, intraurethral or topical alprostadil, intracavernosal injections and selected surgical treatments.

Vacuum erection devices can provide satisfactory erections in many appropriately selected men.

Penile prosthesis implantation may be considered when less-invasive treatment fails or when a patient prefers definitive surgical management after appropriate counselling.

The important point is that ED is not untreatable simply because one tablet did not work.

Modern Treatment of Premature Ejaculation

Treatment should first distinguish lifelong from acquired PE.

For acquired PE, the underlying problem—such as ED, prostatitis, anxiety or hyperthyroidism—should be addressed.

For lifelong PE, current guideline-based pharmacological treatments include **dapoxetine where approved and available**, topical lidocaine/prilocaine formulations and selected SSRIs or clomipramine under professional guidance.

Psychosexual interventions can also be useful, especially alongside appropriate pharmacological treatment. EAU evidence indicates that psychoeducation, mindfulness and psychosexual approaches can reduce PE-related distress, anxiety and depressive symptoms, with combined treatment often performing better than medication alone.

Modern Treatment of Low Libido

Low sexual desire should never be treated with one universal “power medicine.”

The cause determines treatment.

Confirmed testosterone deficiency may require properly supervised testosterone therapy when fertility is not being pursued.

Hyperprolactinaemia requires appropriate endocrine treatment.

Thyroid disorders should be corrected.

Depression or anxiety may require psychological or medical management.

Relationship difficulties may require couple-oriented intervention.

Current EAU guidance recommends testosterone therapy when low desire occurs with signs and symptoms of genuine testosterone deficiency, not simply because sexual interest is reduced.

The Unani Understanding of Male Sexual Problems

The Unani system of medicine takes a broader view of sexual health.

Traditionally, sexual weakness can be discussed within concepts such as **Zoafe Bah / Zu'f-i-Bah**, while the physician also considers Mizaj, Akhlat, Quwwat, diet, digestion, mental condition and lifestyle.

These traditional concepts should not be described as scientifically identical to modern vascular, endocrine or neurological diagnoses.

For example, a humoral imbalance is a classical Unani explanatory model, whereas diabetic neuropathy is a modern physiological diagnosis.

Both frameworks can be discussed, but they should not be falsely presented as the same mechanism.

I believe Unani medicine becomes strongest when its traditional individualized principles are used **alongside accurate modern diagnosis**.

Four Important Treatment Modes in Unani Medicine

The Central Council for Research in Unani Medicine (CCRUM), Ministry of AYUSH, officially describes four broad treatment approaches within Unani medicine:

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

This is important because Unani medicine should not be reduced to "herbal capsules."

Its classical philosophy includes lifestyle, diet, medicines and procedural or surgical approaches according to the condition.

Ilaj-bil-Ghiza: Diet and Male Sexual Health

Nutrition should support general metabolic and vascular health.

A man with obesity, diabetes and ED needs different dietary advice from a thin patient with general debility.

Balanced nutrition, adequate protein, fruits, vegetables, whole grains, nuts and appropriate healthy fats can support general health.

Patients with diabetes should not consume excessive sweet tonics simply because they are described as strengthening.

Individualization is essential.

Ilaj-bil-Tadbir: Lifestyle and Regimental Care

Regular exercise, appropriate sleep, stress management, smoking cessation and healthy body weight are all highly relevant to sexual health.

These measures fit well with both Unani holistic principles and current ED guidelines.

I often explain to patients that improving circulation, metabolic health and psychological well-being can support sexual function in ways that no single medicine can fully replace.

Psychological Care in the Unani Approach

Sexual health cannot be separated from emotional health.

A man who is constantly afraid of failure needs more than a tablet.

Counselling, reassurance, correction of misconceptions and, when appropriate, couple involvement can be extremely valuable.

I particularly discourage words such as **“Namardi”** when they are used to shame men.

A sexual disorder is a health condition.

It does not define masculinity.

Ilaj-bil-Dawa: Physician-Selected Traditional Medicines

Traditional pharmacotherapy can be useful when selected according to the individual patient's diagnosis, Mizaj, general health and reproductive goals.

However, I do not believe every sexual problem should receive the same Nuskha.

The treatment for PE should not automatically be the same as treatment for low sperm count.

The treatment of low libido with confirmed hormonal deficiency differs from anxiety-related loss of desire.

A patient with severe diabetic vascular ED requires metabolic and vascular management.

Unani medicine should be **individualized rather than product-driven**.

Dr. Qasmi's Nuskha No. 129 – Vitasem Max

One formulation used within Saira Health Care's male-health and reproductive programmes is **Dr. Qasmi's Nuskha No. 129 – Vitasem Max**.

The current Saira Health Care Pharmacy page describes it as a Unani Majoon for male debility, general weakness, energy and semen-quality support. Its currently listed ingredients include Asl-us-Soos, Tukhm Sudab, Tukhm Kahu, Gulnar, Gul Surkh and several traditional processed ingredients. The same page advises against self-medication and warns that overdosing may produce adverse effects.

I therefore prefer to describe Nuskha No. 129 as an **individualized traditional supportive formulation**, particularly when general debility or reproductive concerns are clinically relevant.

Its pharmacy description should not be interpreted as proof that the finished formulation is a universally established treatment for every case of ED, PE or low libido.

That level of claim would require appropriate controlled clinical evidence.

Spermogenic Powder

Spermogenic Powder is another formulation used in male reproductive-health programmes.

The Saira Health Care Pharmacy page currently positions it for several male reproductive and sexual-health concerns, including reduced sperm motility, low sperm count, watery semen, low libido and erectile concerns. Listed ingredients include Asgand Nagori, Kaunch Beej, Musli Safed, Satawar and other traditional herbs.

I consider Spermogenic primarily within a **male reproductive-health and fertility context**.

A man with ED but completely normal fertility does not automatically require the same treatment as a man with oligozoospermia.

Likewise, improving sperm production should not be confused with treating vascular ED.

The pharmacy page describes the formulation as clinically researched, but the publicly accessible page does not provide a full independent randomized controlled trial of the finished product sufficient to establish universal efficacy for all listed sexual disorders. Product positioning and guideline-level clinical evidence should therefore be distinguished.

Dr. Qasmi's Nuskha No. 156

The current Saira Health Care Pharmacy page describes **Dr. Qasmi's Nuskha No. 156** as a polyherbal **Ayurvedic** preparation rather than a classical Unani formulation.

Its page positions the product for general health, libido and fertility and lists ingredients including Zingiber officinale, Anacyclus pyrethrum, Cuminum cyminum, Piper longum, Cinnamomum species and other botanicals.

I make this distinction because accurate medicine classification matters.

Although Saira Health Care has a strong Unani focus, not every formulation offered through the pharmacy should automatically be described as classical Unani medicine when its own product page classifies it differently.

Nuskha No. 156 may be considered in an individualized traditional wellness plan, especially where low libido or reproductive-health concerns are present, but it should not be presented as an independently proven universal cure for impotence or premature ejaculation.

Why I Do Not Prescribe the Same Medicine to Every Patient

Consider three men.

The first has ED because of uncontrolled diabetes and vascular disease.

The second is physically healthy but experiences severe performance anxiety.

The third has low libido caused by genuine testosterone deficiency.

All three may say:

"Doctor, I have sexual weakness."

But their treatment should be different.

This is why I repeatedly emphasize:

A medicine name is not a diagnosis.

Natural Does Not Mean Completely Free From Side Effects

Traditional and herbal medicines contain biologically active substances.

Their safety depends on the exact ingredients, dose, duration, manufacturing quality, other medicines being used, liver and kidney health and individual sensitivity.

Even the Nuskha No. 129 product page specifically advises against self-medication and states that excessive dosing may cause adverse effects.

Therefore, I do not describe every natural medicine as “100% side-effect-free.”

The correct principle is:

right medicine + right patient + right dose + right duration + professional supervision.

The Special Saira Health Care Approach

At Saira Health Care, our public website states that the clinic focuses on sexual disorders and infertility and emphasizes treatment after appropriate investigation and diagnosis. It lists conditions including ED, PE, spermatorrhoea, oligozoospermia, azoospermia and varicocele among areas addressed at the centre.

Our approach can be summarized in a simple sequence:

Listen to the patient → identify the exact sexual problem → assess physical, hormonal and psychological factors → investigate where necessary → evaluate Mizaj and general health → correct lifestyle and associated disease → select individualized treatment → follow the patient's response.

This is much more useful than simply selling one “sex power” medicine to every man.

My Work in Sexual Disorders and Infertility

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

My official Saira Health Care profile lists **BUMS, MD, CGO and Certificate in Infertility**, and describes my clinical work in sexual-health and fertility conditions including azoospermia, oligospermia, teratospermia, asthenospermia, varicocele, hormonal problems and related reproductive disorders.

My credential information supplied for this professional profile also includes **Certificate in Urology – London, UK** and **Masters in Male Infertility by MasterHealthPro (HealthPro)**.

MasterHealthPro's publicly available course information lists a **Male Infertility Masters** programme and advanced education in semen analysis, male-infertility diagnostics, hypogonadism, azoospermia, sexual dysfunction and clinical reproductive medicine.

This additional reproductive-health training is particularly relevant because sexual problems and fertility often overlap, yet require different treatment strategies.

Why Sexual Medicine and Male Infertility Expertise Need to Work Together

A man may visit me because he cannot maintain an erection and is also trying to conceive.

Another may have perfectly satisfactory sexual intercourse but azoospermia.

A third may have premature ejaculation and normal semen.

A fourth may be taking testosterone to improve gym performance and unknowingly suppressing his sperm production.

These are very different clinical situations.

Understanding both sexual function and male reproduction allows treatment to protect not only sexual performance but also fertility goals.

Contribution of Saira Health Care in Sexual Disorders and Infertility

One of the most important contributions a sexual-health centre can make is **reducing misinformation**.

Saira Health Care's public material emphasizes proper investigation and diagnosis and states that the centre works in sexual disorders and infertility through a holistic Unani framework combined with contemporary medical information.

Many men arrive after believing myths such as:

semen loss causes permanent weakness, masturbation destroys masculinity, every erection problem requires tadalafil forever, every PE patient has penile hypersensitivity, thick semen guarantees fertility, or herbal medicine can never produce adverse effects.

Good sexual medicine begins by replacing fear with accurate knowledge.

Sex Counselling Is Part of Treatment

Medicine cannot solve every sexual problem.

Sometimes the most important treatment is education.

A patient may need to learn that occasional erection variation is normal.

A man with PE may need help understanding arousal and control.

A couple may need to improve communication.

A man with severe performance anxiety may benefit from psychological therapy.

The EAU strongly recommends CBT when indicated in ED and recognizes psychosexual interventions in PE and low-desire management.

Unani treatment and counselling therefore do not need to be considered separate worlds.

A holistic physician should care for the mind as well as the body.

Can Male Sexual Problems Be Permanently Cured?

There is no single answer.

Some conditions are highly reversible.

A young man with performance anxiety may recover very well.

A patient whose ED is associated with smoking, obesity and poor metabolic health may improve significantly after correcting risk factors.

A medication-related sexual problem may improve when treatment is appropriately modified.

Genuine hormone deficiency can often be managed effectively.

Premature ejaculation can frequently be controlled substantially.

Other conditions may require longer-term management.

Severe diabetic neuropathy, major vascular disease, spinal injury or advanced structural disease may not be completely reversible.

The goal should therefore be **healthy, satisfactory and sustainable sexual function**, not unrealistic promises.

Frequently Asked Questions

Is erectile dysfunction the same as impotence?

“Impotence” is an older and often stigmatizing term. Erectile dysfunction is more precise and refers specifically to persistent difficulty achieving or maintaining an erection adequate for satisfactory sexual activity.

Does every man with ED have low testosterone?

No. Vascular disease, diabetes, medications, neurological problems and psychological factors are very common causes.

Can premature ejaculation and ED occur together?

Yes. A man worried about losing his erection may rush intercourse and develop or worsen acquired PE.

Does low libido mean low testosterone?

Not necessarily. Depression, relationship issues, stress, medications, prolactin and thyroid disorders may also reduce desire.

Is tadalafil the only treatment for ED?

No. PDE5 inhibitors are first-line treatments for many men, but other options include lifestyle treatment, psychosexual therapy, vacuum devices, alprostadil, injections and penile prosthesis in selected cases.

Can testosterone improve sperm count?

External testosterone can actually suppress sperm production and should not be used as fertility treatment in men wishing to father children.

Can Unani medicine help male sexual problems?

Yes, particularly through individualized attention to Mizaj, diet, lifestyle, psychological well-being, general physical condition and physician-selected traditional medicines. However, serious vascular, endocrine, neurological or structural conditions should still receive appropriate modern investigation and treatment.

Are herbal medicines completely safe?

No treatment is automatically risk-free. Herbal and traditional medicines should be selected and dosed professionally.

When Should a Man Seek Professional Medical Advice?

I recommend consultation when erection problems are persistent, sexual desire has changed significantly, ejaculation consistently occurs earlier or much later than desired, orgasm becomes difficult, sexual activity is painful, a penile deformity develops, sexual problems occur together with infertility, or the difficulty is causing significant personal or relationship distress.

A sudden severe penile injury, sudden severe testicular pain or an erection lasting around four hours or longer requires urgent medical evaluation.

Sexual problems are common, but emergency symptoms should never be treated through routine self-medication.

My Message to Patients

If you are experiencing a sexual problem, do not immediately conclude that you have lost your masculinity.

Do not compare yourself with pornography.

Do not start random hormones.

Do not continuously increase tadalafil or sildenafil without understanding why treatment is needed.

Do not assume that every herbal product is completely harmless.

And do not allow embarrassment to stop you from seeking help.

Instead, ask the correct question:

What exactly is my sexual problem, and what is causing it?

Once that question is answered, treatment becomes more logical.

Conclusion

Male sexual problems are common, but they are not one disease.

Erectile dysfunction, premature ejaculation, low sexual desire, delayed ejaculation, anejaculation, orgasmic problems, painful ejaculation, psychological sexual dysfunction and structural penile disorders are different clinical conditions.

The latest EAU guidance defines ED as persistent difficulty achieving or maintaining an erection sufficient for satisfactory sexual performance and recognizes vascular, metabolic, hormonal, neurological, medication-related and psychological causes. Lifestyle and risk-factor modification are strongly recommended, while PDE5 inhibitors remain first-line pharmacological treatment for many men.

Premature ejaculation also requires accurate classification. Lifelong PE may involve complex neurobiological mechanisms, whereas acquired PE can occur with ED, prostatitis, anxiety, hyperthyroidism and sleep problems. Dapoxetine where available, topical anaesthetics and selected serotonergic medicines have evidence, and psychosexual approaches can provide additional benefit.

Low libido should not automatically be blamed on testosterone. Modern guidance recognizes biological, psychological and relationship components and recommends endocrine investigation where appropriate. Testosterone should be given only when genuine deficiency exists, and men planning children require particular caution because exogenous testosterone suppresses spermatogenesis.

The **Unani system of medicine** provides a valuable whole-person framework through Mizaj assessment, dietary management, regimental therapy, psychological consideration and individualized pharmacotherapy. CCRUM formally recognizes Ilaj-bil-Tadbir, Ilaj-bil-Ghiza, Ilaj-bil-Dawa and Ilaj-bil-Yad as major treatment modes.

At **Saira Health Care**, I use this individualized philosophy while emphasizing proper investigation and cause-based treatment.

Dr. Qasmi's Nuskha No. 129, Spermogenic Powder and Nuskha No. 156 may form part of selected traditional or reproductive-health programmes according to the patient's actual condition. However, they should not be described as universal cures for every male sexual disorder. Nuskha No. 129 is currently positioned primarily for male debility and semen-quality support; Spermogenic for male reproductive and fertility concerns; and the current Nuskha No. 156 product page classifies it as a polyherbal Ayurvedic preparation for libido, fertility and general wellness.

As **Dr. Nizamuddin Qasmi**, my work at Saira Health Care is particularly focused on sexual disorders and infertility. My public professional profile lists **BUMS, MD, CGO and Certificate in Infertility** and describes my work across sexual and reproductive-health disorders. My credential information supplied for publication additionally includes **Certificate in Urology – London, UK** and **Masters in Male Infertility by MasterHealthPro (HealthPro)**; MasterHealthPro publicly lists its Male Infertility Masters programme and extensive male-infertility and sexual-medicine curriculum.

The most important principle I want every patient to remember is:

Do not treat “sexual weakness” as one disease. Identify whether the problem involves desire, erection, ejaculation, orgasm, hormones, psychological health, reproductive function or a combination of these. Once the cause is understood, modern sexual medicine and appropriately practiced Unani medicine can be integrated to provide a safer, more rational and more individualized treatment plan.

About Saira Health Care

Saira Health Care is a registered Unani clinic with a clinical and educational focus on **sexual disorders and infertility**. Its public website describes individualized care, proper investigation and diagnosis, and the use of Unani principles alongside contemporary medical understanding.

Visit Saira Health Care

Visit Saira Health Care Pharmacy

Medical Disclaimer

This article is intended for **general medical education and sexual-health awareness**. It should not replace an individual consultation, physical examination, laboratory testing or diagnosis by an appropriately qualified healthcare professional.

Male sexual problems can result from cardiovascular, metabolic, hormonal, neurological, psychological, medication-related and structural causes. Treatment should therefore be individualized.

Do not start or stop prescription ED medicines, testosterone, antidepressants, fertility hormones or other medicines without professional advice. PDE5 inhibitors such as sildenafil or tadalafil must not be combined with nitrate medicines because the combination can cause dangerous hypotension.

Traditional, Unani, Ayurvedic and herbal formulations contain biologically active ingredients and cannot responsibly be described as universally free from adverse effects or interactions.

No conventional medicine, herbal formulation, Unani Nuskha, supplement, oil or treatment programme can guarantee permanent cure, a particular erection duration, ejaculation time, fertility or identical results for every patient.