Sexual Problems in Heart Patients: Understanding Erectile Dysfunction, Low Libido, Safety of Sexual Activity and Treatment Through Modern Medicine and the Unani System

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility
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

Introduction: "Doctor, I Have Heart Disease—Is Sexual Activity Safe for Me?"

This is one of the most important questions heart patients ask me during a sexual-health consultation.

Some patients say:

"Doctor, after my heart attack I became afraid of having sex."

Others tell me:

"My heart condition is controlled, but my erection has become weak."

Another common question is:

"Can I take sildenafil or tadalafil if I am already taking heart medicines?"

These are very reasonable concerns.

Heart disease and sexual health are closely connected. The penis, brain, nerves, hormones and cardiovascular system all work together during sexual activity. Conditions that damage the heart and blood vessels—such as coronary artery disease, high blood pressure, diabetes, obesity and high cholesterol—can therefore also affect erections and sexual function.

At the same time, the emotional experience of having a heart attack, undergoing angioplasty, bypass surgery or being diagnosed with heart failure can create **fear, anxiety, depression and loss of sexual confidence**. Sometimes the patient's heart is medically stable, but the fear that sexual activity could trigger another heart attack prevents a normal sexual response.

The good news is that **many people with stable cardiovascular disease can safely continue or resume sexual activity**. The American Heart Association states that sexual activity is generally safe when cardiovascular disease has been stabilized and notes that cardiovascular events during sexual activity are uncommon because the activity is usually brief. Patients

with unstable angina or severe uncontrolled symptoms, however, should first be evaluated and stabilized.

Current sexual-medicine guidance also gives us a much clearer framework for deciding **who can safely have sex, who needs further cardiac testing and who should temporarily avoid sexual activity**.

The **European Association of Urology's 2026 Sexual and Reproductive Health Guidelines** incorporate the cardiovascular-risk framework of the Princeton IV Consensus into erectile-dysfunction management.

From the **Unani system of medicine**, sexual health is approached in a broader way. I consider the patient's **Mizaj, general physical strength, diet, sleep, psychological state, lifestyle, metabolic health and associated diseases**, rather than treating the erection as an isolated mechanical problem.

My approach at Saira Health Care is therefore simple:

First make sure the heart is safe. Then determine the exact sexual problem. Finally, select an individualized treatment plan that may combine cardiology care, evidence-based sexual medicine, lifestyle improvement, psychological support and appropriately supervised Unani treatment.

Why Are the Heart and Sexual Function So Closely Connected?

A normal erection is largely a **vascular event**.

When a man becomes sexually aroused, nerve signals cause release of nitric oxide within penile tissue. This relaxes the smooth muscle of the penile arteries and erectile chambers, allowing blood to enter rapidly.

The blood then becomes temporarily trapped within the penis, producing a firm erection.

For this mechanism to function normally, a man needs:

healthy arteries, healthy endothelium, functioning nerves, adequate hormones and normal psychological arousal.

Heart disease can interfere with several of these mechanisms.

Atherosclerosis can narrow blood vessels.

Diabetes can damage both blood vessels and nerves.

Hypertension can damage the vascular lining.

Smoking accelerates vascular disease.

Obesity and metabolic syndrome can worsen circulation and hormonal health.

Certain medicines may influence sexual response.

Fear and depression after heart disease can interfere with arousal.

For this reason, erectile dysfunction in a heart patient is often **multifactorial rather than caused by one single problem**.

Erectile Dysfunction Can Sometimes Be a Cardiovascular Warning Sign

One of the most important developments in modern sexual medicine is the recognition that erectile dysfunction can sometimes appear **before obvious cardiovascular disease**.

The Princeton IV Consensus notes that ED and cardiovascular disease share common risk factors and that ED can precede clinically evident cardiovascular disease by approximately **two to five years in some men**.

This makes persistent ED more than a quality-of-life issue.

In selected men, it can be an opportunity to look for:

diabetes, hypertension, abnormal cholesterol, obesity, smoking-related vascular disease and underlying coronary artery disease.

I therefore tell my patients:

“If your erection has changed, particularly without an obvious psychological reason, we should sometimes think about your blood vessels as well as your sexual performance.”

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

It means that ED deserves a proper medical history and cardiovascular-risk assessment rather than indefinite self-medication.

Common Sexual Problems in Heart Patients

Heart patients may experience several different sexual difficulties.

Sexual problem	Common presentation
Erectile dysfunction	Difficulty obtaining or maintaining a firm erection
Reduced libido	Decreased interest in sexual activity
Performance anxiety	Fear of heart symptoms or sexual failure interferes with arousal

Sexual problem	Common presentation
Ejaculatory difficulty	Delayed or altered ejaculation due to disease, medication or anxiety
Reduced orgasmic satisfaction	Orgasm feels weaker or becomes more difficult
Female arousal difficulties	Reduced desire, lubrication or genital arousal
Painful intercourse	Particularly in postmenopausal women with vaginal dryness
Relationship avoidance	Patient or partner becomes afraid that sex may trigger a cardiac event

These conditions require different treatment.

Simply calling all of them “sexual weakness” can lead to inappropriate therapy.

Erectile Dysfunction in Heart Patients

Erectile dysfunction is probably the most recognized sexual problem associated with cardiovascular disease.

A patient may say:

“My desire is normal, but the erection is not hard enough.”

Another says:

“The erection comes, but it disappears during intercourse.”

Another may be able to achieve an erection during sleep or masturbation but lose it during intercourse because of anxiety.

The cause can therefore be primarily:

vascular, neurological, hormonal, medication-related, psychological—or a mixture.

Current EAU guidance recommends that ED assessment include a medical and sexual history, focused examination and appropriate metabolic and hormonal investigations. It also incorporates cardiovascular assessment because ED and cardiovascular disease are closely linked.

Coronary Artery Disease and Sexual Function

Coronary artery disease develops when plaque builds up in the arteries supplying the heart.

The same underlying process—atherosclerosis and endothelial dysfunction—may also affect penile arteries.

This helps explain why ED is common among men with coronary artery disease.

Sexual-health treatment in such patients should therefore not focus solely on obtaining a temporary erection.

Long-term treatment also involves:

control of cholesterol, blood pressure and diabetes; smoking cessation; physical activity; healthy body weight and appropriate cardiovascular medication.

Improving general vascular health benefits both the heart and the sexual system.

High Blood Pressure and Erectile Dysfunction

Hypertension can gradually damage arteries and contribute to ED.

Some men also worry that their blood-pressure medicines are responsible.

Certain antihypertensive medicines—particularly some older beta-blockers and thiazide-type diuretics—may contribute to sexual dysfunction in some individuals, although the effect varies substantially between patients and medicines. Current international sexual-medicine recommendations emphasize that hypertension itself must remain properly controlled.

A very important rule is:

Never stop a heart or blood-pressure medicine on your own because you think it has affected your sexual function.

The American Heart Association specifically advises patients not to skip cardiovascular medicines because of concerns about sex drive or sexual performance.

If a medicine appears to be contributing, the cardiologist or treating physician can determine whether an alternative is medically appropriate.

Diabetes, Heart Disease and Sexual Dysfunction

Diabetes deserves particular attention because it is simultaneously an important cardiovascular risk factor and an important cause of erectile dysfunction.

Longstanding high blood glucose can damage:

- small and large blood vessels;
- autonomic nerves;

- sensory nerves;
- endothelial function.

A diabetic heart patient may therefore have both vascular and neurological ED.

If diabetes remains poorly controlled, repeatedly changing erection medicines without managing glucose does not address the complete problem.

For these patients I prefer to think of ED as part of the **whole metabolic and cardiovascular picture**.

Heart Failure and Sexual Problems

People with heart failure often reduce sexual activity for several reasons.

Fatigue, breathlessness, reduced exercise tolerance, anxiety, depression and fear of worsening the heart condition can all interfere.

The American Heart Association's current heart-failure guidance states that people with **mild, stable heart failure can usually have sexual activity**, whereas people with more severe symptoms should avoid sexual activity until the condition has been appropriately stabilized.

The Princeton IV framework similarly considers appropriately treated patients with **NYHA class I or II heart failure** who can achieve adequate exercise capacity without ischemia as generally lower risk, while NYHA class III requires further evaluation and class IV represents a high-risk situation.

This is why “heart failure” by itself is not enough information.

Severity and stability matter.

Arrhythmias and Sexual Activity

Many patients with abnormal heart rhythms are frightened that sexual activity could cause a dangerous event.

Again, risk depends on the type and control of the rhythm problem.

The Princeton IV framework identifies conditions such as **exercise-induced ventricular tachycardia, poorly controlled atrial fibrillation and an implanted defibrillator producing frequent shocks** among high-risk situations requiring cardiovascular assessment before sexual activity.

A stable, appropriately treated arrhythmia is a different situation.

Patients should follow individualized advice from their cardiologist rather than assuming that all arrhythmias prohibit sex.

Psychological Effects After a Heart Attack

After a heart attack, patients sometimes become frightened of normal physical activities.

Sex can be especially frightening because heart rate and blood pressure naturally increase during arousal and orgasm.

A man may think:

“What if sex causes another heart attack?”

His partner may also be afraid.

The couple gradually stops physical intimacy.

Even when the cardiologist says that the patient's condition is stable, fear can remain.

This anxiety itself may create erectile dysfunction.

A man who constantly checks his pulse, breathing and erection during intercourse is unlikely to remain relaxed enough for normal arousal.

This is why psychological counselling and cardiac rehabilitation can sometimes restore sexual confidence as effectively as changing medication.

How Much Work Does the Heart Do During Sexual Activity?

This question helps patients understand the actual risk.

The Princeton IV Consensus estimates that ordinary sexual activity with a usual partner is generally equivalent to approximately **2–3 metabolic equivalents (METs)**—roughly comparable to walking a mile on flat ground in about 20 minutes or briskly climbing two flights of stairs.

More vigorous sexual activity may require approximately **5–6 METs**.

This gives us a practical concept.

If a patient can comfortably perform moderate physical activity without chest pain, marked breathlessness, dizziness or rhythm symptoms, sexual activity is often well tolerated.

However, this is **not a do-it-yourself cardiac clearance test** for a high-risk patient.

When risk is uncertain, formal exercise testing may be appropriate.

Is Sexual Activity Safe for People With Heart Disease?

For many patients, **yes—once the cardiovascular condition is stable**.

The American Heart Association states that cardiovascular events during sexual activity are uncommon and that sex is probably safe when heart disease has stabilized.

The Princeton IV/EAU framework divides patients into three broad categories.

Low-Risk Patients

These patients can generally perform modest exercise without symptoms.

Examples include appropriately treated patients who have undergone successful revascularization, people with controlled asymptomatic hypertension, mild valvular disease and selected patients with mild heart failure who demonstrate adequate exercise tolerance without ischemia.

Most can resume sexual activity and receive ED treatment without additional testing.

Intermediate or Indeterminate Risk

This category may include people with mild-to-moderate stable angina, some patients two to eight weeks after an untreated myocardial infarction, NYHA class III heart failure or significant vascular disease elsewhere.

Further assessment—often exercise stress testing—is recommended before sexual activity is resumed.

High-Risk Patients

Sexual activity should be postponed until the cardiovascular condition has been treated and stabilized.

Examples include:

unstable or refractory angina, uncontrolled hypertension, NYHA class IV heart failure, a very recent untreated myocardial infarction, certain dangerous arrhythmias and poorly controlled atrial fibrillation.

This classification is one of the most useful modern tools because it replaces fear with structured clinical assessment.

When Can Sexual Activity Resume After a Heart Attack?

There is no single date that applies to every patient.

The American Heart Association's scientific guidance has stated that sexual activity can be reasonable **one or more weeks after an uncomplicated myocardial infarction** if the patient is free from cardiac symptoms during mild-to-moderate physical activity.

More recent AHA patient guidance states that people without chest pain, shortness of breath or rhythm problems can often resume sexual activity after approximately **one to two weeks**, but the exact timing should be discussed with the treating healthcare professional.

A complicated heart attack, continuing angina, heart failure or rhythm instability requires a different timeline.

After Angioplasty or Stent Placement

The AHA scientific statement notes that sexual activity may often be resumed **several days after uncomplicated percutaneous coronary intervention**, provided the vascular access site has healed without complications.

Again, the interventional cardiologist's advice should take priority because the indication for the procedure and the patient's recovery differ.

After Bypass or Other Open-Heart Surgery

After CABG or other surgery involving a sternotomy, the issue is not only cardiovascular workload.

The breastbone also needs time to heal.

AHA guidance commonly allows sexual activity around **six to eight weeks after standard open-heart surgery**, provided healing is satisfactory and the patient is otherwise stable.

Position and pressure on the healing chest may also need adjustment initially.

When Should Sexual Activity Be Stopped?

During sexual activity, stop and seek medical advice if symptoms such as:

significant chest pain, severe breathlessness, faintness, unusual palpitations or severe weakness develop.

If symptoms suggest a possible heart attack or another acute cardiovascular event, emergency medical services should be contacted.

A patient should not try to “push through” significant cardiac symptoms simply because intercourse has already started.

Modern Treatment of Erectile Dysfunction in Stable Heart Patients

For a medically stable, appropriately assessed cardiovascular patient, erectile dysfunction can often be treated effectively.

Current EAU guidance states that **PDE5 inhibitors are established first-line ED therapy**, and available randomized and observational data have not shown increased myocardial-infarction rates from these medicines in appropriately selected patients. They do not appear to worsen exercise-induced ischemia in men with stable angina.

Common examples include:

sildenafil and **tadalafil**.

However, their safety depends very strongly on the other medications the patient takes.

The Most Important Rule: PDE5 Inhibitors and Nitrates Must Not Be Combined

This is perhaps the single most important safety message in this entire article.

Sildenafil, tadalafil and other PDE5 inhibitors enhance cyclic GMP.

Nitrate medicines also increase cyclic GMP.

Using both together can cause **a severe and unpredictable fall in blood pressure**.

Current EAU guidance describes the combination of PDE5 inhibitors with **organic nitrates or nitric-oxide donors as an absolute contraindication**. It also contraindicates their combination with nicorandil because of its nitric-oxide-donating properties.

Nitrate medicines can include:

nitroglycerin/glyceryl trinitrate and isosorbide preparations used for angina.

Patients must also disclose recreational “poppers,” because these contain nitrate compounds.

What If Chest Pain Occurs After Taking Sildenafil or Tadalafil?

Do **not** take your usual nitrate for chest pain after recently using a PDE5 inhibitor without emergency medical advice.

Instead, stop sexual activity, seek urgent medical assistance when appropriate and tell the emergency team **exactly which ED medicine you took and when**.

Princeton IV notes that nitrate administration should generally be avoided for at least **24 hours after sildenafil**, with longer separation required for longer-acting PDE5 inhibitors.

The American Heart Association similarly advises that nitrate therapy should not be administered within roughly **24–48 hours after ED medicines**, depending on the specific drug used.

For tadalafil, because of its longer half-life, the standard interval is generally at least **48 hours** before nitrate administration, unless emergency specialists determine otherwise.

This interaction can be life-threatening and should never be treated casually.

Riociguat Is Another Important Contraindication

Some patients with pulmonary hypertension or chronic thromboembolic pulmonary hypertension use **riociguat**.

Princeton IV states that combining riociguat or other soluble-guanylate-cyclase stimulators with PDE5 inhibitors is contraindicated because of excessive hypotension risk.

Therefore, a patient should always provide the complete medication list—not simply say:

“I take heart tablets.”

What About Ordinary Blood-Pressure Medicines?

Many patients have been told incorrectly:

“If you take a blood-pressure medicine, you cannot use sildenafil.”

That is not universally true.

Princeton IV reports that PDE5 inhibitors taken with most common antihypertensive medicines—including ACE inhibitors, ARBs, calcium-channel blockers, diuretics and beta-blockers—usually produce only **small additional reductions in blood pressure without a major increase in adverse events**.

The important exceptions and cautions include nitrates, nicorandil, riociguat and careful use with certain alpha-blockers or other vasodilating regimens.

This is why the medicine list should be reviewed professionally instead of assuming that every heart patient is either completely safe or completely unsafe.

What If the Patient Needs Nitrates?

If nitrate therapy remains medically necessary, PDE5 inhibitors generally cannot be used.

But this does **not** mean ED is untreatable.

Alternative treatments may include:

vacuum erection devices, professionally prescribed intraurethral or intracavernosal therapies such as alprostadil and, in severe refractory cases, penile prosthesis surgery.

The correct choice depends on erectile function, cardiovascular status, manual ability, preference and other medical conditions.

Cardiac Rehabilitation Can Help Sexual Confidence

Cardiac rehabilitation is not only about returning to walking or work.

It can also help patients regain confidence in their body's ability to tolerate physical activity.

The AHA notes that cardiac rehabilitation and regular exercise after heart failure or myocardial infarction can reduce the risk of complications associated with sexual activity.

For some patients, being able to exercise under supervision gives reassurance that normal physical intimacy is also possible.

Lifestyle Treatment Is Part of Sexual Treatment

I often tell patients:

“A treatment that helps your arteries can also help your erections.”

Important measures include:

healthy body weight, regular physical activity according to cardiac advice, diabetes control, blood-pressure control, appropriate cholesterol treatment, adequate sleep and smoking cessation.

The same cardiovascular risk factors that damage coronary arteries also damage penile arteries.

Therefore, sexual-health treatment becomes much stronger when it is integrated into heart-health treatment.

Should Heart Medicines Be Stopped Because of ED?

No—not without medical supervision.

The purpose of cardiovascular medication is to reduce symptoms, prevent heart attack, prevent stroke, improve heart-failure outcomes or prolong life.

The AHA specifically advises against skipping essential heart medicines simply because a patient is concerned about sexual function.

If a medication is contributing to ED, a clinician may sometimes change the type, dose or timing.

But cardiac safety has priority.

Low Libido in Heart Patients

Not every heart patient with a sexual complaint has ED.

Some have normal erection capacity but reduced sexual desire.

Possible reasons include:

depression, anxiety, fatigue, chronic illness, sleep disturbance, medication effects, testosterone deficiency and fear of cardiovascular symptoms.

A patient who has recently experienced a heart attack may become so frightened of sexual activity that desire itself decreases.

Therefore, treatment should distinguish **lack of desire** from **difficulty producing an erection**.

Giving sildenafil to a patient whose main problem is severe depression or low libido may not solve the underlying problem.

Testosterone in Heart Patients

Testosterone should never be prescribed merely because a man with cardiovascular disease reports fatigue or sexual weakness.

True male hypogonadism requires compatible symptoms plus appropriately confirmed low testosterone.

If hormone therapy is considered in a patient with cardiovascular disease, the potential benefits, risks and contraindications should be reviewed carefully.

Fertility is also important.

External testosterone suppresses sperm production and should not be used as a male-infertility treatment in a man wishing to father children.

This is one reason my work in both **sexual disorders and male infertility** is relevant to these patients: treatment that improves one sexual symptom should not unintentionally damage fertility goals.

Female Sexual Problems in Heart Patients

Women with cardiovascular disease can also experience sexual dysfunction, although this subject has historically received much less attention.

Problems may include:

reduced sexual desire, difficulty becoming aroused, fear of cardiovascular symptoms, reduced lubrication, orgasmic difficulties and painful intercourse.

Heart disease may coexist with menopause, diabetes, depression or medication effects.

Partners may also become overprotective and avoid intimacy because they believe sex is dangerous.

The American Heart Association emphasizes that sexual health is relevant to both men and women with cardiovascular disease and specifically notes that postmenopausal women with heart disease may benefit from **topical or vaginal estrogen for painful intercourse when clinically appropriate**.

Systemic hormone therapy, however, requires a completely separate individualized cardiovascular and gynecological risk assessment.

Anxiety, Depression and Relationship Stress

Sexual dysfunction after cardiovascular disease is often partly psychological.

A patient may develop:

fear of death during intercourse, reduced confidence, depression after a heart attack, embarrassment about sexual performance or loss of body confidence after surgery.

The partner may be equally frightened.

Some couples therefore stop sexual activity even though the cardiologist has cleared the patient.

AHA cardiovascular guidance recognizes the value of assessing anxiety and depression and counselling both the patient and partner when returning to sexual activity after cardiac events.

I consider this an essential part of treatment.

The body and mind cannot be separated in sexual medicine.

The Unani Understanding of Sexual Problems in Heart Patients

The Unani system of medicine developed from the Greco-Arabic medical tradition and was further enriched by generations of Arab, Persian and South Asian physicians.

Its traditional framework considers health through concepts including:

Mizaj (temperament), Akhlat (humours), Quwwat (functional strength), organ health, diet, lifestyle and psychological well-being.

These classical concepts should be respected historically, but they should not be described as scientifically identical to modern concepts such as atherosclerosis, endothelial dysfunction, nitric-oxide signalling or coronary ischemia.

Today we have the benefit of both perspectives.

Modern cardiology can tell us whether the patient has stable angina, ischemia, heart failure, vascular disease or medication interactions.

Unani medicine can contribute a **whole-person, individualized approach** involving diet, lifestyle, general vitality, emotional health and carefully selected traditional pharmacotherapy.

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

CCRUM's **Standard Unani Treatment Guidelines** describe *Zu‘f-i-Bah* as a traditional condition involving reduced sexual desire and reduced ability to perform sexual activity.

Its traditional contributing factors include **Istirkha-i-Qazib**, or penile flaccidity; **Zu‘f-i-A‘za Ra'isa**, weakness of major or vital organs; and **Umur Wahmiyya**, psychological factors.

This is particularly interesting in the context of heart patients.

Traditional Unani medicine recognized that sexual function could be influenced not only by the genital organs but also by **general physical condition and psychological health**.

Modern sexual medicine reaches a similar clinical conclusion through different physiology: erection depends on cardiovascular function, nerves, hormones and the brain.

The two explanatory systems are different, but both support the principle that sexual dysfunction should not be treated as an isolated penile complaint.

Classical Principles of Treatment for Sexual Debility

CCRUM describes several traditional principles for Zu'f-i-Bah, including:

Taqwiyat-i-Qazib—traditional support of penile function;

Taqwiyat-i-A'za Ra'isa—supporting major functional organs;

and **Izala-i-Awariz Nafsani**—addressing psychological contributors.

For modern clinical practice, I interpret this carefully.

A heart patient should not be told that a traditional tonic can "strengthen the heart" enough to replace a stent, beta-blocker, statin or other evidence-based cardiac treatment.

Rather, the Unani principles can help structure **supportive individualized care around the patient's general health and psychological state**, while cardiology manages the cardiovascular disease itself.

The Four Major Modes of Unani Treatment

CCRUM recognizes four broad therapeutic approaches in Unani medicine:

Ilaj-bil-Tadbir — Regimental therapy
Ilaj-bil-Ghiza — Dietotherapy
Ilaj-bil-Dawa — Pharmacotherapy
Ilaj-bil-Yad — Surgery.

This is particularly relevant in cardiovascular sexual health because a genuine holistic approach should not depend only on one herbal product.

Some patients primarily need diet and physical rehabilitation.

Some need stress management.

Some require medication.

Some require modern cardiac intervention.

Some men with severe refractory ED may eventually require a surgical penile prosthesis.

A comprehensive healthcare system should recognize all of these possibilities.

Ilaj-bil-Ghiza: Dietotherapy

In a heart patient, diet should support cardiovascular health first.

The appropriate diet generally aims to support:

healthy blood pressure, body weight, glucose control and lipid management.

From the Unani perspective, the patient's Mizaj, digestive condition and overall strength can also be considered.

However, I do **not** recommend indiscriminate consumption of large quantities of honey, sweets, rich milk preparations or calorie-dense “sexual tonics” to every heart patient.

A patient with obesity, diabetes or high triglycerides may actually worsen his vascular health through such a strategy.

The best sexual-health diet is one that supports the health of the **whole cardiovascular system**.

Ilaj-bil-Tadbir: Regimental and Lifestyle Management

CCRUM describes regimental therapy as including lifestyle modification and physical exercise along with other traditional modalities.

For a cardiovascular sexual-health patient, the most defensible and useful components are:

safe physical activity according to cardiac capacity, sleep improvement, stress reduction, weight management and smoking cessation.

These measures complement contemporary cardiac rehabilitation.

CCRUM has also integrated Unani diet, regimen and lifestyle care within elements of India's national programme addressing **diabetes and cardiovascular diseases**, demonstrating an institutional role for Unani lifestyle care in noncommunicable-disease management.

This does not prove that Unani treatment by itself cures coronary artery disease or cardiovascular ED.

It does show that **diet and lifestyle are legitimate central components of contemporary Unani practice**.

Stress Management in the Unani Approach

Psychological stress can be particularly harmful after a cardiac event.

A patient may be physically stable yet remain afraid to resume intimacy.

Traditional Unani medicine's attention to psychological factors can therefore be highly relevant.

In modern terms, appropriate treatment can include:

reassurance, counselling, cognitive-behavioural approaches, relaxation techniques and couple communication.

This is one of the strongest areas for integration because neither cardiology nor sexual medicine can achieve optimal results if severe fear remains untreated.

Ilaj-bil-Dawa: Unani Pharmacotherapy

Unani medicines may be considered as **physician-selected supportive treatment** after the patient's cardiovascular status and medication list have been carefully reviewed.

This qualification is particularly important in heart patients.

A sexual-health medicine that lowers blood pressure, affects heart rhythm, influences blood clotting or interacts with cardiovascular drugs could potentially cause harm.

Therefore, before I consider any traditional formulation in a heart patient, I believe we must know:

what cardiac disease the patient has, whether the condition is stable, whether nitrates are being used, whether the patient is taking anticoagulants or antiplatelet medicines, whether digoxin or antiarrhythmic medication is present, and whether kidney or liver disease affects medicine handling.

This is how traditional treatment becomes safer and more professional.

Herbal Does Not Mean Automatically Safe for Heart Patients

This point deserves special emphasis.

Some patients believe:

“A herbal sexual medicine cannot interact with my heart tablets.”

That is incorrect.

The U.S. National Center for Complementary and Integrative Health warns that herbal supplements can either increase or decrease the effects of prescription medicines. Particular care is needed with drugs such as **warfarin and digoxin**, where relatively small changes in blood levels can create significant problems.

The American Heart Association likewise advises cardiovascular patients to tell clinicians about all herbal products and supplements because interactions can occur with blood thinners, blood-pressure medicines, statins and other cardiovascular drugs.

For this reason:

I do not consider the word “natural” to be a substitute for a medication-safety review.

What About Massage, Cupping and Other Regimens?

Massage and other traditional regimens may provide relaxation in appropriately selected patients.

However, I would not describe massage, cupping or hydrotherapy as proven treatments for coronary artery disease-related erectile dysfunction.

A patient taking blood thinners or antiplatelet medicines also requires particular caution with invasive procedures that can produce bleeding.

These therapies, if used at all, should remain **supportive**, not substitutes for cardiology assessment, cardiac rehabilitation or established ED treatment.

Unani Medicine and Modern Cardiology Should Complement One Another

I do not believe patients should be asked to choose between:

"heart medicine" and **"Unani treatment."**

That is the wrong question.

The more appropriate question is:

"What does this patient actually need?"

A man with unstable angina needs cardiovascular stabilization.

A patient with nitrate-dependent angina should not receive sildenafil.

A stable post-stent patient with ED may be eligible for ED treatment.

A man whose sexual dysfunction is primarily fear-related may need counselling.

A patient with diabetes and obesity needs metabolic improvement.

An appropriate Unani programme may then add individualized dietary, lifestyle and supportive traditional care.

Integration is useful only when it **increases safety and personalization**, not when it replaces necessary treatment.

My Special Approach at Saira Health Care

When a heart patient comes to me with a sexual-health concern, I prefer to follow a clear sequence.

Step 1: Identify the Exact Sexual Problem

Is the main complaint:

weak erection, loss of desire, early ejaculation, difficulty reaching orgasm, fear of sexual activity—or a combination?

We cannot treat the condition correctly without defining it.

Step 2: Understand the Heart Disease

I ask whether the patient has:

coronary artery disease, previous heart attack, angioplasty or stent, bypass surgery, heart failure, valvular disease, hypertension or arrhythmia.

The severity and stability of the cardiovascular condition determine whether sexual activity itself is safe.

Step 3: Review Every Medication

This is essential.

I pay particular attention to:

nitrates, nicorandil, riociguat, blood-pressure medicines, alpha-blockers, anticoagulants, antiplatelet medicines and other cardiovascular treatment.

This step may completely change which sexual-health treatments are safe.

Step 4: Assess Exercise Capacity and Cardiovascular Risk

If the cardiac status is uncertain, cardiology clearance or stress testing may be needed.

Princeton IV recommends exercise-capacity assessment and classifies patients as low, intermediate or high risk for sexual activity.

Step 5: Look for Other Causes of Sexual Dysfunction

Diabetes, obesity, testosterone deficiency, smoking, depression, sleep problems and medication effects may contribute.

Step 6: Assess the Patient From the Unani Perspective

Mizaj, diet, general physical condition, sleep, stress and lifestyle are considered.

Step 7: Select an Individualized Treatment Plan

Depending on the patient, treatment may involve:

cardiac rehabilitation and lifestyle improvement, counselling, guideline-supported ED medication when safe, treatment of genuine hormonal abnormalities, vacuum or injectable ED therapy, and physician-supervised Unani supportive treatment.

The important principle is that **the heart's safety is established before sexual-performance treatment is intensified**.

The Saira Health Care Approach to Erectile Dysfunction

Saira Health Care's published ED treatment pathway emphasizes identification of the underlying cause, correction of reversible factors such as smoking, obesity, physical inactivity, uncontrolled diabetes, hypertension, sleep problems and stress, followed by individualized treatment that may include counselling, guideline-supported ED medication, vacuum devices, injectable treatment, hormonal treatment where indicated, traditional Unani medicines and surgery in selected severe cases.

I believe this is particularly important in heart patients because two men with the same complaint—"weak erection"—can have completely different cardiovascular risks.

One may safely use tadalafil.

Another may be taking nitrates and must not use it.

A third may need cardiac stabilization before sexual activity itself is advisable.

The diagnosis comes before the prescription.

Sexual Problems and Male Fertility in Heart Patients

Sexual function and fertility are separate issues.

A heart patient may have erectile dysfunction but completely normal sperm production.

Another man may have normal erections but an abnormal semen analysis.

A younger cardiac patient may also wish to father children.

This matters when hormones are being considered.

External testosterone can suppress sperm production.

Therefore, reproductive goals should be discussed before testosterone treatment or certain other hormonal strategies are used.

My focused practice in both **sexual dysfunction and male infertility** helps make this distinction clinically important rather than treating sexual performance and fertility as though they were the same thing.

About Me: Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with my clinical work focused particularly on **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 **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK**, and describes my focused work in sexual disorders and infertility.

MasterHealthPro publicly lists a **six-month Male Infertility Masters programme** and related advanced training covering male infertility and sexual dysfunction.

This combination of Unani medical training, reproductive-health education and focused sexual-health practice is particularly relevant when treating heart patients because sexual symptoms may involve **vascular disease, medications, hormones, psychological health and fertility simultaneously**.

Contribution of Saira Health Care to Sexual Disorders and Infertility

At Saira Health Care, I believe one of our most important responsibilities is correcting dangerous misinformation.

Heart patients are often told:

“You can never have sex again.”

“Viagra is dangerous for every heart patient.”

“If you take blood-pressure medicine, you cannot treat ED.”

“A herbal product is automatically safer than sildenafil.”

“If your erection is weak after a heart attack, your sexual life is finished.”

None of these statements is universally correct.

Our clinic describes its philosophy as patient-centered and focused on providing a safe environment for people to discuss sexual and infertility concerns, combining traditional

Unani knowledge with individualized treatment, lifestyle guidance and contemporary medical understanding.

For cardiovascular patients, accurate education can itself prevent harm.

It helps patients understand when sex is safe, when cardiology clearance is required, when an ED medicine is appropriate and when a medicine combination could be dangerous.

Common Myths About Sexual Activity and Heart Disease

“Sex commonly causes heart attacks.”

Cardiac events during sexual activity are uncommon. AHA guidance notes that sexual activity accounts for only a very small proportion of acute myocardial infarctions.

“Every heart patient must stop sexual activity.”

No. Many patients with stable cardiovascular disease can safely resume or continue sexual activity.

“Sildenafil is dangerous for everyone with heart disease.”

No. PDE5 inhibitors have established cardiovascular safety in appropriately selected **stable** patients. The major concern is specific contraindicated drug combinations and unstable cardiovascular disease.

“Every blood-pressure medicine prevents sildenafil use.”

Incorrect. Most standard antihypertensive medicines can generally be combined with PDE5 inhibitors with only small additional reductions in blood pressure.

“Nitrates and sildenafil can be taken several hours apart.”

This can be dangerous. Organic nitrates and PDE5 inhibitors are contraindicated together, and appropriate drug-specific waiting periods are required.

“Herbal medicines cannot interact with heart medicines.”

Incorrect. Herbal supplements can interact with anticoagulants, digoxin, antihypertensive medicines, statins and other drugs.

“ED after a heart attack means permanent impotence.”

No. ED may result from vascular disease, medications, anxiety or a combination of factors, many of which can be treated or substantially improved.

Frequently Asked Questions

Can a heart patient safely have sexual intercourse?

Many patients with stable heart disease can. Patients with unstable angina, severe heart-failure symptoms, uncontrolled blood pressure, dangerous arrhythmias or certain recent cardiac events require assessment and stabilization first.

How strenuous is sexual intercourse?

Typical sexual activity is often around 2–3 METs, comparable to moderate everyday physical activity, although more vigorous sex can reach about 5–6 METs.

When can sex resume after a heart attack?

For an uncomplicated heart attack without ongoing symptoms, many patients can resume after approximately one to two weeks, but individual cardiology advice is essential.

When can sex resume after bypass surgery?

Often around six to eight weeks, once the sternum and surgical wounds are satisfactorily healed and the cardiovascular condition is stable.

Can heart patients take sildenafil or tadalafil?

Many stable, appropriately evaluated heart patients can. However, nitrates, nicorandil and riociguat are important contraindications, and the full cardiovascular medication list should be reviewed first.

Can sildenafil be taken with blood-pressure tablets?

It can often be used with many common antihypertensive medicines under professional guidance. The combination may lower blood pressure slightly, and special caution applies to certain drugs such as alpha-blockers.

What should I do if chest pain occurs after taking an ED medicine?

Stop sexual activity and seek appropriate urgent medical help. Do not self-administer nitrate medication after recent PDE5-inhibitor use without emergency medical advice, and tell the medical team exactly which ED medicine you took and when.

Can cardiac rehabilitation improve sexual health?

It may help patients regain exercise capacity and confidence, and AHA guidance supports cardiac rehabilitation and regular activity as useful when returning to sexual activity after cardiac illness.

Can Unani medicine help sexual problems in heart patients?

Unani medicine can provide useful **individualized supportive care** through dietotherapy, lifestyle and regimental management, psychological support and carefully selected

traditional pharmacotherapy. It should complement, not replace, necessary cardiology treatment.

Can I stop my cardiac medicines while taking Unani treatment?

No. Essential cardiovascular medicines should not be stopped or changed without the treating cardiologist or appropriate physician.

Are herbal sexual medicines always safer for heart patients?

No. Heart patients often use multiple medicines, and herbal or traditional products can interact with them. A complete medication review is necessary before adding a supplement or Unani formulation.

When Should a Heart Patient Seek Sexual-Health Advice?

I recommend professional evaluation when:

erection difficulty becomes persistent, libido decreases significantly, sexual symptoms begin after a new heart medicine, fear prevents all intimacy, intercourse produces unusual cardiac symptoms or the patient is uncertain whether sexual activity is safe.

Patients should also seek advice **before self-starting ED medicines** if they have known cardiovascular disease.

This is particularly important if nitrate therapy, pulmonary-hypertension medicines or multiple cardiovascular medications are being used.

Prognosis

The outlook for sexual dysfunction in heart patients is often much better than patients expect.

A man whose ED is partly caused by smoking, obesity and poorly controlled diabetes may improve considerably after cardiovascular-risk-factor management.

A medically stable man with vasculogenic ED may respond well to appropriately prescribed PDE5-inhibitor treatment.

A patient whose main difficulty is fear after a heart attack may improve substantially through cardiac rehabilitation, reassurance and counselling.

More advanced vascular disease may require vacuum devices, injections or other treatment.

Women with postmenopausal dryness or painful intercourse may also benefit from appropriate local treatment and psychological support.

The prognosis depends on the **cause and cardiovascular stability**, not simply the label "heart patient."

Conclusion

When a patient with heart disease asks me about sexual activity, I want to remove two dangerous extremes.

The first extreme is:

"I have heart disease, so I can never have sex again."

The second is:

"I can take any sexual medicine because the heart problem is already treated."

Neither approach is safe.

Current cardiovascular and sexual-medicine evidence tells us that **sexual activity is generally safe for many patients with stable heart disease**, while people with unstable angina, uncontrolled hypertension, severe heart failure, dangerous arrhythmias or certain recent cardiac events require stabilization or further cardiovascular assessment first.

The Princeton IV Consensus provides a practical framework based on exercise capacity and cardiovascular risk. Ordinary sexual activity commonly requires around 2–3 METs of physical effort, and patients who can tolerate adequate exercise without ischemia are generally at lower risk.

For erectile dysfunction, modern medicines such as sildenafil and tadalafil are well-established options in appropriately selected stable patients. Current EAU guidance has not identified an increased myocardial-infarction rate from PDE5 inhibitors in properly assessed patients and notes that they do not worsen exercise ischemia in men with stable angina.

But one safety rule must never be forgotten:

PDE5 inhibitors and organic nitrates must not be used together.

The combination can cause dangerous hypotension. Nicorandil and riociguat also require important avoidance considerations.

The **Unani system of medicine** adds an important whole-person dimension. CCRUM's traditional framework of *Zu'f-i-Bah* recognizes sexual debility, penile flaccidity, general functional weakness and psychological contributors. Unani medicine also formally includes dietotherapy, regimental therapy, pharmacotherapy and surgery as distinct modes of treatment.

For a heart patient, I believe the greatest value of this system lies in **individualized diet, lifestyle, stress management, general-health assessment and carefully supervised traditional treatment**.

However, responsible Unani care must respect cardiovascular medicine.

A traditional sexual medicine should never be used to replace essential treatment for coronary disease, heart failure, hypertension or arrhythmia. Herbal medicines should also not be assumed to be harmless simply because they are natural, as important interactions with cardiovascular medicines can occur.

At **Saira Health Care**, my treatment philosophy as **Dr. Nizamuddin Qasmi** is therefore based on an integrative principle:

First understand the heart condition and make sure sexual activity is medically safe. Then identify whether the patient's difficulty is vascular, hormonal, psychological, medication-related or mixed. Correct reversible cardiovascular and lifestyle factors, review every medicine carefully, and finally select an individualized sexual-health treatment in which evidence-based modern therapy and professionally supervised Unani care may complement each other.

My focused practice in **sexual disorders and infertility**, together with training in Unani medicine, infertility, urology, male infertility and integrated sexual and reproductive health, supports this comprehensive approach.

The most important message I want every heart patient and partner to remember is:

Heart disease does not automatically mean the end of sexual life. In many stable patients, intimacy and sexual activity can continue safely. The key is not fear and not self-medication—it is proper cardiovascular assessment, accurate diagnosis and individualized treatment.

About Saira Health Care

Saira Health Care describes its approach as patient-centered, with a focus on **sexual disorders, infertility and reproductive health**, combining individualized Unani assessment, lifestyle guidance 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 individual assessment by a cardiologist, urologist, sexual-medicine clinician or other appropriately qualified healthcare professional.

People with unstable angina, significant uncontrolled cardiovascular symptoms, severe heart failure, dangerous arrhythmias or a recent complicated cardiac event should obtain medical clearance before resuming sexual activity.

Do not discontinue prescribed cardiac medicines because of sexual side effects without professional guidance.

Sildenafil, tadalafil and other PDE5 inhibitors must not be combined with organic nitrate medicines or nitric-oxide donors. Nicorandil and soluble-guanylate-cyclase stimulators such as riociguat also require specific avoidance because of potentially dangerous hypotension.

If chest pain or other serious cardiovascular symptoms occur after use of an ED medicine, do not self-administer nitrates without appropriate emergency medical advice. Inform the medical team which ED medicine was used and when.

Unani, herbal and traditional medicines contain biologically active substances and may interact with anticoagulants, antiplatelet agents, antihypertensive medicines, digoxin, statins or other cardiovascular therapies.

No conventional medicine, Unani formulation, herbal treatment or sexual-health programme can responsibly guarantee complete restoration of sexual function or identical results in every heart patient.