Absent Ejaculation and Anorgasmia in Men: Causes, Diagnosis, Fertility Impact, Modern Treatment and the Unani Approach

Introduction

The inability to ejaculate or reach orgasm is an important but often under-discussed male sexual-health problem. A man may experience normal sexual desire and erection but remain unable to release semen, unable to experience orgasm, or both. For some patients, the problem occurs only occasionally or with a particular partner or type of sexual activity. For others, it is persistent and may significantly affect confidence, intimacy, relationships, and fertility.

Modern sexual medicine recognizes that **ejaculation and orgasm are related but separate physiological events**. A man may experience orgasm without visible ejaculation, ejaculation with reduced orgasmic pleasure, delayed ejaculation, or complete absence of both ejaculation and orgasm. These distinctions are critical because the causes and treatment can differ substantially. Current European Association of Urology guidance includes delayed ejaculation, anejaculation, retrograde ejaculation, and anorgasmia as distinct disorders within the broader spectrum of ejaculatory dysfunction.

In traditional Unani medicine, sexual disorders are approached holistically, considering the individual's **Mizaj (temperament), Akhlat (humoral balance), general physical strength, nervous function, diet, sleep, emotional state, sexual habits, and associated diseases**. This whole-person framework can be valuable in men with absent or delayed ejaculation, particularly when psychological stress, general debility, lifestyle disturbances, or other sexual complaints coexist.

However, modern investigations remain essential. A man whose ejaculation is absent because of diabetic neuropathy, spinal injury, retrograde ejaculation, a medication, hormonal disease, or previous pelvic surgery requires a very different approach from a man whose main difficulty is performance anxiety or inability to reach orgasm during partnered intercourse.

The most responsible treatment philosophy is therefore:

accurate diagnosis → identification of the underlying cause → correction of reversible factors → individualized modern and/or Unani treatment → fertility planning when required → regular follow-up.

Ejaculation and Orgasm Are Not the Same Thing

This is the first concept every patient should understand.

Ejaculation

Ejaculation is the physical process through which semen is moved into and expelled from the urethra.

It involves two coordinated stages:

Emission – semen and reproductive secretions are moved into the posterior urethra.

Expulsion – rhythmic muscular contractions propel semen outward through the penis.

This process depends on the brain, spinal cord, autonomic nerves, reproductive ducts, prostate, seminal vesicles, bladder neck, and pelvic-floor muscles working together.

Orgasm

Orgasm is the subjective sensation of sexual climax and pleasure.

Although ejaculation and orgasm usually occur together in healthy men, they can become separated.

A man can therefore experience:

Condition	Ejaculation	Orgasm
Normal sexual response	Present	Present
Delayed ejaculation	Eventually present or absent	Often delayed
Anejaculation	Absent	May be preserved
Retrograde ejaculation	Little/no semen outward	Usually present
Anorgasmia	May be present or absent	Absent
Anhedonic orgasm	May be present	Climax occurs but pleasure is markedly reduced

The AUA/SMSNA guideline specifically distinguishes anejaculation—the absence of seminal ejaculation—from anorgasmia, in which sexual climax cannot be achieved.

What Is Delayed Ejaculation?

Delayed ejaculation refers to a **persistent and bothersome difficulty reaching ejaculation despite adequate sexual stimulation and a desire to ejaculate**.

In its most severe form, ejaculation may never occur.

The EAU describes delayed ejaculation as marked delay, infrequency, or absence of ejaculation that occurs repeatedly and causes distress. It may be lifelong, acquired later in life, generalized across all forms of sexual activity, or situational.

Some men can ejaculate normally during masturbation but not during intercourse.

Others can ejaculate only after prolonged stimulation.

Some cannot ejaculate under any circumstances.

These differences provide important diagnostic information.

What Is Anejaculation?

Anejaculation means that no semen is expelled forward or backward during sexual climax.

The EAU defines true anejaculation as failure of semen emission from the seminal vesicles, prostate, and ejaculatory ducts into the urethra. It is classically associated with neurological dysfunction or medication effects, although clinical presentations can overlap with severe delayed ejaculation and orgasmic disorders.

A man with true anejaculation may:

- have a normal erection;
- experience sexual pleasure;
- feel an orgasm;
- but produce no semen.

This is particularly important in male infertility because **absence of ejaculation does not necessarily mean that the testes are not producing sperm**.

A man can produce adequate sperm within the testes but be unable to transport or ejaculate them.

What Is Anorgasmia?

Anorgasmia means an absence of the subjective orgasm experience despite appropriate sexual stimulation.

It may be:

Primary or lifelong: orgasm has never been experienced.

Secondary or acquired: orgasm was previously normal but has become difficult or impossible.

Current EAU guidance identifies causes and associations including testosterone deficiency, hypothyroidism, antidepressant medication, antipsychotic medication, opioids, psychological factors, excessive or highly specific stimulation patterns, and loss of penile sensation.

A patient with anorgasmia may or may not also have anejaculation.

What Is Retrograde Ejaculation?

Retrograde ejaculation is different from true anejaculation.

Normally, the bladder neck closes during ejaculation so semen moves outward through the penis.

In retrograde ejaculation, the bladder neck fails to close adequately and semen travels **backward into the urinary bladder**.

The patient may experience:

- normal orgasm;
- little or no visible semen;
- cloudy urine after sexual activity.

Current EAU guidance identifies neurological disease, diabetes, pelvic or prostate surgery, bladder-neck problems, and medicines such as alpha-adrenergic blockers among important causes.

This distinction matters greatly in men seeking fertility treatment because sperm may sometimes be recovered from post-ejaculatory urine for use in assisted reproduction.

How Common Are These Disorders?

Delayed ejaculation is considerably less common than premature ejaculation.

Current EAU epidemiological information estimates delayed ejaculation at approximately **3% of sexually active men**, although figures vary according to definitions and populations. Surveys have reported inability to climax in anywhere from less than 1% to several percent of younger adult men, with higher rates reported among older men.

True anejaculation is substantially rarer. Historical population estimates cited by the EAU place its prevalence at approximately 0.14%, with spinal-cord injury, diabetes mellitus, and multiple sclerosis among important causes.

Accurate prevalence is difficult to establish because many patients—and sometimes even non-specialist clinicians—use terms such as delayed ejaculation, anejaculation, and anorgasmia interchangeably.

Normal Physiology of Ejaculation

Understanding the mechanism helps explain why so many different diseases can interfere with ejaculation.

Sexual stimulation sends sensory signals from the genital region to the spinal cord and brain.

During emission, sympathetic nerve pathways stimulate contraction of the:

- epididymides;
- vas deferens;
- seminal vesicles;
- prostate.

The bladder neck closes to prevent semen from travelling backward.

During expulsion, coordinated contractions of pelvic-floor muscles propel the seminal fluid through the urethra.

The orgasmic experience is produced through complex central nervous-system processing involving sensory input, emotional state, neurotransmitters, hormonal influences, and psychological context.

Any disruption involving these systems may delay or prevent ejaculation or orgasm.

Causes of Absent or Delayed Ejaculation

There is no single cause.

Current international guidelines describe **neurological, anatomical, hormonal, infectious, medication-related, psychological, and behavioural factors**.

1. Diabetes Mellitus

Long-standing or poorly controlled diabetes can damage autonomic nerves.

These nerves are essential for normal emission and bladder-neck closure.

Diabetic neuropathy can therefore lead to:

- delayed ejaculation;

- anejaculation;
- retrograde ejaculation;
- erectile dysfunction.

A man with diabetes who suddenly develops a dry orgasm or markedly reduced ejaculate should therefore receive proper assessment rather than assuming that he has simply become “sexually weak.”

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2. Spinal-Cord Injury

Spinal-cord injury is one of the best-recognized causes of anejaculation.

The erection and ejaculation pathways involve different neurological centres, meaning that some men with spinal injury may retain erection ability while being unable to ejaculate voluntarily.

For fertility purposes, specialized techniques such as penile vibratory stimulation or electroejaculation can sometimes obtain semen.

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3. Multiple Sclerosis and Other Neurological Diseases

Diseases affecting the central or peripheral nervous system can interrupt sexual sensory and motor pathways.

Possible conditions include:

- multiple sclerosis;
- Parkinson's disease;
- autonomic neuropathy;
- spinal lesions;
- cauda equina disorders;
- peripheral neuropathies.

The exact sexual symptoms depend on which nerves and neurological pathways are affected.

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4. Pelvic, Prostate, Abdominal or Retroperitoneal Surgery

Operations involving structures close to sympathetic nerves can affect ejaculation.

Examples include:

- radical prostatectomy;
- bladder-neck surgery;
- retroperitoneal lymph-node dissection;
- colorectal surgery;
- major aortic surgery;
- certain spinal procedures.

Some procedures may produce retrograde ejaculation, while others can cause failure of emission.

Current EAU guidance emphasizes nerve-preserving surgical techniques whenever feasible because of these reproductive consequences.

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5. Medications

Medication review is one of the most important parts of assessment because several commonly used drugs can delay or inhibit ejaculation and orgasm.

Important categories include:

- SSRIs and other antidepressants;
- antipsychotics;
- some antihypertensive medicines;
- alpha-adrenergic blockers;
- opioids;
- some sedative or centrally acting medicines.

The AUA/SMSNA guideline specifically recommends considering replacement, dose adjustment, or staged discontinuation of a medication contributing to delayed ejaculation **when medically appropriate**.

Patients should never stop psychiatric, blood-pressure, pain, or prostate medicines themselves.

The prescribing clinician should determine whether adjustment is safe.

Antidepressants and Delayed Orgasm

Selective serotonin reuptake inhibitors are particularly important.

Medicines such as:

- paroxetine;
- sertraline;
- fluoxetine;
- citalopram;

can delay ejaculation and orgasm in some men.

This effect is sometimes deliberately used when treating premature ejaculation—but it can become undesirable when ejaculation becomes excessively delayed or impossible.

If symptoms started after beginning or increasing the dose of an antidepressant, the timing should be discussed with the prescribing clinician.

Treatment may involve changing dose, switching medication, or addressing the sexual side effect through another strategy.

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6. Opioids and Substance Use

Chronic opioid exposure can affect sexual function through both hormonal and nervous-system pathways.

It may contribute to:

- reduced libido;
- testosterone deficiency;
- erectile dysfunction;
- delayed orgasm;
- anorgasmia.

Alcohol can also impair sexual response, especially in larger amounts.

Current EAU guidance includes alcohol and several centrally acting substances among recognized contributors to delayed ejaculation.

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7. Testosterone Deficiency

Testosterone contributes to sexual desire and the overall sexual-response system.

A man with genuine hypogonadism may experience:

- reduced libido;
- fewer spontaneous erections;
- fatigue;
- reduced sexual pleasure;
- delayed orgasm.

Testing is appropriate when symptoms or examination suggest hormonal disease.

However, testosterone should not be prescribed simply because ejaculation is delayed.

For men wishing to father children, this is particularly important: **external testosterone suppresses gonadotropins and sperm production and is contraindicated in men actively seeking fertility**.

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8. Thyroid Disorders

Hypothyroidism has been associated with delayed ejaculation and anorgasmia.

Thyroid testing may therefore be appropriate in selected patients—particularly when sexual symptoms occur alongside fatigue, weight changes, cold intolerance, constipation, or other suggestive features.

Current EAU guidance includes hypothyroidism among recognized endocrine causes of delayed orgasm and anorgasmia.

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9. Prolactin Abnormalities

Prolactin participates in neuroendocrine regulation of sexual function.

When symptoms warrant investigation, clinicians may measure prolactin along with testosterone and thyroid-stimulating hormone.

Current European guidance specifically identifies testosterone, prolactin, and TSH as useful adjunctive laboratory tests when an organic cause of anorgasmia is being considered.

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10. Reduced Penile Sensation

Ageing, peripheral neuropathy, diabetes, neurological disorders, or previous trauma may reduce penile sensation.

A man may still have adequate erection but require much stronger or longer stimulation to reach orgasm.

Current guidelines recognize penile sensation loss as a potential cause of delayed orgasm/anorgasmia.

Further neurological or sensory investigation may be appropriate if a meaningful loss of genital sensation is identified.

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11. Psychological Causes

Psychological factors can be particularly important in delayed orgasm and anorgasmia.

Examples include:

- performance anxiety;
- fear of pregnancy;
- guilt regarding sexuality;
- depression;
- excessive self-monitoring;
- previous traumatic experiences;
- difficulty surrendering control during sexual activity;
- relationship conflict;
- reduced attraction or emotional connection.

Current EAU and AUA/SMSNA guidance recognize psychosexual and relationship factors as important contributors and support referral to sexual-health mental-health professionals in appropriate cases.

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12. Very Specific Masturbation or Stimulation Patterns

Some men can reach orgasm easily during masturbation but not during partnered sexual activity.

In such cases, the problem may relate partly to conditioning.

For example, the patient may habitually use:

- unusually strong pressure;
- a particular body position;
- very high-speed stimulation;

- highly specific fantasy or visual stimulation.

Partnered intercourse may not reproduce the same sensory or psychological environment.

Current sexual-medicine guidance therefore recommends reviewing masturbation patterns and, when appropriate, gradually retraining arousal and stimulation techniques.

This does not mean masturbation itself is inherently harmful.

The issue is a possible mismatch between the stimulation to which the person has become accustomed and the stimulation available during partnered activity.

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13. Relationship Difficulties

Sexual function does not occur independently of emotional context.

Conflict, resentment, poor communication, fear of disappointing a partner, or lack of emotional intimacy can interfere with arousal and orgasm.

For this reason, assessment sometimes needs to include the couple rather than focusing exclusively on one man's physical function.

Shared decision-making and partner involvement are emphasized in the AUA/SMSNA approach to ejaculatory disorders.

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14. Ageing

Sexual-response patterns often change with age.

Some older men require:

- more direct stimulation;
- more time to reach orgasm;
- greater arousal;
- longer recovery between sexual encounters.

Ageing can also bring medical conditions, medications, reduced penile sensation, and hormonal changes that compound the problem.

Delayed ejaculation therefore becomes more common in older populations.

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15. Infections and Inflammation

Urethritis, prostatitis, orchitis, and other inflammatory conditions are listed among potential contributors to delayed or absent ejaculation.

Symptoms such as:

- burning urination;
- pelvic pain;
- painful ejaculation;
- genital discharge;
- testicular discomfort;
- fever;

should prompt medical evaluation for infection or inflammation.

Such patients should not be treated only with sexual tonics.

Absent Ejaculation and Erectile Dysfunction

Erectile dysfunction and delayed ejaculation may coexist.

Sometimes ED develops first.

A man who struggles to maintain an erection may become so focused on the erection that his arousal and orgasmic response are disturbed.

In other patients, long-standing delayed ejaculation leads to frustration and anxiety, which eventually contributes to erection difficulties.

Current AUA guidance recommends determining which problem developed first and treating comorbid erectile dysfunction according to established ED guidelines.

Absent Ejaculation and Male Infertility

Absent ejaculation can have a major reproductive impact.

Natural conception usually requires semen containing sperm to be deposited in the female reproductive tract.

A man with anejaculation may therefore be infertile even if his testes are producing normal sperm.

This creates an important distinction:

Failure to ejaculate is not the same as failure to produce sperm.

When fatherhood is desired, reproductive specialists may attempt to obtain sperm through:

- penile vibratory stimulation;
- electroejaculation;
- recovery of sperm from urine in retrograde ejaculation;
- testicular or epididymal sperm retrieval in selected cases.

The sperm can then potentially be used with assisted reproductive procedures.

Can Anejaculation Cause Azoospermia?

Not in the strict biological sense.

Azoospermia means sperm are absent from the ejaculate after appropriate laboratory assessment.

In true anejaculation there is **no ejaculate available**, so the main problem is failure of semen emission rather than necessarily failure of sperm production.

A patient should therefore not automatically be told that he has “zero sperm” simply because no semen appears during orgasm.

The reproductive system needs further evaluation.

Diagnosis of Absent Ejaculation and Anorgasmia

Diagnosis begins with **conversation**, not a scan.

Both EAU and AUA/SMSNA guidance emphasize detailed medical and sexual history and focused physical examination as the most important parts of evaluation.

The physician should clarify:

- whether orgasm occurs;
- whether semen appears;
- whether the problem is lifelong or acquired;
- whether it occurs during masturbation as well as intercourse;
- whether erections are normal;
- whether sexual desire is normal;
- whether any medication was started before symptoms appeared;

- whether the patient has diabetes or neurological disease;
- whether previous surgery occurred;
- whether genital sensation has changed;
- whether psychological or relationship difficulties are present.

This distinction often identifies the likely pathway before laboratory testing begins.

A Simple Clinical Example

Consider four patients.

Patient A

He experiences orgasm but no semen appears, and his urine becomes cloudy afterward.

Possible concern: retrograde ejaculation.

Patient B

He has a strong erection and orgasm sensation, but no semen enters either the urethra or bladder.

Possible concern: true anejaculation or failure of emission.

Patient C

He maintains an erection and can continue intercourse for a long time but never feels climax.

Possible concern: anorgasmia/severe delayed orgasm.

Patient D

He reaches orgasm normally during masturbation but cannot do so with his partner.

Possible concern: situational delayed orgasm with behavioural, arousal, or psychosexual contributors.

All four may tell the doctor:

“I cannot ejaculate.”

But they do not have the same disorder.

Physical Examination

A focused examination may include assessment of:

- genital anatomy;
- testes;
- epididymides;
- vas deferens;
- prostate when indicated;
- penile sensation;
- secondary sexual characteristics;
- neurological reflexes where relevant.

The examination is directed by the patient's history rather than performed identically in everyone.

Hormonal and Metabolic Tests

Depending on the presentation, laboratory assessment may include:

- morning testosterone;
- prolactin;
- TSH;
- blood glucose or HbA1c;
- additional endocrine testing when indicated.

EAU guidance specifically recommends considering testosterone, prolactin, and TSH when evaluating anorgasmia for organic causes.

AUA/SMSNA guidance also notes that metabolic testing such as glycosylated haemoglobin may be helpful when neuropathy or metabolic disease is suspected.

Post-Ejaculatory Urine Testing

When a man experiences orgasm but little or no semen appears, retrograde ejaculation should be considered.

Urine collected immediately after orgasm can be examined for sperm.

The presence of significant sperm in the post-orgasmic urine, when interpreted in the correct clinical context, supports retrograde ejaculation.

WHO laboratory methodology also describes processing post-ejaculatory urine to recover sperm in men with retrograde ejaculation.

Semen Analysis

If some ejaculate is produced and fertility is a concern, semen analysis can assess:

- semen volume;
- sperm concentration;
- total sperm number;
- sperm motility;
- morphology;
- other parameters where indicated.

The current WHO laboratory manual remains the international reference for standardized semen examination.

Semen analysis evaluates fertility potential—it does not by itself diagnose the reason orgasm is absent.

Is MRI or Ultrasound Necessary?

Not routinely.

Imaging should be selected according to the suspected cause.

It may be considered when clinicians suspect:

- structural reproductive-tract abnormalities;
- ejaculatory-duct obstruction;
- neurological disease;
- pelvic pathology;
- complications of previous surgery.

AUA/SMSNA guidance states that additional testing in delayed ejaculation should be **clinically indicated rather than routinely performed in every patient**.

Modern Treatment: The Cause Comes First

There is no single tablet that reliably treats all forms of absent ejaculation or anorgasmia.

This is one of the most important conclusions from current guidelines.

The 2026 EAU guideline states that evidence remains insufficient to support one definitive pharmacological treatment for delayed ejaculation.

Treatment must therefore be individualized.

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1. Correct Medication-Related Causes

If symptoms began after a medicine was started, the prescribing physician may consider:

- reducing the dose;
- switching to another agent;
- changing timing;
- gradually discontinuing an offending drug when medically appropriate.

This should always occur under professional supervision.

Abruptly stopping antidepressants, antipsychotics, opioids, or cardiovascular medications can cause significant harm.

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2. Psychosexual Therapy

Psychosexual treatment can be especially useful in patients with:

- situational anorgasmia;
- performance anxiety;
- highly specific masturbation conditioning;
- relationship problems;
- difficulty maintaining arousal;
- fear or guilt surrounding sex.

Current European guidance describes approaches including:

- sexual education;
- increased genital-specific stimulation;
- retraining masturbation practices;
- reducing performance anxiety;

- adapting arousal techniques;
- addressing mismatches between fantasy and partnered stimulation.

The objective is not to force ejaculation.

It is to remove barriers to arousal and restore a more natural orgasmic response.

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3. Improve Communication and Intimacy

Some men respond better when pressure to “perform” is reduced.

Helpful principles may include:

- discussing sexual preferences;
- allowing more stimulation time;
- trying positions that produce stronger sensory stimulation;
- reducing pressure to reach orgasm on every encounter;
- involving the partner in treatment when appropriate.

The AUA/SMSNA guideline specifically notes that modifying sexual practices or positions to increase arousal may benefit some patients.

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4. Treat Hormonal Disease

If genuine testosterone deficiency, hypothyroidism, hyperprolactinaemia, or another endocrine condition is identified, treatment should target that disorder.

Testosterone should **not** be given to a man with normal testosterone simply to try to make him ejaculate.

Furthermore, men seeking fertility require special caution because exogenous testosterone suppresses spermatogenesis.

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5. Manage Diabetes and Neuropathy

Good diabetes control may help reduce progression of neuropathy and other sexual complications.

However, established severe autonomic nerve damage may not fully reverse.

When ejaculation remains absent and fertility is desired, assisted ejaculation or sperm retrieval may become more relevant than repeated use of sexual-performance medicines.

6. Penile Vibratory Stimulation

For men with certain neurological causes of anejaculation—especially spinal-cord injury—**penile vibratory stimulation (PVS)** is an important treatment.

A medical vibrator delivers controlled stimulation to the penis to trigger the ejaculation reflex.

Current EAU guidance describes PVS as first-line therapy for anejaculation in men with spinal-cord injury and selected neurological causes, provided the relevant spinal reflex pathways remain intact.

This is a specialized medical procedure and should not be confused with ordinary consumer vibrators.

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7. Electroejaculation

If penile vibratory stimulation fails, **electroejaculation** may be considered.

This involves medically controlled electrical stimulation of reproductive organs through the rectal region to provoke ejaculation.

It is particularly used in fertility treatment for selected patients with neurological ejaculatory failure.

WHO laboratory guidance describes processing semen obtained through vibratory or electrical stimulation.

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8. Sperm Retrieval for Fertility

If ejaculation cannot be restored, fatherhood may still be possible.

Depending on the condition, sperm may be obtained through:

- post-ejaculatory urine;
- penile vibratory stimulation;
- electroejaculation;
- epididymal sperm retrieval;
- testicular sperm aspiration or extraction.

These sperm may then be used with fertility procedures such as IVF or ICSI.

The appropriate method depends on sperm quality, female-partner fertility, and the exact cause of ejaculatory failure.

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9. Treatment of Retrograde Ejaculation

Selected patients with retrograde ejaculation may respond to medicines that improve bladder-neck closure.

EAU guidance discusses sympathomimetic agents such as pseudoephedrine, ephedrine, and midodrine, but available studies are generally small and these medicines can cause adverse effects such as hypertension.

They are therefore **not appropriate for unsupervised self-treatment**.

When medical treatment fails and fertility is desired, sperm can sometimes be recovered from urine.

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10. Medicines for Delayed Orgasm and Anorgasmia

Several drugs have been explored, including:

- cabergoline;
- bupropion;
- yohimbine;
- amantadine;
- buspirone;
- oxytocin;
- cyproheptadine.

However, current EAU guidance states that evidence remains insufficient to recommend a standard drug treatment for anorgasmia.

A 2025 systematic review found signals of improvement with agents such as cabergoline, yohimbine, and bupropion, but the total evidence involved only a small number of studies and patients, so these therapies should still be considered **off-label and specialist-directed rather than established routine treatment**.

No patient should purchase these drugs simply to “increase orgasm.”

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11. Experimental Treatments

Research continues into approaches such as neuromodulation.

The 2026 EAU guideline describes a small randomized study of repetitive transcranial magnetic stimulation for anejaculation/anorgasmia, but the evidence remains preliminary and is insufficient for routine clinical use.

Likewise, the AUA/SMSNA guideline states that invasive procedures for delayed ejaculation lack convincing evidence and should not be used routinely outside proper research settings.

Lifestyle Measures

Lifestyle improvement does not cure every neurological or anatomical cause of absent ejaculation, but it supports overall sexual health.

Useful areas include:

- controlling diabetes;
- maintaining healthy body weight;
- regular exercise;
- reducing excessive alcohol;
- avoiding recreational drugs;
- improving sleep;
- managing chronic stress;
- addressing depression and anxiety;
- maintaining healthy relationship communication.

Lifestyle should complement diagnosis—not replace it.

The Unani Concept of Absent or Difficult Ejaculation

Classical Unani medicine discusses sexual disorders broadly under **Amraz-e-Bah**, encompassing disturbances of sexual desire, erectile capacity, seminal function, ejaculation, and reproductive strength.

A precise one-to-one historical Unani term corresponding to the modern neurological definition of **true anejaculation** is not consistently standardized across contemporary English-language Unani sources. This is important because modern anejaculation itself is a highly specific neurological or pharmacological disorder.

Unani physicians traditionally understand sexual function through concepts involving:

- **Mizaj** – individual temperament;
- **Akhlat** – humoral state;
- **Quwwat** – functional strength;
- general nervous and physical vitality;
- reproductive-organ health;
- diet and digestion;
- sleep;
- emotional state;
- sexual habits.

This framework encourages the clinician to look beyond a single symptom.

That can be particularly valuable in acquired delayed ejaculation or anorgasmia, which often involves several contributing factors simultaneously.

How Unani Medicine Can Be Useful

The most valuable role of contemporary Unani medicine in this condition is a **holistic and individualized treatment strategy**, rather than assuming that one herbal product can stimulate ejaculation in every patient.

Ilaj-bil-Ghiza – Dietotherapy

Diet is selected according to the patient's constitution and general health.

A balanced modern diet should support:

- appropriate body weight;
- metabolic health;
- adequate protein intake;
- micronutrient sufficiency;
- cardiovascular health.

Patients with diabetes, obesity, or nutritional deficiencies require individualized dietary planning.

No particular food has been scientifically proven to restore a neurologically absent ejaculation reflex.

Ilaj-bil-Tadbeer – Lifestyle and Regimental Therapy

Lifestyle management fits particularly well with modern sexual-medicine principles.

It may include:

- adequate sleep;
- regular exercise;
- stress reduction;
- moderation of alcohol;
- smoking cessation;
- healthy sexual habits;
- improvement in mental relaxation;
- partner communication.

Patients with psychological or situational delayed orgasm may particularly benefit from the combination of lifestyle management and psychosexual counselling.

Ilaj-bil-Dawa – Individualized Pharmacotherapy

Unani physicians may select traditional formulations according to the patient's Mizaj, general strength, associated sexual problems, digestive status, nervous-system complaints, reproductive goals, and other clinical findings.

However, one critical principle should be maintained:

Herbal or traditional treatment cannot replace neurological, endocrine, medication-related, or anatomical diagnosis when such a disorder is present.

A man with diabetic autonomic neuropathy should not be treated in exactly the same way as a man with performance anxiety.

A man with retrograde ejaculation needs a different plan from a man with anorgasmia.

A man with spinal-cord injury requires specialized reproductive techniques if fertility is the goal.

Important Evidence Limitation

There is extensive traditional Unani literature regarding sexual debility, reproductive weakness, premature ejaculation, and sperm-related disorders.

However, high-quality modern clinical trials specifically evaluating **Unani formulations for true anejaculation or male anorgasmia** are currently very limited.

This means Unani treatment should be presented as an **individualized integrative approach**, not as a scientifically proven replacement for penile vibratory stimulation, electroejaculation, hormonal treatment, medication adjustment, sex therapy, or assisted reproduction when these are clinically required.

That evidence-aware approach protects patients and strengthens the credibility of Unani medicine.

Dr. Qasmi's Nuskha No. 108

Saira Health Care Pharmacy currently describes **Dr. Qasmi's Nuskha No. 108** as a traditional Unani Majoon used for general weakness, stamina, nervine support, urinary and digestive complaints, and broader wellness. Its listed ingredients include Salab Misri, pine nuts, ginger, black pepper, amla, honey, and other traditional ingredients.

Within an individualized Unani programme, such a formulation may be considered where general debility, poor stamina, or associated constitutional complaints are part of the patient's presentation.

However, its current product information does **not establish Nuskha No. 108 as a clinically proven treatment for neurological anejaculation or anorgasmia**.

It should therefore be considered supportive when professionally selected, rather than a replacement for diagnosis.

Dr. Qasmi's Nuskha No. 104 – Vitaflow Max

Dr. Qasmi's Nuskha No. 104 – Vitaflow Max is currently described by Saira Health Care Pharmacy as an externally applied Unani oil intended for male sexual wellness, circulation, premature ejaculation, and genital hypersensitivity.

This distinction is important.

Nuskha No. 104 is **not currently positioned on the official product page as a specific treatment for absent ejaculation or anorgasmia**.

In a patient who already has reduced genital sensation or difficulty reaching orgasm, indiscriminate use of any sensation-reducing approach could theoretically be counterproductive.

Therefore, its role should be determined only after a qualified clinician identifies the patient's actual sexual dysfunction.

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

Saira Health Care Pharmacy describes **Dr. Qasmi's Nuskha No. 129 – Vitasem Max** as a Unani formulation for male vitality, general weakness, energy, and semen-related reproductive support. Its current product description also discusses sperm count, semen quality, and nervous hypersensitivity.

For patients with absent ejaculation, an important distinction must again be maintained:

sperm quality and ejaculation are different physiological processes.

A man may have excellent sperm production but be unable to ejaculate because his autonomic nerves are damaged.

Therefore, Nuskha No. 129 may be considered within a broader physician-guided Unani wellness or reproductive-support programme where appropriate, but it should not be represented as capable of restoring every absent ejaculation reflex.

Spermogenic Powder

Saira Health Care Pharmacy currently markets **Spermogenic Powder** for male fertility-related concerns including low sperm count, reduced sperm motility, watery semen, low libido, and general male reproductive health.

This formulation may be relevant if a patient with ejaculatory dysfunction also has a demonstrated abnormality in semen or sperm parameters.

However:

Spermogenic treatment and treatment of anejaculation are not the same thing.

If a man's testes are producing sperm normally but he cannot ejaculate because of spinal injury, retrograde flow, surgery, or nerve dysfunction, increasing sperm production alone will not restore the ejaculation pathway.

In fertility care, both questions must be answered:

Are sperm being produced?

and

Can those sperm be delivered or retrieved?

Why the Same Medicine Should Not Be Given to Every Patient

Consider these examples.

Patient 1

A 28-year-old man has never been able to reach orgasm during partnered sex but ejaculates normally during masturbation.

His main issue may be psychosexual or stimulation-related.

Patient 2

A 55-year-old man with long-standing diabetes experiences normal orgasm but no visible semen.

Retrograde ejaculation or autonomic neuropathy may be present.

Patient 3

A man becomes unable to orgasm shortly after starting an SSRI antidepressant.

The medicine may be the principal factor.

Patient 4

A man with spinal-cord injury has erections but cannot ejaculate.

Penile vibratory stimulation or electroejaculation may be needed if fertility is desired.

Patient 5

A man has no ejaculate and laboratory evaluation shows severe male-factor infertility.

He requires reproductive investigation rather than simply a sexual-performance tonic.

All five may describe themselves as having **“absent ejaculation.”**

Their treatment should not be identical.

Dr. Nizamuddin Qasmi and the Saira Health Care Approach

Saira Health Care identifies **Dr. Nizamuddin Qasmi** as its founder and chief physician with a focused clinical practice in **sexual disorders and infertility**.

His current public professional profile lists the following qualifications:

- **BUMS – Bachelor of Unani Medicine and Surgery**
- **MD**
- **CGO**

- **Certificate in Infertility**
- **Certificate in Urology – London, UK**

According to additional professional information supplied by Saira Health Care for publication, Dr. Qasmi has also completed **Masters in Male Infertility from Master Health Pro (MHPro)**.

MasterHealthPro publicly lists a six-month **Male Infertility Masters** programme and separate fellowship training in male infertility, covering reproductive physiology, semen analysis, diagnostic work-up, sexual dysfunction, and evidence-based management of male infertility.

For final website publication, the degree/course wording should be reproduced exactly as it appears on Dr. Qasmi's issued MHPro certificate.

Dr. Qasmi's Specialized Approach to Absent Ejaculation and Orgasmic Disorders

A specialist approach to this condition should begin by identifying exactly **which component of the sexual-response cycle is disturbed**.

At Saira Health Care, an individualized treatment framework may therefore assess:

- sexual desire;
- erection quality;
- orgasm sensation;
- ejaculation;
- semen production;
- fertility status;
- medications;
- diabetes or neurological disease;
- hormonal symptoms;
- psychological factors;
- relationship concerns;
- Mizaj and general Unani constitutional assessment.

Modern investigations can then be recommended where clinically relevant.

Unani dietary, lifestyle, and selected pharmacological support may be integrated according to the individual patient's presentation.

This diagnosis-first strategy is more scientifically and clinically meaningful than simply giving one “sexual-power medicine” to every patient.

Contribution of Saira Health Care to Sexual Disorders and Infertility

Saira Health Care publicly describes itself as a registered Unani clinic specializing in **sexual disorders and infertility**, with a philosophy that combines traditional Unani principles, modern diagnostic insights, nutritional advice, lifestyle modification, and patient-centred care.

Its disease and educational sections currently include conditions such as:

- erectile dysfunction;
- premature ejaculation;
- nightfall;
- Dhat syndrome;
- penile hypersensitivity;
- Jiryan-e-Mazi;
- hypospermia;
- absent orgasm;
- low testosterone;
- male infertility and related disorders.

This type of educational work is especially important in male sexual medicine because embarrassment and misinformation often lead patients toward inappropriate self-medication.

A man who understands the difference between **erection, orgasm, ejaculation, semen volume, and sperm production** is better able to seek the correct treatment.

Psychological Impact

Absent orgasm or ejaculation can cause considerable emotional distress.

Men may begin believing:

“I am not masculine.”

“My marriage will fail.”

“I can never become a father.”

“My sexual organs have become weak.”

Such conclusions are not medically justified.

Anejaculation is a medical problem involving ejaculation.

Anorgasmia is an orgasmic disorder.

Neither defines masculinity or personal worth.

Many underlying causes are treatable or manageable, and fertility may still be possible even when ejaculation cannot be restored naturally.

Fertility Planning at Saira Health Care

When pregnancy is the main goal, treatment should not focus only on sexual performance.

The questions become:

1. **Is sperm production normal?**
2. **Is ejaculation occurring?**
3. **Is semen entering the bladder instead of coming forward?**
4. **Can sperm be recovered?**
5. **What is the reproductive health of the female partner?**

Men with anejaculation may still produce viable sperm.

Therefore, fertility counselling, semen or sperm assessment, and referral for assisted reproductive techniques can be important components of care.

Common Myths About Absent Ejaculation and Anorgasmia

Myth 1: No semen means no sperm are being produced.

Fact: Sperm production and ejaculation are separate processes.

A man may have normal spermatogenesis but be unable to ejaculate.

Myth 2: Orgasm and ejaculation always happen together.

Fact: They usually coincide, but neurological, surgical, psychological, and medication-related conditions can separate them.

Myth 3: A dry orgasm always means anejaculation.

Fact: Semen may be travelling backward into the bladder in retrograde ejaculation.

Myth 4: Masturbation permanently destroys the ability to orgasm.

Fact: Ordinary masturbation does not inherently destroy orgasmic function. In selected men, however, very specific stimulation habits can make partnered orgasm more difficult.

Myth 5: Every case is psychological.

Fact: Diabetes, neurological disease, surgery, hormonal disorders, and medications can all cause absent or delayed ejaculation.

Myth 6: Every case is caused by "sexual weakness."

Fact: Some men with excellent erections and physical fitness have neurological or medication-related ejaculatory dysfunction.

Myth 7: Increasing sperm count will automatically restore ejaculation.

Fact: Sperm production and semen emission are different physiological processes.

Myth 8: Testosterone is the solution for every sexual problem.

Fact: Testosterone is appropriate only for properly diagnosed deficiency. It can suppress sperm production and should not be used as fertility treatment in men trying to father children.

When Should a Man Seek Medical Advice?

Professional evaluation is particularly important when:

- ejaculation has become persistently absent;
- orgasm cannot be achieved despite adequate stimulation;
- the problem has developed suddenly;

- semen volume has become extremely low or absent;
- urine becomes cloudy after orgasm;
- diabetes or neurological disease is present;
- previous prostate, pelvic, abdominal, or spinal surgery has occurred;
- an antidepressant or other medication preceded the symptoms;
- genital sensation has decreased;
- erectile dysfunction is also present;
- infertility is a concern;
- symptoms cause significant emotional or relationship distress.

When Is Urgent Evaluation Needed?

Absent ejaculation itself is usually not an emergency.

Prompt medical assessment is nevertheless appropriate if it occurs together with:

- sudden neurological weakness;
- loss of bladder or bowel control;
- severe back pain with new genital numbness;
- significant genital or testicular pain;
- fever or severe infection symptoms;
- blood in urine or semen;
- acute psychological crisis.

New neurological symptoms affecting the legs, bladder, bowel, or genital sensation can occasionally indicate serious spinal or nerve pathology.

Frequently Asked Questions

Can a man have orgasm without ejaculation?

Yes.

This can occur in true anejaculation, after certain surgeries, and in other neurological or medication-related conditions.

Can a man ejaculate without enjoying orgasm?

Yes.

Orgasmic pleasure and ejaculation are related but separable neurological processes.

Some men experience markedly diminished pleasure despite semen being expelled.

Can anejaculation be treated?

Sometimes.

Treatment depends on the cause.

Medication adjustment, treatment of endocrine disease, psychosexual therapy, penile vibratory stimulation, electroejaculation, or sperm retrieval may be appropriate in different patients.

Is there one medicine that restores ejaculation?

No.

Current international guidelines specifically note the lack of a definitive universally effective pharmacological treatment for delayed ejaculation and anorgasmia.

Can antidepressants cause absent orgasm?

Yes.

SSRIs and other antidepressants are well-recognized causes of delayed ejaculation and orgasmic dysfunction.

Do not discontinue them without consulting the prescribing clinician.

Can diabetes cause a dry orgasm?

Yes.

Diabetes-related autonomic neuropathy may impair emission or cause retrograde ejaculation.

Can a man with anejaculation become a father?

Yes, in many cases sperm production may remain intact.

Depending on the condition, semen or sperm can sometimes be obtained through vibratory stimulation, electroejaculation, urine recovery, or surgical sperm-retrieval techniques and used with assisted reproduction.

Can Unani medicine help?

Unani medicine can be valuable as part of a holistic plan addressing:

- general physical health;
- stress;
- sleep;
- diet;
- lifestyle;
- associated sexual dysfunction;
- constitutional factors;
- patient confidence.

Selected traditional formulations may also be used under professional supervision.

However, modern causes such as spinal injury, retrograde ejaculation, medication side effects, hormonal disease, or diabetic neuropathy require appropriate medical diagnosis and cause-specific care.

Are Nuskha No. 108, 104 and 129 proven treatments for anejaculation?

Their current Saira Health Care Pharmacy descriptions address different aspects of male sexual and general wellness, but they do not provide independent clinical evidence proving that these formulations restore true neurological anejaculation or anorgasmia.

Their use should therefore be individualized and physician-guided.

Can Spermogenic treat absent ejaculation?

Spermogenic is primarily positioned by Saira Health Care Pharmacy for sperm and male fertility-related support.

It may be relevant when abnormal sperm parameters coexist, but increasing sperm production does not necessarily correct failure of ejaculation.

A Practical Integrative Clinical Pathway

For textbook clarity, the management of absent ejaculation or orgasm can be summarized as:

Confirm exactly what is absent

↓

Differentiate delayed ejaculation, anejaculation, retrograde ejaculation and anorgasmia

↓

Review medications, diabetes, neurological disease and previous surgery

↓

Assess erections, libido, genital sensation and psychological factors

↓

Perform focused physical examination

↓

Order testosterone, prolactin, thyroid or metabolic tests when indicated

↓

Check post-ejaculatory urine if retrograde ejaculation is suspected

↓

Assess semen/sperm production when fertility is relevant

↓

Treat the underlying condition

↓

Integrate lifestyle, psychosexual and individualized Unani support where appropriate

↓

Use penile vibratory stimulation, electroejaculation or sperm retrieval when indicated

↓

Follow the patient's sexual satisfaction, emotional well-being and fertility goals

Prognosis

The outlook depends entirely on the cause.

Medication-related delayed orgasm may improve after clinician-supervised modification of the offending medicine.

Situational psychosexual problems may respond well to behavioural and relationship-focused treatment.

Endocrine disorders may improve when the hormone abnormality is corrected.

Retrograde ejaculation may sometimes respond to medication or sperm-recovery techniques.

Men with neurological anejaculation may require penile vibratory stimulation, electroejaculation, or sperm retrieval.

Some cases remain difficult to treat, particularly when severe neurological damage is present.

Current guidelines emphasize that evidence for delayed ejaculation and anorgasmia treatments remains more limited than for common disorders such as erectile dysfunction or premature ejaculation.

Conclusion

Absent ejaculation and absent orgasm are often spoken about as though they were one condition, but modern sexual medicine makes an important distinction.

Anejaculation refers principally to absence of semen emission or ejaculation.

Anorgasmia refers to absence of the subjective orgasm experience.

Delayed ejaculation describes excessive difficulty or delay in reaching ejaculation.

Retrograde ejaculation occurs when semen travels backward into the urinary bladder.

Recognizing these differences is the foundation of effective treatment.

The causes can range from performance anxiety and medication effects to diabetes, spinal injury, multiple sclerosis, endocrine abnormalities, reduced genital sensation, previous surgery, and relationship difficulties.

For this reason, treatment should never consist merely of prescribing a generic sexual tonic.

Modern management may include medication review, psychosexual therapy, treatment of hormonal or metabolic disorders, penile vibratory stimulation, electroejaculation, post-ejaculatory sperm recovery, or assisted reproduction. Current evidence does not support one universally effective drug for male anorgasmia or delayed ejaculation.

The **Unani system of medicine** can provide meaningful complementary value through its emphasis on individualized assessment of Mizaj, diet, sleep, physical strength, psychological well-being, lifestyle, sexual habits, and associated reproductive concerns. Selected Unani formulations may be incorporated under qualified supervision when appropriate, but they should not replace the investigation of neurological, endocrine, structural, or medication-related causes.

At **Saira Health Care**, Dr. Nizamuddin Qasmi's specialized practice focuses on sexual disorders and infertility. His publicly listed credentials include **BUMS, MD, CGO, Certificate in Infertility, and Certificate in Urology – London, UK**. Saira Health Care has additionally supplied for publication his credential of **Masters in Male Infertility from Master Health Pro (MHPro)**.

Dr. Qasmi's Nuskha No. 108, Nuskha No. 104, Nuskha No. 129, Spermogenic, and other traditional formulations may form part of an individualized programme according to the patient's overall sexual and reproductive condition. Their role should be supportive and diagnosis-led rather than presented as guaranteed treatments for every case of absent ejaculation or orgasm.

The most important message for patients is simple:

Not ejaculating does not necessarily mean that you cannot produce sperm, and not reaching orgasm does not mean that you have lost your masculinity. Identify exactly which sexual function is affected, find the underlying cause, and choose treatment according to that diagnosis.

About Saira Health Care

Saira Health Care describes itself as a registered Unani clinic focused on sexual disorders and infertility, using a patient-centred approach combining traditional Unani principles with modern diagnostic insights, nutritional advice, counselling, and lifestyle modification.

Visit Saira Health Care

Saira Health Care Pharmacy

Medical Disclaimer

This article is intended for **general medical education and sexual/reproductive-health awareness**. It does not provide an individual diagnosis and should not replace consultation, physical examination, neurological assessment, laboratory testing, semen analysis, or treatment by an appropriately qualified healthcare professional.

Do not stop antidepressants, prostate medicines, blood-pressure medicines, opioids, hormones, or other prescribed treatments without consulting the clinician who prescribed them.

Traditional, herbal, and Unani medicines should be used under qualified professional supervision. “Natural” does not automatically mean free from adverse effects, interactions, or contraindications.

No medicine, supplement, herbal formulation, psychosexual intervention, or reproductive procedure can guarantee restoration of ejaculation, orgasm, fertility, or pregnancy for every patient.