

Anejaculation: Causes, Diagnosis, Fertility Impact, Treatment and an Integrative Unani Approach

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

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Anejaculation is an important but often misunderstood male sexual and reproductive-health problem. A man may have normal sexual desire, obtain a satisfactory erection and even experience orgasm, yet no semen is expelled from the penis. In other men, the inability to reach orgasm and the inability to ejaculate occur together.

For many patients, this is frightening. Some immediately assume that their sperm production has stopped, that they have become infertile, or that they have permanently lost sexual function. These conclusions are not necessarily correct.

As I explain to patients, **ejaculation, orgasm, erection and sperm production are related functions, but they are not the same process.** A problem in one does not automatically mean that all the others are abnormal. Proper diagnosis is therefore essential before treatment begins.

Current international sexual-medicine terminology has also become more precise. The 2024 International Consultation on Sexual Medicine, with its consensus definitions published in 2026, distinguishes ejaculation from orgasm and defines anejaculation by the absence of the normal ejaculatory expulsion process. European guidelines similarly describe anejaculation as complete absence of normal antegrade or retrograde ejaculation.

What Is Anejaculation?

Anejaculation means an inability to produce the normal outward ejaculation of semen during sexual climax or sexual stimulation.

In simple language, the man does not release semen in the expected way.

However, the exact experience differs from patient to patient. One man may reach orgasm normally but notice that nothing comes out. Another may be unable to reach orgasm at all and therefore does not ejaculate. A third may ejaculate during masturbation but not during intercourse. Another may stop ejaculating after surgery, neurological injury, diabetes or the introduction of a medication.

Cleveland Clinic describes primary anejaculation, in which ejaculation has never occurred, and secondary or acquired anejaculation, in which a man who previously ejaculated normally later loses that ability. It also recognizes situational and total patterns.

This distinction is important because **anejaculation is not one single disease with one single treatment**. It is a clinical problem that can arise from several different mechanisms.

How Normal Ejaculation Happens

To understand anejaculation, patients first need to understand normal ejaculation.

Male ejaculation requires coordination between the brain, spinal cord, autonomic nervous system, peripheral nerves, prostate, seminal vesicles, vas deferens, urethra, pelvic-floor muscles and bladder neck.

The process can be simplified into two major stages.

During **emission**, sperm and secretions from the male reproductive glands move into the posterior urethra.

During **expulsion**, rhythmic muscular contractions propel semen outward through the urethra and penis.

At approximately the same time, the bladder neck normally closes so that semen travels forward rather than backward into the urinary bladder.

A problem with neural signalling, emission, bladder-neck closure or muscular propulsion can therefore change or completely prevent normal ejaculation. The 2026 International Consultation recommendations describe disorders involving failure of emission, retrograde flow through the bladder neck and failure of antegrade propulsion as distinct mechanisms that can present with absent outward semen.

Anejaculation, Anorgasmia, Aspermia and Retrograde Ejaculation Are Not the Same

These terms are commonly confused, even though distinguishing them can completely change management.

Condition

What usually happens?

Anejaculation

Normal ejaculatory expulsion does not occur



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Condition	What usually happens?
Anorgasmia	The man cannot experience orgasm despite adequate stimulation
Orgasmic anejaculation / dry orgasm presentation	Orgasm occurs but no normal outward ejaculate is produced
Retrograde ejaculation	Semen travels backward into the bladder instead of outward
Delayed ejaculation	Ejaculation can occur but requires unusually prolonged or difficult stimulation
Aspermia	No semen is expelled; terminology overlaps historically with some descriptions of dry orgasm and requires clarification of the underlying mechanism

Modern terminology is evolving. The Fifth International Consultation on Sexual Medicine specifically notes that earlier literature has not always used *anejaculation* and *aspermia* consistently, which is one reason clinical history and objective evaluation are more important than relying on a label alone.

Can a Man Have an Orgasm Without Ejaculating?

Yes.

Orgasm is primarily the sensation of sexual climax, whereas ejaculation is the physical reproductive process that normally expels semen.

They usually occur together, which is why patients often consider them one event. Medically, however, they are separable processes.

The 2026 International Consultation recommendations describe **orgasmic anejaculation** as a situation in which a man reaches climax but there is no normal antegrade ejaculation. They separately describe **anorgasmic anejaculation**, in which the patient cannot reach orgasm and therefore does not ejaculate.

This distinction is one of the first things I would want to establish during an evaluation.

Types of Anejaculation

Anejaculation may be lifelong or acquired.



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In **lifelong or primary anejaculation**, the man reports that he has never experienced normal ejaculation.

In **acquired or secondary anejaculation**, ejaculation was previously normal but was later lost. Acquired cases deserve careful investigation because medications, diabetes, neurological disease, surgery, radiation, hormonal abnormalities or other medical events may be responsible.

Anejaculation may also be **situational**. For example, ejaculation may occur during masturbation but repeatedly fail during intercourse. Another patient may experience the problem only when intercourse is scheduled during the fertile period because pressure to conceive produces severe performance anxiety.

The 2026 international recommendations specifically discuss this fertility-related situational pattern, sometimes described as periovulatory anejaculation.

At the other extreme is **total anejaculation**, in which ejaculation does not occur during intercourse, masturbation or other stimulation.

What Causes Anejaculation?

There is no single universal cause.

Some cases are predominantly neurological or anatomical. Others are related to medication, endocrine disease, psychological factors or sexual-response patterns. More than one factor may be present in the same patient.

This is why I strongly advise against treating every patient who says “semen is not coming out” with the same sexual tonic, hormonal medicine or herbal preparation.

The underlying mechanism has to be identified first.

Neurological Causes

Normal ejaculation depends heavily on the nervous system.

A spinal cord injury may interrupt the nerve pathways involved in ejaculation. Diabetic neuropathy can progressively damage autonomic nerves. Multiple sclerosis and other neurological disorders can also interfere with the ejaculatory reflex.

Current European guidelines describe central and peripheral neurological dysfunction among the principal causes of true anejaculation, while the 2026 International Consultation also identifies diabetic neuropathy, spinal cord injury and multiple sclerosis among important neurological causes.



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Neurological anejaculation requires particular attention when fertility is desired because the man's testes may still produce sperm even though he cannot naturally expel semen.

This is an extremely important difference.

Failure to ejaculate does not automatically mean failure to produce sperm.

Diabetes and Anejaculation

Long-standing diabetes can damage nerves throughout the body, including the autonomic nerves involved in erection, bladder-neck function and ejaculation.

A diabetic patient may therefore develop erectile dysfunction, delayed ejaculation, retrograde ejaculation, anejaculation or a combination of sexual problems.

Current sexual-medicine recommendations identify diabetic neuropathy as an organic cause that needs to be considered when ejaculation is absent.

For such a patient, simply prescribing a medicine intended to stimulate sexual desire does not address the main problem. Diabetes control, neurological assessment and identification of the exact ejaculatory disorder become important parts of management.

Spinal Cord Injury and Anejaculation

Anejaculation is particularly important in men with spinal cord injuries.

The testes may remain capable of producing sperm, yet neurological disruption prevents normal ejaculation. These patients can sometimes obtain semen through **penile vibratory stimulation**, and if that fails, **electroejaculation** or surgical sperm retrieval may be considered for fertility treatment.

European guidance recommends penile vibratory stimulation as a first-line sperm-recovery approach in appropriate men with neurological anejaculation, particularly spinal cord injury, with electroejaculation considered when vibratory stimulation fails.

The recent International Consultation recommendations similarly recognize penile vibratory stimulation, electroejaculation and surgical sperm retrieval as possible pathways when fertility is desired.

These are specialist procedures, not treatments that should be attempted without appropriate medical supervision.

Surgery and Anejaculation



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Certain operations can damage or interrupt nerves that are essential for seminal emission.

Pelvic, abdominal, retroperitoneal, bladder, prostate or other surgeries involving autonomic nerve pathways can sometimes lead to ejaculatory dysfunction.

Cleveland Clinic lists nerve injury related to bladder surgery, prostate surgery, lymph-node removal, radiation therapy and pelvic injuries among recognized causes.

The 2026 sexual-medicine recommendations similarly identify retroperitoneal and pelvic procedures among potentially important causes.

A history of surgery is therefore extremely important when a man reports that ejaculation was normal before an operation and absent afterward.

Medication-Induced Anejaculation

Medicines are another important and sometimes overlooked cause.

Certain antidepressants can interfere with orgasm and ejaculation. Alpha-blocking medicines and some other drugs may affect the neural and muscular processes involved in semen emission.

Cleveland Clinic identifies antidepressants and alpha-blockers among medications that may contribute to anejaculation.

Recent international sexual-medicine literature also recognizes antidepressants, antipsychotics and therapies affecting the genitourinary system among medication-related contributors to male ejaculatory dysfunction.

Patients should **not abruptly stop prescribed medication** because of sexual side effects. The correct approach is to discuss the problem with the prescribing clinician. Sometimes the dose can be modified or an alternative medicine considered, but this depends on the disease being treated.

Psychological and Psychosexual Causes

Not all cases of absent ejaculation result from structural disease.

Anxiety, severe performance pressure, depression, relationship stress, fear of pregnancy and other emotional factors may contribute particularly to situational or anorgasmic anejaculation.

Cleveland Clinic specifically recognizes anxiety, depression, stress and pregnancy-related fear among possible psychological contributors.



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The 2026 International Consultation recommendations also describe performance anxiety, sexual inhibition, traumatic experiences, specific masturbation patterns, pregnancy fears and relational factors among possible contributors to anorgasmic anejaculation and severe delayed ejaculation.

These causes should be discussed professionally rather than judgmentally.

Psychological sexual dysfunction is still genuine sexual dysfunction. The brain is fundamental to sexual arousal and orgasm.

Anejaculation While Trying to Conceive

This deserves special attention at Saira Health Care because our focused clinical work includes sexual disorders and infertility.

A couple may undergo repeated fertility investigations without anyone asking a simple question:

“Is semen actually being deposited inside the vagina during intercourse?”

If the answer is no because the husband repeatedly cannot ejaculate, pregnancy may not occur even when spermatogenesis is relatively preserved.

The Fifth International Consultation on Sexual Medicine states that persistent anejaculation causing absence of antegrade ejaculate can itself result in infertility because semen cannot be deposited intravaginally.

Therefore, sexual history is not optional in infertility care.

A semen report alone does not describe the complete reproductive process.

Does Anejaculation Mean There Are No Sperm?

No.

This is one of the most important messages for patients.

Anejaculation and azoospermia are completely different concepts.

Azoospermia means that sperm are absent from the ejaculated semen after appropriate laboratory evaluation.

Anejaculation means that normal ejaculation does not occur.

A man with anejaculation may still have sperm production inside the testes. If fertility is desired, specialist techniques may sometimes obtain sperm or induce ejaculation.



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Cleveland Clinic notes that biological fatherhood may remain possible through penile vibratory stimulation, electroejaculation or sperm retrieval followed by fertility treatment where appropriate.

This is why a man should not automatically conclude that he is infertile simply because he does not see semen.

Can Anejaculation Cause Infertility?

Yes, when semen cannot reach the female reproductive tract.

Natural conception generally requires adequate sperm-containing semen to be deposited in the vagina during the fertile period. Persistent inability to ejaculate intravaginally can therefore prevent natural conception even if sperm production continues.

Current international recommendations specifically identify persistent orgasmic or anorgasmic anejaculation as a cause of infertility and recommend a combined sexual-health and reproductive approach.

When fertility is the patient's priority, evaluation should not be unnecessarily delayed.

How Is Anejaculation Diagnosed?

Diagnosis begins with a careful conversation.

When I evaluate this type of complaint, the first objective is not to prescribe medicine. The first objective is to establish **what is actually happening**.

I need to know whether orgasm occurs, whether semen ever comes out, whether ejaculation occurs with masturbation, whether the problem is lifelong or acquired, whether it happens every time, whether the patient's erection and libido are normal, and whether the couple is trying for pregnancy.

The history should also examine diabetes, neurological disease, spinal injury, pelvic operations, prostate or bladder procedures, cancer treatments, medications, hormone-related symptoms, psychological stress and relationship factors.

Recent international recommendations emphasize detailed medical, sexual and fertility history together with focused physical examination when sexual dysfunction and infertility coexist.

Why a Post-Orgasm Urine Test May Be Important



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If a patient experiences orgasm but no visible semen appears, one important question is whether the semen has travelled backward into the urinary bladder.

This is **retrograde ejaculation**, not true absence of seminal movement.

A post-orgasm urine specimen can therefore be examined for sperm.

Cleveland Clinic explains that the presence of sperm in urine after orgasm suggests retrograde ejaculation, whereas the absence of sperm helps direct the clinician toward other explanations.

The 2026 International Consultation similarly notes that post-orgasm urinalysis is important when retrograde ejaculation is suspected.

Some men with retrograde ejaculation notice cloudy urine after orgasm, but symptoms alone are not enough to establish the diagnosis.

Physical Examination and Laboratory Evaluation

The necessary investigations depend on the patient's history.

A genital examination may assess the testes, epididymides, penis and other reproductive structures. Neurological examination may be relevant when nerve dysfunction is suspected.

Blood glucose or HbA1c may be appropriate when diabetes is possible. Hormonal assessment can include morning testosterone when hypogonadism is suspected, with prolactin, thyroid testing or other endocrine evaluation selected according to the clinical situation.

The 2026 International Consultation identifies hypogonadism, hyperprolactinemia and hypothyroidism among endocrine conditions that can contribute to serious ejaculatory dysfunction.

Investigation should be targeted rather than simply ordering every available test.

Severe Hypogonadism and Anejaculation

Severe androgen deficiency is not the most common explanation, but it may contribute in selected patients.

Recent international recommendations recognize severe hypogonadism as one possible organic contributor to orgasmic anejaculation.

However, this does **not** mean that testosterone should be given to every man who cannot ejaculate.



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This is particularly important for patients seeking pregnancy because externally administered testosterone can suppress the hormonal stimulation needed for sperm production. The 2026 international fertility/sexual-medicine recommendations advise against exogenous testosterone replacement in men actively interested in fertility and discuss fertility-preserving alternatives where medically appropriate.

Hormones should therefore be prescribed only after proper assessment.

Treatment of Anejaculation

There is no universal tablet for anejaculation.

Treatment depends on whether the cause is neurological, medication-related, endocrine, psychological, anatomical, surgical or mixed.

For a man whose problem began after medication, review of the responsible drug may be important. For a man with diabetes, metabolic and neurological management may be required. A patient with situational anorgasmic anejaculation may benefit from psychosexual treatment. A man with spinal cord injury may require vibratory stimulation or electroejaculation if fertility is desired.

This is why accurate classification matters more than simply attaching the word *anejaculation* to every patient.

Psychosexual Therapy

When neurological or structural disease has been reasonably excluded and the patient has a situational or anorgasmic pattern, psychosexual therapy can be valuable.

Treatment can focus on reducing performance monitoring, improving arousal, addressing anxiety, changing problematic stimulation patterns, resolving relationship difficulties and helping partners communicate more effectively.

The 2026 International Consultation recommends psychosexual therapy or vibrator-assisted approaches in appropriate non-neurogenic anorgasmic anejaculation and severe delayed ejaculation.

This should never be interpreted as telling a patient that the problem is imaginary.

Sexual response depends on neurological and psychological processes working together.

Penile Vibratory Stimulation

Penile vibratory stimulation (PVS) uses specialized vibration to trigger the ejaculatory reflex.

It has an established role particularly in neurological ejaculatory dysfunction, including certain men with spinal cord injury.

The European Association of Urology recommends PVS as the first-line method for appropriate cases of anejaculation associated with neurological dysfunction, provided the required reflex pathways are intact.

The American Society for Reproductive Medicine has also described vibratory stimulation as a method of obtaining ejaculation in men with neurological injury and some other forms of ejaculatory failure.

It should be performed according to specialist advice, particularly in neurologically injured patients.

Electroejaculation

When PVS is unsuccessful or unsuitable, **electroejaculation** may be considered.

During electroejaculation, controlled electrical stimulation is applied through specialized equipment to stimulate structures involved in seminal emission.

European guidance identifies electroejaculation as an option when vibratory stimulation fails.

ASRM guidance notes that electroejaculation is generally performed in a specialist setting and may require anesthesia depending on neurological sensation.

Its main use is often reproductive: obtaining semen when natural ejaculation is not possible.

Sperm Retrieval and Assisted Reproduction

When ejaculation cannot be restored but the couple wishes to have a child, reproductive medicine may bypass the ejaculatory problem.

Depending upon sperm production and the couple's overall fertility profile, sperm obtained through masturbation where possible, penile vibratory stimulation, electroejaculation or surgical retrieval may be used for reproductive treatment.

Depending on semen quality and female factors, this can involve appropriately selected intrauterine insemination, IVF or intracytoplasmic sperm injection.



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The 2026 international recommendations provide a strong recommendation for assisted reproduction using sperm obtained through these routes when persistent anejaculation prevents natural conception.

Therefore, even severe anejaculation does not automatically mean that biological fatherhood is impossible.

Can Medicines Restore Ejaculation?

Medicines have a role in selected circumstances, but this is an area where patients need to be cautious.

Various sympathomimetic or other medications have been used in specific neurogenic and retrograde ejaculatory disorders. The evidence and effectiveness vary substantially according to the underlying mechanism.

These medicines can affect blood pressure, heart rate and other physiological functions. They should therefore not be taken on the basis of internet recommendations.

For non-neurogenic anorgasmic anejaculation and delayed ejaculation, contemporary literature notes that several medications have been investigated, but evidence is insufficient for a universally reliable pharmacological treatment.

A treatment that helps one type of ejaculation disorder may be inappropriate for another.

Anejaculation and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine** with focused work in sexual and reproductive health, I believe that one of the useful features of Unani clinical thinking is its emphasis on treating the individual rather than treating a single symptom in isolation.

The Central Council for Research in Unani Medicine describes the major therapeutic approaches of Unani medicine as **Ilaj-bil-Tadbir (regimental therapy)**, **Ilaj-bil-Ghiza (dietotherapy)**, **Ilaj-bil-Dawa (pharmacotherapy)** and **Ilaj-bil-Yad (surgical treatment)**.

Traditional Unani principles also emphasize **Izala-i-Sabab**, or removal/addressing of the causative factor, together with consideration of constitution, lifestyle and overall health. CCRUM describes this cause-oriented and holistic framework as part of classical Unani treatment principles.



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This concept is particularly relevant to anejaculation because the same symptom can result from many different causes.

How I Apply the Unani Principle of Treating the Cause

If a man's absent ejaculation is caused by diabetic neuropathy, the priority cannot simply be a medicine described as a sexual tonic.

If a prescribed antidepressant is responsible, the medication needs professional review.

If retrograde ejaculation is present, the mechanism needs to be identified.

If there is spinal cord injury, appropriate neurological and reproductive techniques become essential.

If the problem is predominantly psychosexual, counselling may have greater relevance than repeatedly changing medicines.

If general health factors such as poor sleep, chronic stress, unhealthy diet, inactivity and metabolic dysfunction are present, the Unani emphasis on lifestyle and individualized dietary/regimental care can be incorporated as supportive management.

This is consistent with the traditional Unani principle of addressing the underlying cause rather than merely suppressing a symptom.

Ilaj-bil-Ghiza: Diet and General Health

Unani medicine gives considerable importance to diet.

CCRUM describes **Ilaj-bil-Ghiza**, or dietotherapy, as an important component of maintaining and restoring health, with dietary selection traditionally individualized according to constitution, health status and other factors.

For a patient with anejaculation, appropriate nutrition may help improve general metabolic health, weight control and overall physical well-being, particularly when diabetes, obesity or nutritional problems coexist.

However, diet should be described accurately.

No particular food has been proven to restore ejaculation in a man whose problem is caused by severe nerve damage, anatomical obstruction or major neurological disease.

Nutrition is supportive care, not a substitute for diagnosis.



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Ilaj-bil-Tadbir and Lifestyle Management

Unani medicine also emphasizes regimental and lifestyle measures.

The Ministry of AYUSH describes the traditional **Asbab-e-Sitta Zarooriya**, or six essential factors of life, including air, food and drink, physical movement and rest, psychological activity and rest, sleep and wakefulness, and appropriate retention and elimination.

In modern practical terms, relevant aspects can include adequate sleep, regular physical activity, stress management, healthy weight, avoidance of excessive alcohol, appropriate dietary habits and management of chronic disease.

These measures can support sexual and reproductive health, although they should not be represented as a guaranteed cure for anejaculation.

Ilaj-bil-Dawa: Unani Pharmacotherapy

The Unani pharmacological tradition contains numerous herbal and compound preparations historically used for male sexual and reproductive complaints.

In my view, however, a responsible contemporary approach requires us to distinguish **traditional use** from **scientifically established treatment of anejaculation**.

At present, high-quality clinical evidence specifically demonstrating that a particular Unani herbal formulation reliably cures anejaculation is lacking.

Research into complementary and herbal approaches for male reproductive disorders continues, but a 2024 umbrella review concluded that the overall evidence for complementary and alternative therapies in male infertility remains limited and that many existing systematic reviews have methodological weaknesses.

Therefore, any Unani medicine used for a patient with anejaculation should be individualized, quality-controlled, compatible with the patient's conventional medication and used without delaying neurological, endocrine, urological or reproductive evaluation when indicated.

Where Unani Medicine May Be Most Useful

The greatest potential value of an integrative Unani approach in this condition is not to claim that one herbal formula can restore every absent ejaculation.

Its value is in **individualized supportive management**.



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For appropriate patients, Unani care can help structure attention to diet, sleep, stress, physical activity, metabolic health and general sexual well-being. When reversible contributing factors coexist, improving whole-body health can form part of the treatment plan.

But if the patient has spinal cord injury, severe autonomic nerve damage, ejaculatory-duct obstruction or another structural problem, he may require specialist urological or reproductive intervention.

Recognizing that limitation is part of responsible medicine.

The Saira Health Care Approach to Anejaculation

At **Saira Health Care**, I approach anejaculation from both the sexual-function and fertility perspectives.

The objective is not merely to ask whether semen is coming out. We need to determine why ejaculation is absent, whether orgasm is present, whether the problem is situational or complete, whether sperm production is preserved, whether retrograde ejaculation is occurring, and whether natural conception is currently being prevented.

The clinical approach may therefore combine sexual-history assessment, medication review, evaluation for diabetes and endocrine problems, reproductive assessment, semen or post-orgasm urine investigation where relevant, psychosexual counselling, lifestyle optimization and individualized Unani supportive care.

When the problem requires neurological evaluation, urological treatment, assisted reproduction or a specialist sperm-retrieval technique, appropriate referral should be considered rather than delaying definitive management.

This multidisciplinary philosophy is particularly important because sexual dysfunction and infertility frequently coexist. Current international recommendations specifically call for detailed sexual assessment within infertility care.

Special Attention to Couples Trying for Pregnancy

When a couple presents because pregnancy is not occurring, I believe both partners need to be considered.

For the male partner, this means asking not only about sperm count and motility but also about erection, intercourse, ejaculation and semen deposition.

A patient can have sperm in the testes and still be unable to achieve natural pregnancy because no semen reaches the vagina.

Conversely, retrieving sperm does not automatically solve the couple's fertility problem if significant female infertility is also present.

Therefore, fertility planning should consider **both the male and female partner simultaneously**.

Anejaculation After Marriage

Some patients first discover the problem after marriage because they had never previously attempted ejaculation during intercourse.

This can create tremendous emotional pressure.

The man may begin worrying about masculinity. The wife may assume that she is not attractive to him. Families may focus exclusively on pregnancy. Every sexual encounter may gradually become a fertility examination rather than an intimate experience.

This psychological pressure can make situational ejaculation even more difficult.

The correct approach is confidential assessment, reassurance that the condition has identifiable mechanisms, and systematic evaluation of both sexual and reproductive function.

Blame has no therapeutic value.

Anejaculation During the Fertile Window

Some men can ejaculate normally during most of the month but repeatedly develop erectile or ejaculation difficulty precisely when intercourse is scheduled around ovulation.

This is not imaginary.

The pressure of “today is the important day” can transform sexual activity into a performance test.

The 2026 International Consultation specifically recognizes this phenomenon in fertility care and discusses periovulatory anejaculation as a situational problem related to performance pressure.

For such couples, counselling can be just as important as laboratory investigation.

Can Anejaculation Be Cured?

The prognosis depends on the cause.



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Medication-related cases may improve if an appropriate medication change can safely be made. Psychosexual or situational cases may improve with therapy and modification of sexual-response patterns. Certain metabolic or endocrine causes may improve when the underlying condition is treated.

Neurological injury can be more difficult to reverse. In those cases, the goal may shift from restoring spontaneous ejaculation to enabling sperm collection and fertility treatment.

For this reason, I do not believe every patient should be promised a “100% permanent cure.”

A scientifically responsible treatment plan should give the patient a realistic explanation of what can and cannot be changed.

When Should a Man Seek Medical Advice?

Persistent absence of ejaculation deserves evaluation when it is new, distressing, affecting the relationship, associated with inability to orgasm, accompanied by erectile or neurological symptoms, occurs after pelvic or prostate surgery, begins after a new medication, or prevents pregnancy.

A man should also seek assessment if he repeatedly experiences orgasm without visible semen because retrograde ejaculation and other causes need to be distinguished.

Cleveland Clinic specifically recommends medical evaluation when anejaculation interferes with sexual well-being or the ability to have biological children.

What Patients Should Avoid

Patients should be especially cautious about assuming that absent semen automatically means low testosterone or infertility. They should not stop antidepressants or other prescribed medications without medical supervision, take testosterone merely to improve sexual performance, use unregulated sexual stimulants, or spend months taking random products without first establishing whether the problem is neurological, retrograde, psychosexual or anatomical.

For men interested in fertility, inappropriate testosterone use deserves particular emphasis because exogenous testosterone can suppress sperm production.

Accurate diagnosis usually saves more time than repeatedly changing medicines.



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A Message From Dr. Nizamuddin Qasmi

When a patient tells me, **“Doctor, I feel the climax but semen does not come out,”** my first response is that we need to identify the mechanism rather than immediately assume infertility.

When another patient says, **“I cannot reach orgasm and therefore I cannot ejaculate,”** that is a different clinical situation.

And when a third patient says, **“I can ejaculate during masturbation but never during intercourse,”** that again points us in another direction.

All three patients may use the same words—“semen does not come”—but they may require very different treatment.

That is why detailed, respectful sexual history is so important.

Anejaculation is not a statement about a man's masculinity. It is a sexual and reproductive-health condition that can arise from neurological, medical, medication-related, psychological and other causes.

When fertility is affected, modern reproductive techniques also mean that the inability to ejaculate normally does **not necessarily eliminate the possibility of biological fatherhood.**

My approach is therefore to combine careful diagnosis, modern sexual and reproductive-health knowledge, individualized counselling and responsible Unani supportive care, while arranging specialist intervention whenever the underlying cause requires it.

Dr. Nizamuddin Qasmi and Saira Health Care

Dr. Nizamuddin Qasmi is the **Founder & Chief Physician of Saira Health Care**, with a focused practice in **Sexual Disorders & Infertility**. Saira Health Care's current published professional profile lists his education and additional training as **BUMS – Hamdard University, Delhi; MD; CGO; Certificate in Infertility – MGBIMS, Delhi; Certificate in Urology – London, UK; Masters in Male Infertility – MasterHealthPro (HealthPro); and Integrated Sexual and Reproductive Health – ISRH, UNFPA.**

The clinic's published educational material describes an approach combining confidential sexual-health consultation, infertility assessment, patient education, appropriate modern investigation, individualized Unani supportive care and referral to psychological, urological, gynecological or other specialist services when required.

At Saira Health Care, an important contribution in the field of sexual disorders and infertility is therefore not simply providing treatment, but helping patients distinguish



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conditions such as **anejaculation, delayed ejaculation, retrograde ejaculation, anorgasmia, erectile dysfunction and male infertility**, so that treatment is directed toward the actual problem.

Frequently Asked Questions About Anejaculation

Can a man have an erection but not ejaculate?

Yes. Erection and ejaculation are different physiological processes. A man can have a satisfactory erection and still have anejaculation.

Can a man have an orgasm without semen coming out?

Yes. This may occur in orgasmic anejaculation or retrograde ejaculation, among other mechanisms. Further assessment may be needed to determine where the semen has gone and whether emission occurred.

Is anejaculation the same as azoospermia?

No. Azoospermia refers to absence of sperm in an ejaculate. Anejaculation refers to failure of normal ejaculation. A man with anejaculation may still produce sperm.

Is anejaculation the same as retrograde ejaculation?

No. In retrograde ejaculation, semen enters the bladder rather than coming out normally. In true anejaculation, the normal ejaculatory process is absent. Post-orgasm urine examination can help distinguish the conditions.

Can diabetes cause anejaculation?

Yes. Diabetic neuropathy can damage nerves responsible for ejaculation and is a recognized organic cause of serious ejaculatory dysfunction.

Can antidepressants cause it?

Certain antidepressants can interfere with orgasm and ejaculation. Patients should discuss sexual side effects with the prescribing clinician rather than discontinuing medication themselves.

Can a man with anejaculation become a biological father?

In many cases, yes. Depending on sperm production and the underlying cause, semen or sperm may sometimes be obtained through vibratory stimulation, electroejaculation or surgical sperm retrieval and used with fertility treatment.

Is penile vibratory stimulation effective?



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It is an established method particularly for selected neurological cases, especially spinal cord injury. European guidelines position it as first-line therapy for appropriate neurogenic anejaculation, with electroejaculation considered if it fails.

Can Unani medicine treat anejaculation?

Unani medicine can form part of individualized supportive care, particularly through diet, lifestyle, regimental therapy and carefully selected pharmacotherapy. However, scientific evidence proving a specific Unani medicine as a reliable cure for anejaculation is currently insufficient. Neurological, anatomical, medication-related and fertility causes must be appropriately investigated.

Conclusion

Anejaculation is a clinically important male sexual and reproductive disorder in which normal ejaculation is absent. It should not be confused with delayed ejaculation, anorgasmia, retrograde ejaculation or azoospermia.

Its causes range from spinal cord injury, diabetic neuropathy and neurological disease to surgery, medications, endocrine disorders and psychosexual factors. Diagnosis therefore requires more than asking whether semen appears after intercourse.

For men who wish to become fathers, the condition is particularly significant because persistent anejaculation prevents normal deposition of semen in the female reproductive tract. Nevertheless, modern reproductive medicine offers several routes to sperm acquisition—including penile vibratory stimulation, electroejaculation and surgical sperm retrieval—when appropriate.

The Unani system provides a useful holistic framework emphasizing identification of causes, individualized diet, lifestyle and supportive treatment. Its role should complement—not replace—appropriate neurological, endocrine, urological and fertility investigation. Official CCRUM material itself describes removal of the causative factor and individualized whole-person assessment as fundamental Unani treatment principles.

At **Saira Health Care**, the appropriate objective is therefore not simply to “increase semen discharge.” It is to understand the patient's sexual function, identify the mechanism of absent ejaculation, protect fertility where relevant, address reversible causes and develop an individualized treatment plan based on both responsible Unani principles and contemporary sexual and reproductive medicine.

For more information:

<https://www.sairahealthcare.com/>



+91-9452580944



+91-5248-359480



www.sairahealthcare.com



For appointment and consultation:

<https://www.sairahealthcare.com/Appointment.aspx>

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<https://pharmacy.sairahealthcare.com/>

Medical Disclaimer: This article is intended for general medical education and patient awareness. It does not replace an individualized examination, diagnosis or treatment plan. Patients should not start or stop prescription medicines, hormones, herbal preparations or supplements without appropriate professional advice. Persistent anejaculation—especially when associated with infertility, neurological disease, surgery or medication use—requires proper clinical evaluation.



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+91-5248-359480



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