

Medication-Induced Male Sexual Dysfunction

Causes, Symptoms, Diagnosis, Treatment, Fertility Effects and an Integrative Unani Approach

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Introduction

One question I frequently consider when evaluating a man with a new sexual problem is very simple:

“Did this difficulty start after you began a new medicine or after the dose of an existing medicine was increased?”

This question is important because medicines prescribed for otherwise completely unrelated illnesses can sometimes affect sexual desire, erection, ejaculation, orgasm, hormones or fertility.

A patient may have been sexually healthy for many years and then notice that his desire has reduced after starting an antidepressant. Another man may develop difficulty maintaining an erection after changes in cardiovascular treatment. Someone taking medication for an enlarged prostate may suddenly notice that little or no semen comes out during orgasm. A patient receiving long-term opioids may gradually develop low testosterone, reduced libido and erectile problems.

Collectively, these situations can fall under **medication-induced male sexual dysfunction**.

The 2026 European Association of Urology Sexual and Reproductive Health guideline recognizes several drug-related causes of male sexual dysfunction, including certain antidepressants, antipsychotics, antihypertensive medicines, antiandrogen therapies and 5-alpha-reductase inhibitors. The same guideline emphasizes that sexual



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dysfunction is frequently multifactorial; therefore, the medicine, the disease being treated, psychological factors and general health all need to be considered together.

One of the most important messages I give my patients is:

Never stop an important prescribed medicine suddenly because you think it is affecting your sexual function.

Many medication-related sexual problems can be managed successfully, but treatment should be coordinated with the doctor who prescribed the original medicine.

What Is Medication-Induced Male Sexual Dysfunction?

Medication-induced male sexual dysfunction means that a medicine contributes to a new sexual problem or significantly worsens a pre-existing one.

The medicine may affect one or several phases of sexual function:

- Sexual desire or libido
- Sexual arousal
- Penile erection
- Ejaculation
- Orgasm
- Semen emission
- Testosterone or other reproductive hormones
- Sperm production
- Fertility

Medication-related sexual dysfunction does **not** necessarily mean that the medicine is “bad.”

A medicine may be extremely important for treating depression, hypertension, psychosis, chronic pain, prostate disease, cancer or another serious condition while simultaneously producing an unwanted sexual side effect.

The clinical task is therefore to balance two goals:

Control the underlying disease and protect the patient's sexual and reproductive quality of life.



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Why Can Medicines Affect Sexual Function?

Sexual function is not controlled by one organ.

Normal male sexual response requires coordination between:

- The brain
- Spinal cord
- Autonomic nervous system
- Peripheral nerves
- Hormones
- Blood vessels
- Penile tissue
- Prostate and seminal tract
- Pelvic-floor muscles
- Psychological state
- Relationship circumstances

Medicines can interfere with any of these systems.

For example, a medicine may increase serotonin and consequently delay ejaculation. Another may reduce dopamine activity and therefore reduce sexual motivation. A drug can increase prolactin, which may interfere with testosterone signalling and libido. Some medicines alter sympathetic nervous-system activity and affect ejaculation. Others reduce androgen activity or interfere with sperm production.

This explains why medication-induced sexual dysfunction does not look the same in every patient.

What Sexual Problems Can Medicines Cause?

1. Reduced Sexual Desire

A man may notice that he thinks about sex less frequently, initiates sexual activity less often or no longer experiences his previous level of interest.

This may occur with certain antidepressants, antipsychotics, hormonal treatments, opioids and other medicines.



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However, low libido should never automatically be blamed on medication because **depression, anxiety, chronic disease, low testosterone, relationship difficulties, poor sleep and stress can produce the same symptom.**

The EAU guideline therefore recommends assessment of medical and sexual history, endocrine disorders and chronic therapies that may negatively affect desire.

2. Erectile Dysfunction

Some medicines can contribute to difficulty obtaining or maintaining an erection sufficiently firm for satisfactory sexual activity.

Medication-related ED is particularly relevant because many patients assume the problem is purely psychological or simply due to age.

Current EAU guidance includes drug-induced ED among recognized etiological categories and specifically mentions some antihypertensive agents, antidepressants, antipsychotics, antiandrogens and 5-alpha-reductase inhibitors.

At the same time, we must be careful with cause and effect.

A man taking blood-pressure medicine may have ED because of:

- The medicine,
- Hypertension itself,
- Diabetes,
- Vascular disease,
- Obesity,
- Smoking,
- Low testosterone,
- Anxiety,

or several of these factors together.

So merely seeing a drug name on the prescription does not establish the diagnosis.

3. Delayed Ejaculation

Certain medicines—particularly drugs that strongly influence serotonin—can make ejaculation substantially slower.

Some men taking antidepressants describe intercourse lasting much longer than previously. Others eventually lose their erection before ejaculation occurs because the stimulation continues for such a long period.

Both American and European sexual-medicine guidelines recognize medication as an important cause of delayed ejaculation, especially SSRIs and other centrally acting drugs.

4. Anejaculation

In some patients, ejaculation may disappear completely.

A man may experience sexual stimulation and even orgasm but notice that no semen comes out.

Medicines affecting serotonin, sympathetic pathways or the lower urinary tract can contribute to this type of problem.

However, anejaculation must be distinguished from retrograde ejaculation and anorgasmia because these are different physiological problems.

5. Difficulty Reaching Orgasm

Some medicines can make orgasm much harder to reach or prevent orgasm entirely.

A man might maintain a good erection yet be unable to reach climax.

SSRIs are particularly well known for producing delayed or absent orgasm in some individuals. Mayo Clinic lists decreased sexual desire, difficulty reaching orgasm and erectile problems among recognized SSRI sexual adverse effects.

6. Reduced or Absent Semen During Ejaculation

Some medicines used for urinary symptoms and enlarged prostate affect the emission phase of ejaculation.

The man may feel orgasm but notice a major reduction in ejaculatory volume or no visible semen.

This is particularly relevant with certain selective alpha-1 blockers.

The current EAU guideline for male lower urinary tract symptoms states that alpha-blockers can cause abnormal ejaculation and that the risk is especially notable with

tamsulosin and silodosin; sexual desire and erectile function are generally not affected in the same way.

This distinction is important.

A medicine can affect ejaculation without actually causing erectile dysfunction.

7. Hormonal Sexual Dysfunction

Some medications alter testosterone, prolactin or the hypothalamic-pituitary-gonadal axis.

The consequences can include:

- Reduced sexual desire
- Erectile dysfunction
- Reduced spontaneous erections
- Fatigue
- Reduced sperm production
- Testicular changes
- Infertility

Long-term opioid therapy is an important example. Opioids can suppress gonadotropin-releasing hormone and consequently reduce androgen production. A recent review reported wide variation in the prevalence of opioid-induced androgen deficiency because risk depends upon the specific opioid, duration, dose, population and definition used.

8. Effects on Fertility

Sexual function and fertility are connected, but they are not the same thing.

A medicine may affect fertility by:

- Suppressing sperm production
- Reducing sperm concentration or motility
- Preventing ejaculation
- Reducing semen volume
- Lowering testosterone within the testes



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- Causing erectile problems severe enough to prevent intercourse

For example, externally administered testosterone can improve symptoms of hypogonadism in selected men but suppress the hormonal signals necessary for spermatogenesis.

The current EAU male-infertility guideline states that **testosterone therapy should not be used to treat male infertility** and is contraindicated when preserving fertility is the objective.

This is why fertility plans must be discussed before starting hormonal sexual-health treatments.

Common Medicines Associated With Male Sexual Dysfunction

The following table provides a practical overview. It should not be interpreted to mean that every patient taking these medicines will develop sexual problems.

Medication group	Possible sexual effects
SSRIs	Reduced libido, delayed ejaculation, anorgasmia, anejaculation, sometimes ED
SNRIs	Delayed orgasm/ejaculation, decreased libido, erectile difficulties
Tricyclic antidepressants	Libido, erection and orgasm/ejaculation problems
Antipsychotics	Reduced libido, ED, orgasmic difficulties, prolactin-related hormonal effects
Some beta-blockers	Erectile problems in susceptible patients
Centrally acting antihypertensives	Reduced libido or ED
Some diuretics	Possible erectile effects; evidence varies
Alpha-blockers for LUTS/BPH	Reduced or absent ejaculation, particularly some selective agents
Finasteride/dutasteride	Reduced libido, ED, ejaculation changes in a subset of men



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Medication group	Possible sexual effects
Opioids	Reduced testosterone, libido and erectile function; possible fertility effects
Antiandrogen/cancer hormonal therapy	Marked reduction in libido and erectile function
Exogenous testosterone/anabolic steroids	Suppressed sperm production and fertility
Some anticonvulsant/CNS-active drugs	Libido, erectile or orgasmic problems in selected patients
Certain chemotherapy treatments	Hormonal, erectile and fertility effects depending on the agent

This is not a complete list. Sexual adverse effects vary considerably between individual medicines, doses and patients.

Antidepressants and Male Sexual Dysfunction

Antidepressant-related sexual dysfunction deserves particular attention because it is one of the best-recognized forms of medication-induced sexual dysfunction.

SSRIs

Selective serotonin reuptake inhibitors include drugs such as:

- Sertraline
- Fluoxetine
- Paroxetine
- Citalopram
- Escitalopram

They are widely prescribed for depression, anxiety disorders and several other psychiatric conditions.

Increasing serotonin can improve mood and anxiety, but serotonin also influences sexual pathways.

Some patients may consequently experience:

- Reduced desire



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- Difficulty maintaining arousal
- Erectile dysfunction
- Delayed ejaculation
- Anejaculation
- Delayed orgasm
- Anorgasmia

This effect on ejaculation is so well established that SSRIs are also deliberately used to **delay ejaculation in premature ejaculation treatment**. The 2026 EAU guideline notes both their therapeutic effect in PE and recognized adverse effects including decreased libido, anorgasmia, anejaculation and ED.

In other words, the same pharmacological effect can be helpful for one patient and troublesome for another.

Does Every Antidepressant Carry the Same Risk?

No.

The risk varies between drugs, dose, individual biology and the underlying psychiatric condition.

A 2024 clinical review emphasizes that treatment-emergent sexual dysfunction is a major issue with antidepressants and can influence treatment adherence. Management options discussed in the literature include careful observation, dose modification, switching medication and selected add-on treatments, but each strategy has advantages and risks.

Mayo Clinic notes that some antidepressants, including **bupropion, mirtazapine, vilazodone and vortioxetine**, tend to have lower rates of sexual adverse effects than strongly serotonergic antidepressants, although individual responses vary.

Switching antidepressants is a psychiatric treatment decision and should not be attempted without the prescribing clinician.

Should a Patient Take an “Antidepressant Holiday”?

Patients sometimes hear online that they should simply skip antidepressant tablets before sexual activity.

I do **not** advise patients to do this independently.



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Interrupting psychiatric medication can result in:

- Withdrawal symptoms
- Recurrence of depression
- Anxiety
- Mood destabilization
- Reduced treatment effectiveness

Any dosing strategy must be determined by the treating psychiatrist or physician.

Can Sexual Problems Continue After Stopping an SSRI?

Persistent sexual symptoms after SSRI discontinuation have been reported in the medical literature.

A systematic review found evidence describing sexual dysfunction after SSRI discontinuation but concluded that available research does not allow a reliable estimate of how commonly it occurs.

Therefore, persistent symptoms should be taken seriously, but it would be scientifically incorrect to assume that every continuing sexual problem after an SSRI was necessarily caused permanently by that medicine.

Other medical and psychological explanations should also be investigated.

Antipsychotic Medicines and Sexual Dysfunction

Antipsychotic medicines may influence male sexuality through several pathways.

Some block dopamine receptors and increase **prolactin**.

High prolactin can interfere with reproductive hormones and may contribute to:

- Reduced sexual desire
- Erectile dysfunction
- Reduced testosterone
- Fertility problems
- Occasionally breast-related symptoms

In addition, antipsychotics may affect sexual function through sedation, autonomic effects, serotonin pathways and psychological factors.



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A recent analysis of the WHO pharmacovigilance database found reports of erectile dysfunction and other sexual adverse events across antipsychotic classes, although such spontaneous-report data cannot by itself prove that the drug caused every event.

When sexual dysfunction develops during antipsychotic treatment, the correct response is **not to stop the medication abruptly**.

Depending upon the psychiatric diagnosis, the prescribing psychiatrist may consider dosage, prolactin level, alternative medicines or other management strategies.

Blood Pressure Medicines and Erectile Dysfunction

This is an area where misinformation is common.

Patients sometimes stop their antihypertensive medicine because they believe every blood-pressure tablet causes ED.

That can be dangerous.

Hypertension itself is an important risk factor for erectile dysfunction because healthy erections depend upon healthy blood vessels.

A 2025 review found that centrally acting antihypertensive agents have a clearer negative association with erectile function and that beta-blockers remain one of the classes most frequently associated with ED, although differences exist between individual beta-blockers. The same review found generally neutral or potentially favorable effects with several newer cardiovascular drug classes and noted that the older belief regarding thiazide-associated ED is less clear in contemporary evidence.

The important lesson is:

Do not assume that all antihypertensive medicines have the same sexual effects.

A doctor should evaluate both the medication and the vascular disease.

Beta-Blockers

Beta-blockers are extremely useful medications used for conditions such as hypertension, heart disease, heart-rate control and certain arrhythmias.

Some have been associated with erectile problems.

However, the relationship is not identical for every beta-blocker, and psychological expectation can also influence sexual performance.



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Therefore, switching medicines purely because of fear without medical supervision is inappropriate.

ACE Inhibitors, ARBs and Calcium-Channel Blockers

Current evidence generally suggests that ACE inhibitors, angiotensin-receptor blockers and calcium-channel blockers have more neutral sexual profiles than some older cardiovascular therapies.

Some studies even suggest that particular renin-angiotensin system drugs may have favorable effects on erectile physiology, although they should never be prescribed solely as sexual-performance treatments without a cardiovascular indication.

Prostate Medicines and Ejaculatory Dysfunction

This is one of the clearest examples of why patients need to describe exactly **which sexual function has changed**.

Alpha-Blockers

Medicines such as tamsulosin and silodosin are commonly prescribed for lower urinary tract symptoms related to benign prostate enlargement.

They can improve urinary flow but may significantly reduce semen emission in some men.

Current EAU evidence states that ejaculatory dysfunction is considerably more common with alpha-blockers than placebo and especially with more selective medicines such as tamsulosin and silodosin.

Patients should be informed about this effect, particularly younger men and men trying to conceive.

Finasteride and Dutasteride

Finasteride and dutasteride inhibit 5-alpha reductase and reduce conversion of testosterone to dihydrotestosterone.

They are used for conditions such as:

- Benign prostate enlargement
- Male-pattern hair loss



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Clinical literature has associated these medicines with sexual adverse effects in a subset of men, including:

- Reduced libido
- Erectile dysfunction
- Ejaculatory changes

A recent review also examined possible effects on semen parameters and reproductive health, emphasizing the importance of counseling men of reproductive age.

This does not mean that every man taking finasteride or dutasteride will develop these problems.

The therapeutic benefit and individual risk should be evaluated together.

Opioid Pain Medicines

Long-term opioid use can interfere with the hypothalamic-pituitary-gonadal axis.

This can reduce testosterone production.

A patient may gradually develop:

- Loss of libido
- Erectile dysfunction
- Fatigue
- Reduced vitality
- Reduced fertility

A 2025 review reported that opioid-induced androgen deficiency is well recognized, although reported prevalence varies widely depending on the opioid, exposure and population.

When symptoms suggest hormonal suppression, appropriately selected hormonal testing may be indicated.

But opioid treatment should never be stopped suddenly without medical supervision.

Testosterone, Anabolic Steroids and the Fertility Paradox

This subject is extremely important in my infertility practice.

A man may believe:

“Testosterone is the male hormone, therefore taking testosterone should improve my fertility.”

In reality, externally administered testosterone can suppress LH and FSH signals from the brain and consequently reduce testosterone concentration inside the testes, where very high local testosterone levels are required for sperm production.

The result can be severe suppression of spermatogenesis and occasionally azoospermia.

The 2026 EAU male-infertility guideline specifically recommends against testosterone therapy for treating male infertility and recommends withdrawal of anabolic steroids in infertile men before considering fertility-restoring hormonal approaches.

Therefore, men planning children should always tell their doctor before starting testosterone or anabolic hormones.

Medication-Induced Sexual Dysfunction and Male Infertility

Sexual dysfunction and infertility frequently overlap.

Suppose a man's sperm production is normal but an antidepressant produces severe anejaculation.

Natural conception can become difficult because semen is not deposited in the vagina.

In another patient, intercourse remains normal but anabolic steroids suppress sperm production.

Both men may present with infertility, but the mechanism is completely different.

This is why at Saira Health Care I believe that male infertility assessment should include not only semen analysis, but also questions about:

- Libido
- Erectile function
- Ejaculation
- Orgasm
- Medications
- Hormonal treatments
- Gym or bodybuilding steroids
- Chronic pain medicines



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- Psychiatric treatment

A semen report alone cannot provide the complete sexual and reproductive history.

How Do I Suspect That a Medicine Is Responsible?

Medication-induced sexual dysfunction is often a **clinical diagnosis** rather than something that appears on one laboratory test.

Important clues include:

Sexual function was normal before treatment

If the patient reports normal function before a drug was introduced, the temporal relationship becomes relevant.

Symptoms appeared after starting a medicine

For example:

“My ejaculation was normal until two weeks after the antidepressant was started.”

That history deserves attention.

The problem became worse after a dose increase

Dose-response relationships can sometimes provide another clue.

Several sexual functions changed together

For example, lower libido plus erectile difficulty and delayed orgasm after initiating a centrally acting medication may strengthen suspicion.

Other causes are absent

Diabetes, vascular disease, depression, low testosterone and relationship stress must still be considered.

Why Diagnosis Can Be Difficult

Suppose a patient develops erectile dysfunction after starting an antidepressant.

The medicine may be responsible.

But depression itself can also produce:

- Low libido
- Erectile difficulty



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- Reduced pleasure
- Fatigue
- Low self-confidence

Similarly, a man taking antihypertensive medicine may have ED because of underlying vascular disease rather than the drug.

This is called **confounding by the underlying disease**.

Therefore, responsible diagnosis requires more than asking, “Is this drug known to cause ED?”

We must ask:

“What was the patient's sexual function before the disease and before the medicine?”

How I Evaluate Medication-Induced Male Sexual Dysfunction

When a patient consults me at Saira Health Care with suspected medicine-related sexual dysfunction, I believe the assessment should be structured.

Step 1: Identify the Exact Sexual Problem

I first determine whether the main complaint is:

- Loss of libido
- Erectile dysfunction
- Premature ejaculation
- Delayed ejaculation
- Anejaculation
- Reduced semen volume
- Delayed orgasm
- Anorgasmia
- Infertility

The words “sexual weakness” are not sufficiently specific for diagnosis.

Step 2: Establish the Timeline



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I ask:

- When did the symptom begin?
- What medicines were started before that?
- Was a dose recently increased?
- Was another drug added?
- Was sexual function normal previously?
- Has the patient ever experienced this problem without the medication?

Timeline can be one of the most valuable diagnostic clues.

Step 3: Review Every Medicine

A proper medication review should include:

- Prescription medicines
- Over-the-counter medicines
- Herbal products
- Supplements
- Hormonal products
- Bodybuilding products
- Recreational drugs
- Alcohol

Patients sometimes forget to mention hair-loss tablets, pain medicines or bodybuilding hormones because they do not consider them “medical treatment.”

They may be highly relevant.

Step 4: Assess General Health

The patient should also be evaluated for other common causes of sexual dysfunction, including:

- Diabetes
- Hypertension
- Cardiovascular disease



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- Obesity
- Dyslipidemia
- Thyroid disease
- Testosterone deficiency
- Hyperprolactinemia
- Neurological disease
- Depression
- Anxiety
- Poor sleep
- Smoking
- Excessive alcohol use

The EAU recommends glucose, lipid assessment and testosterone testing where appropriate during ED evaluation because reversible metabolic and hormonal factors should not be missed.

Step 5: Focused Laboratory Testing

Tests are selected according to the symptoms rather than ordering every possible test.

These may include:

- Fasting blood glucose or HbA1c
- Lipid profile
- Morning total testosterone
- Prolactin when clinically indicated
- Thyroid function when appropriate
- Liver or kidney tests depending upon medication and health status

If fertility is a concern, semen analysis may also be required.

Step 6: Evaluate Psychological and Relationship Factors

Sexual side effects can create a secondary psychological problem.

For example:



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A medicine initially causes mild erectile difficulty.

The patient becomes frightened.

During the next encounter he monitors his erection continuously.

Performance anxiety develops.

Eventually the psychological component becomes stronger than the original medication effect.

Therefore, even when medication initiated the problem, sexual counselling may still be useful.

Management of Medication-Induced Sexual Dysfunction

Treatment should be individualized.

There is no single “antidote” suitable for every medication.

Rule No. 1: Do Not Stop Essential Medicines Yourself

This is the most important principle.

Suddenly stopping medicines for:

- Depression
- Anxiety
- Psychosis
- Epilepsy
- Hypertension
- Heart disease
- Chronic pain

may cause serious consequences.

The AUA/SMSNA guideline specifically advises that decisions about stopping, reducing or substituting medicines contributing to delayed ejaculation should involve the prescribing clinician and careful consideration of risks and benefits.

Medication Review With the Prescribing Doctor



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When the connection between a medication and sexual dysfunction appears likely, possible strategies can include:

- Continued observation if symptoms are mild
- Dose adjustment
- Changing the time of administration
- Switching to another medication
- Treating the sexual symptom directly
- Managing an associated hormonal abnormality

The correct choice depends on the reason the medicine was prescribed.

A psychiatrist may approach an antidepressant differently from how a cardiologist approaches antihypertensive treatment.

Switching to a Lower-Risk Medicine

In some circumstances, another drug within or outside the same therapeutic class may have fewer sexual adverse effects.

For example, some antidepressants have lower reported rates of sexual dysfunction than strongly serotonergic agents.

Similarly, antihypertensive agents differ in their effect on erectile function.

Prostate medicines also differ in their tendency to impair ejaculation.

However, medication switching requires professional supervision.

Treating Medication-Associated Erectile Dysfunction

If changing the responsible drug is not possible or does not fully restore erections, the ED itself can be treated.

The EAU guideline recommends **PDE5 inhibitors as first-line pharmacological treatment for erectile dysfunction** when clinically appropriate.

These include medications such as sildenafil and tadalafil.

However, these medicines require medical assessment.



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They can be dangerous with nitrate medicines used for angina because the combination can produce severe hypotension. Mayo Clinic likewise warns that PDE5 inhibitors may be unsafe with nitrates and in certain serious cardiovascular circumstances.

Therefore, patients should not self-prescribe ED tablets simply because another medicine has affected sexual function.

Management of Antidepressant-Associated Sexual Dysfunction

Depending on psychiatric stability and the individual case, professional management may include:

- Waiting briefly to see whether the adverse effect improves
- Adjusting the antidepressant dose
- Switching antidepressants
- Adding another medicine
- Treating associated ED with a PDE5 inhibitor
- Psychosexual counselling

A review of antidepressant-associated sexual dysfunction recommends a multidisciplinary approach because the objective is to reduce sexual adverse effects **without losing control of depression or anxiety.**

This balance is essential.

Treating Hormonal Abnormalities

If medication has caused genuine endocrine dysfunction, treatment should address that problem.

For example, antipsychotic-associated hyperprolactinemia may require psychiatric and endocrine review.

Opioid-associated hypogonadism may need reassessment of pain management and endocrine status.

However, testosterone should not automatically be prescribed simply because libido is reduced.

Hormonal treatment requires biochemical confirmation and consideration of fertility goals.



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Sexual Counselling and Couple Support

A medication side effect can influence both partners.

The patient may believe:

“I am no longer capable.”

The partner may incorrectly believe:

“He is no longer attracted to me.”

This can create avoidable relationship conflict.

Explaining that a medication can affect erection, ejaculation or orgasm frequently reduces blame.

Psychosexual counselling can also address:

- Performance anxiety
- Loss of confidence
- Communication
- Changed stimulation requirements
- Relationship stress
- Fertility-related sexual pressure

Sexual treatment should focus not merely on a laboratory result but on restoring satisfactory, comfortable intimacy.

Medication-Induced Sexual Dysfunction and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine** and focused on sexual disorders and infertility, I find one traditional Unani principle especially relevant to medication-induced sexual dysfunction:

Izala-i-Sabab — Addressing the Causative Factor

CCRUM describes **removal or correction of the causative factor (Izala-i-Sabab)** as one of the fundamental principles of Unani treatment.

In medication-induced sexual dysfunction, this concept is highly relevant.

But it must be applied responsibly.

“Removing the cause” does **not** mean abruptly stopping an essential modern medicine.

It means identifying:

- Which medication may be responsible,
- Why the patient needs it,
- Whether an alternative exists,
- Whether the dose can safely be modified,
- Whether the sexual problem can be treated separately.

This is a good example of how traditional cause-oriented medical thinking can be used alongside contemporary pharmacology.

The Four Main Therapeutic Approaches in Unani Medicine

The Central Council for Research in Unani Medicine describes four principal therapeutic approaches:

- **Ilaj-bil-Ghiza — Dietotherapy**
- **Ilaj-bil-Tadbir — Regimental therapy**
- **Ilaj-bil-Dawa — Pharmacotherapy**
- **Ilaj-bil-Yad — Surgery, where indicated**

For medication-related sexual problems, the first three may have supportive relevance in carefully selected patients, while conventional specialist intervention remains essential when structural, neurological or endocrine disease is present.

Ilaj-bil-Ghiza — Dietotherapy

A balanced diet cannot neutralize every medication side effect, but it can improve the background health upon which sexual function depends.

Particular attention may be given to:

- Healthy body weight
- Adequate protein
- Vegetables
- Fruits



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- Whole grains
- Nuts and seeds
- Appropriate healthy fats
- Adequate micronutrients
- Reduction of excessive processed foods
- Metabolic control in diabetes
- Appropriate salt intake in hypertension

The Unani system traditionally considers diet an important therapeutic component and individualizes dietary advice according to the patient's constitution and health status.

However, diet should be viewed as supportive care.

A particular food cannot reverse a drug-induced hormonal or neurological effect in every patient.

Ilaj-bil-Tadbir — Regimental and Lifestyle Care

The Ministry of AYUSH describes Unani health maintenance around the **Asbab-e-Sitta Zarooriya**, or six essential factors, which include air, food and drink, physical activity and rest, psychological activity and rest, sleep and wakefulness, and appropriate retention and elimination.

In modern clinical terms, relevant lifestyle measures may include:

- Regular exercise
- Sufficient sleep
- Stress reduction
- Weight management
- Smoking cessation
- Limiting excessive alcohol
- Improving metabolic health
- Appropriate sexual counselling

These factors are particularly important because medication-induced dysfunction often exists alongside vascular, hormonal or psychological risks.



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Ilaj-bil-Dawa — Unani Pharmacotherapy

The Unani pharmacological tradition includes herbal and compound formulations used historically for various sexual and reproductive complaints.

At Saira Health Care, I believe these medicines should be selected **only after the cause of dysfunction has been identified.**

A patient with SSRI-induced delayed ejaculation does not necessarily require the same approach as a patient with beta-blocker-associated ED.

Likewise:

- Low libido is not the same as ED.
- ED is not the same as delayed ejaculation.
- Delayed ejaculation is not the same as anejaculation.
- Reduced semen volume is not the same as azoospermia.

The clinical diagnosis should come first.

Can Unani Medicine Reverse Medication-Induced Sexual Dysfunction?

This question requires a scientifically responsible answer.

Unani treatment may have a useful **supportive and individualized role**, particularly in improving general health, diet, lifestyle, stress, sleep, metabolic function and overall sexual well-being.

However, high-quality clinical evidence specifically demonstrating that a particular Unani formulation reliably reverses medication-induced male sexual dysfunction is limited.

Therefore, I do not consider it appropriate to tell every patient:

“Take this herbal medicine and continue everything else; the problem will definitely disappear.”

Responsible integrative practice means combining traditional therapeutic principles with modern pharmacology and diagnosis.

Herbal Medicines Can Also Interact With Prescription Drugs

“Natural” does not automatically mean “interaction-free.”

Herbal products can potentially affect:



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- Blood pressure
- Blood glucose
- Sedation
- Bleeding tendency
- Liver enzymes
- Metabolism of prescription medicines

Therefore, patients taking psychiatric medicines, cardiovascular drugs, anticoagulants, diabetes medicines or several medicines together should disclose all herbal preparations and supplements to their healthcare providers.

CCRUM itself maintains drug-standardization programs addressing quality, manufacturing standards, heavy metals, microbial contamination, aflatoxins and pesticide residues in Unani medicines—illustrating why medicine quality and standardization matter.

My Approach at Saira Health Care

When a patient comes to me saying:

“Doctor, I was fine before this medicine, but now my sexual function has changed,”

I do not begin by assuming that the drug must be stopped.

I first try to answer five questions:

1. What sexual function is actually disturbed?

Is it libido, erection, ejaculation, orgasm or fertility?

2. Did the problem truly begin after medication exposure?

Timing matters.

3. Could the underlying disease itself be causing the problem?

Depression, hypertension, diabetes and chronic pain are themselves associated with sexual dysfunction.

4. Can the responsible medicine be safely modified?

That decision should involve the prescribing physician.

5. What supportive treatment will benefit this particular patient?



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Depending upon the findings, this may include sexual counselling, lifestyle correction, metabolic management, fertility evaluation, evidence-based treatment of ED and individualized Unani supportive therapy.

This is what I consider a rational integrative approach.

The Saira Health Care Contribution to Sexual Disorders and Infertility Care

At **Saira Health Care**, our focus in sexual-health practice is to help patients understand that sexual dysfunction is often a **medical condition with identifiable biological, psychological, relationship and medication-related causes**.

Patients frequently arrive after using multiple sexual-performance products without ever having their medication list reviewed.

A man may have been treated repeatedly for “sexual weakness” even though the major cause was an antidepressant.

Another may be taking testosterone while trying to achieve pregnancy, unaware that testosterone may suppress sperm production.

Another patient may believe that he has retrograde ejaculation when the actual problem is reduced seminal emission from a prostate medicine.

Careful differentiation of these disorders is an important part of responsible sexual and infertility practice.

At Saira Health Care, the objective should therefore be to integrate:

- Detailed sexual history
- Medication review
- Male infertility assessment where needed
- Relevant laboratory investigation
- Psychological and relationship assessment
- Lifestyle modification
- Appropriate modern medical treatment
- Individualized Unani supportive care

rather than treating every sexual complaint with the same medicine.

Medication-Related Sexual Dysfunction in Men Trying for Pregnancy

This deserves a separate discussion.

When a couple is trying for pregnancy, I ask about medications before making a fertility plan.

Some medicines can affect:

- Sexual frequency
- Penetrative intercourse
- Ejaculation
- Semen deposition
- Hormonal production
- Spermatogenesis

For example, a man may have reasonable sperm production but develop severe delayed ejaculation after an antidepressant.

Another man may have normal erections but greatly reduced semen emission because of an alpha-blocker.

Another may have excellent sexual performance but very poor sperm production because of anabolic steroids or external testosterone.

All three require different strategies.

Sexual Dysfunction Does Not Mean Masculinity Has Been Lost

This is another point I strongly emphasize.

A medicine-induced sexual problem does not mean that a patient is weak, less masculine or permanently incapable of satisfying his partner.

Sexual function is biological.

If a drug alters serotonin, dopamine, sympathetic pathways, prolactin, testosterone or penile blood flow, sexual response may change.

Understanding this biological mechanism can remove unnecessary shame.

When Should a Patient Seek Medical Advice?

Professional evaluation is particularly appropriate when:

- Sexual function changed after starting a medicine.



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- Symptoms appeared after increasing a dose.
- Erectile dysfunction persists.
- Ejaculation has become extremely delayed or absent.
- Orgasm cannot be achieved.
- Libido has fallen markedly.
- Very little or no semen appears.
- The couple is trying unsuccessfully for pregnancy.
- Symptoms are affecting medication adherence.
- The patient is considering stopping an important medicine.
- Hormonal symptoms such as loss of body hair, marked fatigue or testicular change are also present.

Important Warning: Priapism

Rarely, medications can contribute to **priapism**, meaning a prolonged erection that does not resolve normally.

An erection lasting around four hours or more—especially when painful—is a medical emergency because prolonged ischemia can permanently damage erectile tissue.

A patient should seek emergency medical care rather than waiting for a clinic appointment.

What Patients Should Not Do

I strongly discourage several common practices:

- Do not abruptly stop antidepressants.
- Do not stop blood-pressure medicine yourself.
- Do not discontinue antipsychotic treatment without psychiatric advice.
- Do not begin testosterone merely because libido is low.
- Do not take bodybuilding steroids while planning fertility.
- Do not combine ED medicines with nitrate drugs.
- Do not assume every sexual problem is caused by the newest medication.



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- Do not take unknown “sex-power” supplements alongside prescription medicine.
- Do not hide sexual side effects from the prescribing doctor.

Sexual adverse effects are legitimate medical concerns.

Patients should feel comfortable reporting them.

Can Medication-Induced Male Sexual Dysfunction Be Reversed?

Often, improvement is possible.

The outlook depends upon:

- The medication involved
- Duration of treatment
- Dose
- Underlying disease
- Patient age
- Vascular health
- Hormonal health
- Psychological factors
- Whether medication can safely be changed

Some symptoms improve after dose modification or substitution.

Others require treatment of ED, hormonal abnormalities or psychological consequences.

In selected patients, the original medication cannot be changed because it is essential. In that situation, treatment focuses on minimizing the sexual side effect while maintaining control of the primary disease.

A guaranteed recovery should never be promised before the cause is understood.

Frequently Asked Questions

Can antidepressants cause erectile dysfunction?



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Yes. Certain antidepressants—particularly serotonergic medicines—can cause reduced libido, erection difficulty, delayed orgasm or delayed ejaculation in some men.

Which antidepressants are most likely to cause sexual problems?

Strongly serotonergic antidepressants, particularly SSRIs, are among the most commonly associated groups. Individual risk differs substantially between medicines and patients.

Should I stop my antidepressant?

No. Speak with your prescribing clinician. Abrupt withdrawal can produce discontinuation symptoms and recurrence of psychiatric illness.

Can blood-pressure medicine cause ED?

Certain agents may contribute, particularly some beta-blockers and centrally acting therapies, but hypertension itself is also a major cause of ED. Modern evidence shows substantial differences between antihypertensive classes.

Can tamsulosin affect ejaculation?

Yes. Alpha-blockers such as tamsulosin—and especially silodosin—can reduce or prevent normal semen emission in some men.

Can finasteride cause sexual side effects?

Sexual adverse effects including reduced libido, ED and ejaculatory changes have been reported with finasteride and dutasteride in a subset of patients.

Can opioids reduce testosterone?

Yes. Long-term opioid exposure can suppress the reproductive hormonal axis and contribute to low testosterone in some men.

Can testosterone injections cause infertility?

Yes. External testosterone can suppress sperm production. Men actively trying to conceive should not use testosterone as a fertility treatment.

Can medicines cause delayed ejaculation?

Yes. SSRIs, SNRIs, tricyclic antidepressants, opioids and several centrally acting agents can contribute to delayed ejaculation.

Can ED medicines treat medication-induced ED?

PDE5 inhibitors can be useful in appropriately selected men, but suitability depends on cardiovascular health and other medicines. They must not be combined with nitrates.

Can Unani treatment be used?



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An individualized Unani approach may be used as supportive treatment after proper assessment, particularly through diet, lifestyle, regimental care and appropriately selected pharmacotherapy. However, the offending medicine and underlying disease must also be addressed, and essential prescription medication should never be stopped solely to begin Unani treatment.

A Message to Patients From Dr. Nizamuddin Qasmi

When a patient tells me:

“Doctor, this problem started only after my medicine was changed,”

I take that history seriously.

But I also explain that we must not immediately blame the medicine.

We should examine the whole picture.

Was the patient depressed before the antidepressant?

Was his blood pressure already damaging the vascular system?

Does he have diabetes?

Has testosterone become low?

Is prolactin elevated?

Is a prostate medicine reducing semen rather than causing true erectile dysfunction?

Is performance anxiety now maintaining a problem that originally began as a medication side effect?

Only after answering these questions can we create a rational treatment plan.

I strongly believe that patients should not have to choose between treating an important disease and maintaining their sexual health whenever a safe alternative is available.

The objective is to work intelligently with the prescribing physician, identify reversible factors and preserve both overall health and quality of life.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

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CGO

Certificate in Infertility, MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility by MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health (ISRH, UNFPA)

Dr. Nizamuddin Qasmi's clinical focus at Saira Health Care includes sexual disorders, male reproductive health, infertility, erectile dysfunction, ejaculatory disorders, sexual counselling and individualized Unani approaches to sexual and reproductive well-being.

Conclusion

Medication-Induced Male Sexual Dysfunction is an important but frequently overlooked cause of low libido, erectile dysfunction, delayed ejaculation, anejaculation, orgasmic problems, reduced semen emission and fertility difficulties.

The medicines most commonly relevant include certain **antidepressants, antipsychotics, antihypertensives, prostate medicines, 5-alpha-reductase inhibitors, opioids, hormonal therapies and external androgens**, although risk differs greatly between individual drugs and patients. Contemporary sexual-medicine guidelines recognize drug-related sexual dysfunction as an important and potentially modifiable contributor.

Correct treatment begins with identifying the precise sexual problem, examining its timing relative to medication exposure, investigating other causes and communicating with the physician responsible for the original prescription.

From the Unani perspective, the principle of **Izala-i-Sabab—addressing the causative factor—** fits naturally with this approach, while **Ilaj-bil-Ghiza, Ilaj-bil-Tadbir and individualized Ilaj-bil-Dawa** may support general health and sexual well-being when used appropriately. Official CCRUM sources emphasize cause-oriented, individualized and holistic treatment within the Unani framework.

At **Saira Health Care**, the appropriate goal is not simply to prescribe another sexual medicine to counteract every side effect. It is to identify the true mechanism, protect treatment of the underlying disease, preserve fertility when relevant, support psychological and relationship well-being, and develop an individualized plan using responsible modern and Unani principles.

Medical Disclaimer: This article is intended for professional patient education and general health awareness. It does not replace individual medical examination, diagnosis or treatment. Never stop or change antidepressants, antipsychotics, blood-pressure medicines, pain medicines, hormonal therapies or other prescription medications without consulting the clinician responsible for your treatment. Herbal or



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Unani medicines should also be reviewed for possible interactions with existing medicines.