Decreased Morning Erection: Causes, Relationship With Erectile Dysfunction, Low Testosterone, Premature Ejaculation and Male Infertility — Modern and Unani Treatment Approach

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility
BUMS, Hamdard University, Delhi
MD, CGO, Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Introduction: "Doctor, I No Longer Wake Up With the Same Strong Erection"

One question I increasingly hear from men is:

"Doctor, earlier I used to wake up with a strong erection almost every morning, but now it has become weak or has disappeared. Does this mean I have erectile dysfunction or low testosterone?"

My answer is that a reduction in morning erections deserves attention, particularly when it persists, but **it is not a disease by itself and it does not automatically prove erectile dysfunction, testosterone deficiency or infertility**.

Morning erections are part of normal spontaneous erections that occur during sleep. They provide useful clinical information about the functioning of the nerves, blood vessels, penile tissue, hormones, sleep system and psychological state.

The current 2026 European Association of Urology guideline specifically recommends asking men with erectile problems about the **rigidity and duration of both sexually stimulated erections and morning erections**. In selected cases, nocturnal penile tumescence and rigidity testing can help distinguish predominantly organic erectile dysfunction from predominantly psychogenic erectile dysfunction, although sleep, depression, age and other factors can influence the test.

A man who occasionally wakes without an erection should not panic.

However, when morning erections become consistently weak or disappear together with reduced libido, difficulty achieving erections during sexual activity, fatigue, low energy or other symptoms, I believe the underlying cause should be investigated.

The clinical material prepared for this article particularly highlights **decreased morning erection, erectile dysfunction, premature ejaculation, low sperm count and reduced sperm**

motility, together with Saira Health Care formulations including Nuskha No. 104, Nuskha No. 108, Nuskha No. 130 and Nuskha Khas.

I will therefore discuss these problems together while making an important distinction:

Morning erection, erection during intercourse, ejaculation and fertility are related aspects of male reproductive health, but they are not the same biological function.

A man can have excellent erections and poor sperm production. Another man may have severe erectile dysfunction but completely normal sperm count. A third may have normal testosterone but premature ejaculation.

Good treatment begins by identifying exactly what is wrong.

What Is a Morning Erection?

A morning erection is medically related to **nocturnal penile tumescence**.

Men can develop several spontaneous erections during sleep without conscious sexual stimulation.

The erection noticed on waking is often simply the final nocturnal erection continuing into the waking period.

This is why a morning erection should not automatically be interpreted as evidence that a man was having a sexual dream or consciously experiencing sexual desire.

The nervous system changes during sleep, particularly during periods associated with dreaming, and these changes support spontaneous erectile activity.

From a clinical perspective, the important point is this:

Morning erections provide information about whether the basic erectile mechanism is capable of working spontaneously.

Does Every Healthy Man Have a Morning Erection Every Day?

No.

There is natural variation.

A man may have no noticeable morning erection on a particular day because:

- he woke during a different stage of sleep;
- sleep was interrupted;
- he slept poorly;

- he was under psychological stress;
- he had consumed excessive alcohol;
- he was physically exhausted;
- he was unwell;
- his sleep schedule changed.

Therefore, I do not diagnose erectile dysfunction because someone says:

“I did not have a morning erection yesterday.”

The concern becomes more meaningful when there is a **persistent change from the man's previous pattern**, particularly when erection quality during partnered sexual activity has also declined.

EAU guidance recognizes morning erections as an important part of the sexual history but also acknowledges that nocturnal erection assessment can be affected by sleep, age, depression and situational factors.

Is Loss of Morning Erection the Same as Erectile Dysfunction?

Not necessarily.

Erectile Dysfunction

Erectile dysfunction, or ED, is the **persistent inability to obtain or maintain an erection sufficient for satisfactory sexual activity**.

A man may report:

- difficulty becoming fully erect;
- erection that remains partly soft;
- erection disappearing before penetration;
- erection disappearing during intercourse;
- decreased spontaneous erections;
- reduced morning erections.

Morning-erection changes can therefore be **one clue**, but the diagnosis of ED is based on the overall sexual history.

Why Morning Erections Can Be Useful in Understanding ED

Consider two different men.

Patient A

He has strong morning erections and normal erections during masturbation but repeatedly loses his erection during intercourse with his partner.

In such a case, psychological factors such as performance anxiety may be particularly important.

Patient B

He gradually loses morning erections, masturbation erections and intercourse erections simultaneously.

He is also diabetic, overweight and hypertensive.

In this situation, an organic vascular, neurological or hormonal cause becomes more likely.

But this is not an absolute rule.

The EAU states that most ED is **mixed rather than purely organic or purely psychological**. Diabetes, cardiovascular disease, obesity, hypertension, smoking, neurological disorders, hormonal abnormalities, depression, anxiety and medications may all contribute.

Nocturnal Penile Tumescence Testing

Most patients do not require sophisticated sleep testing.

However, in selected difficult cases, an **NPTR test—nocturnal penile tumescence and rigidity test—**can objectively measure erections during sleep.

EAU guidance describes assessment over at least two separate nights. An erection reaching at least approximately 60% rigidity at the penile tip and lasting ten minutes or more suggests a functional erectile mechanism.

Psychogenic ED often preserves normal nocturnal erections.

However, the test is not perfect.

Age, sleep disturbances, depression and situational factors can influence results, so it should not be treated as a universal pass-or-fail test.

How Does an Erection Occur?

I explain the erection mechanism to my patients in simple terms.

A normal erection depends on four major systems working together:

The Brain

Sexual thoughts, emotions and sensory stimulation initiate the response.

The Nerves

Nerve pathways carry signals from the brain and spinal cord to the penis.

The Blood Vessels

Penile arteries must open sufficiently to allow increased blood flow.

The Erectile Tissue

The corpora cavernosa must relax and then trap blood effectively.

Nitric oxide activates a chemical pathway involving cyclic GMP. This relaxes penile smooth muscle and increases blood inflow.

At the same time, venous drainage becomes restricted so that blood is temporarily retained.

A problem in any of these systems can reduce erectile rigidity.

Common Causes of Reduced Morning Erections

1. Poor Sleep

Morning erections depend partly on normal sleep physiology.

Irregular sleep, insomnia and other sleep disorders can interfere with nocturnal erectile activity.

Sleep disturbance is also recognized among factors associated with ED and symptoms that may accompany male hypogonadism.

Therefore, before assuming that a patient has severe vascular ED, I ask:

“How are you sleeping?”

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2. Psychological Stress and Anxiety

Stress can reduce sexual response.

A man may constantly worry about:

his erection, ejaculation timing, fertility, relationship or work.

The nervous system then remains in a state of increased alertness rather than relaxed sexual arousal.

EAU guidance identifies depression and anxiety among recognized ED-associated conditions and recommends psychological and cognitive-behavioural interventions where appropriate.

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3. Diabetes

Diabetes is one of the most important causes of organic erectile dysfunction.

Long-term high blood glucose can damage:

blood vessels + nerves + endothelial function.

Therefore, diabetic men may gradually notice:

weaker morning erections, reduced penile rigidity and difficulty maintaining erections during intercourse.

Treating erection alone while ignoring uncontrolled diabetes is not a complete treatment plan.

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4. High Blood Pressure

Hypertension can damage vascular health and is an established ED risk factor.

The EAU identifies hypertension together with cardiovascular disease, dyslipidaemia, diabetes, obesity and metabolic syndrome as important ED-associated conditions.

A patient should **not stop prescribed blood-pressure treatment himself**, however.

If medication is suspected of contributing to ED, the treating clinician can assess whether a suitable alternative exists.

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5. High Cholesterol and Cardiovascular Disease

Healthy erections require healthy arteries.

Atherosclerosis can impair the ability of penile arteries to dilate.

This is why erectile dysfunction can sometimes provide an opportunity to identify broader cardiovascular risk.

Current EAU guidance notes that ED is associated with cardiovascular disease and that persistent ED can precede clinically obvious vascular disease in some men.

I often tell patients:

“Do not look at your erection only as a penile problem. Sometimes it tells us something about the condition of the whole vascular system.”

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6. Obesity and Metabolic Syndrome

Obesity can affect erections through several mechanisms:

- vascular disease;
- insulin resistance;
- inflammation;
- reduced physical fitness;
- functional suppression of testosterone.

The 2026 EAU hypogonadism guideline emphasizes that **obesity and associated medical conditions contribute substantially to functional low testosterone**, often more than ageing alone.

Weight reduction and regular physical activity are therefore part of sexual-health treatment in appropriate patients.

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7. Smoking

Smoking damages vascular endothelium and accelerates atherosclerosis.

Because penile erection depends on healthy arteries, long-term smoking increases the risk of ED.

Smoking cessation should therefore be considered part of the treatment rather than generic advice unrelated to sexual health.

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8. Medication Effects

Several medicines can affect erection or sexual desire.

EAU guidance lists examples including some:

- antihypertensives;
- antidepressants;
- antipsychotics;
- antiandrogenic treatments.

A medication-related sexual problem should be handled by reviewing the prescription, not by abruptly discontinuing an essential medicine.

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9. Neurological Disease

Normal erections require functioning nerves.

Conditions including:

diabetic neuropathy, spinal cord disease, multiple sclerosis, Parkinson's disease and other neurological disorders can contribute to erectile dysfunction.

The treatment therefore depends on the underlying neurological condition.

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10. Chronic Kidney or Liver Disease

Systemic diseases can influence:

vascular health, hormones, energy, psychological well-being and medication metabolism.

EAU guidance includes chronic renal and liver disease among conditions associated with erectile dysfunction.

This is why a general medical history matters.

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11. Thyroid Disease

Both thyroid dysfunction and sexual symptoms deserve careful consideration.

Hyperthyroidism is recognized among conditions associated with erectile dysfunction and is also an important possible underlying factor in **acquired premature ejaculation**.

Patients should not try to “balance thyroid hormones naturally” by stopping levothyroxine, antithyroid medication or other prescribed therapy.

The thyroid disorder itself should be appropriately controlled.

Morning Erection and Testosterone

This association is real—but often misunderstood.

A reduction in spontaneous or morning erections is one of the more specific sexual symptoms of male hypogonadism.

The current 2026 EAU guideline includes:

- decreased libido;
- erectile dysfunction;
- decreased spontaneous/morning erections

among the more specific symptoms associated with late-onset hypogonadism.

But this does **not** mean:

“No morning erection = low testosterone.”

Diagnosis requires laboratory confirmation.

How Low Testosterone Should Be Diagnosed

The EAU recommends diagnosing late-onset hypogonadism only when a patient has **compatible symptoms together with consistently low testosterone**.

Total testosterone should generally be measured:

Between 7:00 AM and 10:00 AM

In a fasting state

Using a reliable laboratory assay

A low result should be repeated on another occasion before testosterone treatment is started.

The current EAU guideline uses approximately **12 nmol/L (3.5 ng/mL)** as a practical threshold in appropriately symptomatic men.

Other tests such as LH, FSH, prolactin, SHBG or calculated free testosterone may be needed according to the clinical picture.

Do Not Diagnose Low Testosterone From Symptoms Alone

Fatigue is not specific to testosterone deficiency.

Low energy can result from:

- insufficient sleep;
- depression;
- obesity;
- diabetes;

- thyroid dysfunction;
- anaemia;
- chronic illness;
- medication;
- poor nutrition.

Similarly, erection problems are frequently vascular or psychological rather than purely hormonal.

That is why I do not give testosterone simply because someone says:

“Doctor, my morning erection is weaker.”

Testosterone Therapy Is Not a General Sexual Tonic

Current EAU recommendations are very clear:

Do not use testosterone therapy in men with normal testosterone.

When genuine hypogonadism exists, testosterone treatment can improve libido and some milder forms of ED.

But testosterone should be prescribed because the patient has **confirmed androgen deficiency**, not simply because he wants a stronger erection.

A Major Fertility Warning About Testosterone

This is one of the most important parts of the article.

External testosterone suppresses LH and FSH from the pituitary gland.

This can suppress the testosterone concentration inside the testes that is required for sperm production.

The 2026 EAU guideline therefore strongly recommends:

Do not use testosterone therapy to treat male infertility or in men who wish to father children.

A man can feel more energetic while his sperm production becomes worse.

This is why I always ask about fertility goals before hormonal therapy.

Reduced Morning Erection and Premature Ejaculation

Many patients think weak erection and premature ejaculation are opposite conditions.

In reality, they can occur together.

Current EAU guidance notes that a significant proportion of men with ED also report PE and that anxiety related to losing an erection may worsen ejaculation control.

A typical patient tells me:

“Doctor, I am afraid my erection will disappear, so I hurry during intercourse—and then I ejaculate too quickly.”

In such a patient, treating only PE may miss the actual problem.

What Is Premature Ejaculation?

The medically preferred abbreviation is **PE**, rather than PME.

Diagnosis is not based only on the number of minutes.

EAU guidance recommends considering:

- ejaculation latency;
- perceived control;
- distress;
- interpersonal difficulty.

There are also important differences between **lifelong PE and acquired PE**.

Acquired Premature Ejaculation Requires Evaluation of the Cause

A man who previously had satisfactory ejaculation but suddenly develops PE should be evaluated for associated problems.

EAU guidance specifically recommends first addressing causes such as:

erectile dysfunction, prostatitis, lower urinary-tract symptoms, anxiety and hyperthyroidism.

For lifelong PE, current guideline-supported options include on-demand dapoxetine or lidocaine/prilocaine spray as first-line pharmacological treatment, with SSRIs or clomipramine among alternatives.

Psychosexual and behavioural treatment may be combined with medication where appropriate.

Morning Erection and Male Fertility Are Not the Same Thing

This point is essential.

A strong erection does not prove that sperm are normal.

A weak erection does not prove low sperm count.

The erectile system primarily depends on:

blood vessels + nerves + erectile tissue + psychological and hormonal factors.

Sperm production depends on:

testicular function + hormones + genetics + temperature regulation + reproductive anatomy and other factors.

The two systems can share risk factors, but they are different.

Low Sperm Count

Low sperm concentration is often called **oligozoospermia**.

The current WHO sixth-edition lower reference value used by the EAU is approximately:

16 million sperm/mL

Total sperm number is approximately:

39 million per ejaculate

These values are lower fifth-percentile reference values from men whose partners conceived naturally.

They are **not absolute boundaries between fertility and infertility**.

Reduced Sperm Motility

Motility describes how sperm move.

Current reference values include approximately:

Total motility: 42%

Progressive motility: 30%

Poor progressive motility is often called asthenozoospermia.

A man may have low motility despite completely normal erections.

Abnormal Sperm Morphology

The lower reference value for normal sperm morphology is approximately:

4% normal forms

using strict criteria.

This number often frightens patients unnecessarily.

A morphology value should never be interpreted alone.

Sperm concentration, total count, motility, volume, female fertility factors and duration of infertility all matter.

When Should an Abnormal Semen Test Be Repeated?

The new WHO 2025 infertility guideline suggests that when one or more semen parameters are outside WHO reference ranges, semen analysis should generally be repeated after a **minimum of 11 weeks** during male infertility evaluation.

Sperm production takes time.

A report performed only a few days after starting a treatment cannot reliably demonstrate full improvement in spermatogenesis.

Causes of Low Sperm Count or Motility

Possible causes include:

- varicocele;
- hormonal abnormalities;
- testicular disease;
- genetic causes;
- reproductive-tract obstruction;
- infection or inflammation;
- obesity and metabolic disease;

- smoking;
- excessive heat exposure;
- medications;
- previous chemotherapy or radiation;
- certain environmental exposures.

Current EAU guidance emphasizes that semen values require a **multiparametric interpretation** and that no individual sperm parameter alone can diagnose infertility.

Varicocele

Varicocele deserves particular attention because it may affect sperm quality while the man has completely normal sexual performance.

It involves enlarged scrotal veins and may contribute to abnormal sperm production through mechanisms that include altered temperature and oxidative stress.

A patient with varicocele therefore needs a proper infertility evaluation rather than simply an “erection medicine.”

Does Masturbation Cause Weak Morning Erection, ED or Low Sperm Count?

This is a common concern and one that deserves a scientifically accurate answer.

Routine masturbation does **not** cause permanent erectile dysfunction, penile shrinkage, low sperm count or infertility.

Cleveland Clinic specifically lists ED, penis shrinkage, reduced sperm count and infertility among common masturbation myths not supported by evidence.

A recent Mayo Clinic update similarly states that frequent masturbation is unlikely to have a meaningful adverse effect on male fertility.

Excessive or compulsive sexual behaviour can certainly interfere with relationships, sleep or psychological well-being, and very vigorous friction can temporarily cause soreness.

But I do not use **“masturbation weakness” as a modern medical diagnosis**.

If a man develops ED, low sperm count or loss of morning erections, the actual cause deserves evaluation.

Venous Leakage: A Frequently Misunderstood Diagnosis

Some men are told:

“Your erection falls because you have venous leakage.”

True veno-occlusive dysfunction is one possible mechanism of ED, but it should not be diagnosed from symptoms alone.

When vascular evaluation is clinically required, **dynamic penile duplex Doppler ultrasound** may be used to assess penile blood flow and veno-occlusive function. The EAU considers this a second-level test in selected men with suspected vasculogenic ED.

I would therefore not label every man whose erection goes down as having venous leakage.

Performance anxiety can produce exactly the same complaint.

How I Evaluate Reduced Morning Erection at Saira Health Care

When a patient comes to me, I first want to understand the complete pattern.

I ask:

How long has the problem been present?

Are morning erections completely absent or only less frequent?

Can you achieve a satisfactory erection during masturbation?

What happens during intercourse?

Is sexual desire normal?

Is premature ejaculation also present?

Are there symptoms of low testosterone?

Do you have diabetes, hypertension, thyroid disease, obesity or heart disease?

How is your sleep?

Are you taking antidepressants, blood-pressure medicines or other regular medication?

Are you trying for pregnancy?

Has semen analysis been performed?

This history often tells me far more than a random “sexual power” test.

Physical Examination

Depending on the patient, examination may include:

- blood pressure;
- body weight and waist circumference;
- genital examination;
- testicular size;
- penile abnormalities such as Peyronie's disease;
- signs of hormonal deficiency;
- vascular or neurological findings.

Current EAU guidance strongly recommends focused physical examination in men with persistent ED.

Laboratory Investigation

Depending on the clinical picture, tests may include:

Fasting glucose or HbA1c

Lipid profile

Early-morning fasting total testosterone

EAU strongly recommends metabolic and hormonal evaluation as part of basic ED assessment where appropriate.

Additional tests such as:

LH, FSH, prolactin, thyroid tests or other investigations may be selected according to symptoms.

I do not believe every patient needs every possible hormone test.

Testing should answer a clinical question.

Modern Treatment of Reduced Erection

Lifestyle and Reversible Risk Factors

Current EAU guidelines strongly recommend lifestyle and risk-factor modification before or alongside specific ED treatment.

This can include:

- diabetes control;

- weight reduction;
- regular physical activity;
- smoking cessation;
- cholesterol and blood-pressure management;
- better sleep;
- reducing excessive alcohol;
- stress management.

For some men, these interventions improve more than erection—they improve the underlying health problem causing the erection difficulty.

PDE5 Inhibitors

For properly diagnosed erectile dysfunction, medicines such as:

sildenafil and tadalafil

belong to the PDE5 inhibitor class.

The current EAU guideline gives a **strong recommendation for PDE5 inhibitors as first-line ED treatment**.

These medicines improve the natural erectile response to sexual stimulation.

They do not automatically increase testosterone.

They do not increase sperm production.

They do not permanently cure every underlying cause of ED.

But they are well-established treatments when appropriately prescribed.

Important Nitrate Warning

PDE5 inhibitors must not be combined with **nitrate medicines** used for angina because the combination may produce dangerous hypotension.

Patients with cardiovascular disease should therefore disclose all medicines before using ED drugs.

Psychological and Couple Therapy

When performance anxiety, relationship stress or fear contributes to ED, psychological treatment is not an optional "extra."

EAU guidance supports cognitive-behavioural and psychosexual interventions, and combining CBT with medical treatment may provide better outcomes in appropriate patients.

Vacuum Devices, Injections and Surgery

If oral medicines are ineffective or unsuitable, additional established options include:

- vacuum erection devices;
- intracavernosal injections;
- intraurethral/topical alprostadil;
- penile prosthesis surgery in selected severe cases.

EAU guidance recognizes these within individualized ED treatment.

Therefore, failure of one tablet does not mean treatment has ended.

The Unani Concept of Male Sexual Weakness

Traditional Unani literature discusses reduced sexual desire or sexual capacity under the concept of **Zu'f-i-Bah**.

The Central Council for Research in Unani Medicine's Standard Unani Treatment Guidelines describes possible traditional contributors including:

Qillat-i-Mani — reduced semen quantity;
Zu'f-i-A'za Ra'isa — weakness of major/vital organs;
Istirkha-i-Qazib — penile flaccidity;
Umur Wahmiyya — psychological factors.

Traditional treatment principles include:

Afza'ish-i-Mani — traditionally supporting semen production;
Taqwiyat-i-Qazib — supporting penile function;
Taqwiyat-i-A'za Ra'isa — strengthening general functional health;
Izala-i-Awariz Nafsani — addressing psychological contributors.

I find this last point particularly important.

Classical Unani medicine did not regard sexual function as simply a problem of the genital organ.

Psychological factors were also recognized.

Unani and Modern Physiology Are Not Identical

This distinction is important if the article is to be academically responsible.

Traditional Unani concepts such as:

Mizaj, Akhlat, Quwwat and Hararat-i-Ghariziyya

are historical physiological models.

They should not be presented as if they are scientifically identical to:

nitric-oxide deficiency, endothelial dysfunction, testosterone deficiency, diabetic neuropathy or venous occlusive dysfunction.

I believe we can respect traditional medicine while still being clear about these differences.

That approach strengthens Unani medicine rather than weakening it.

The Four Main Modes of Unani Treatment

CCRUM officially describes four major modes:

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

This broad framework is useful in sexual medicine because no single tablet should be expected to solve every cause of sexual dysfunction.

Ilaj-bil-Ghiza: Dietotherapy

Diet should be individualized according to the patient's health.

For example:

A diabetic and obese patient with ED requires metabolic improvement.

A nutritionally deficient man needs different dietary support.

A patient with high cholesterol requires cardiovascular consideration.

A fertility patient may also need adequate nutrition without unnecessary high-calorie or high-sugar preparations.

I therefore do not recommend the same “sexual-strength diet” to everyone.

Ilaj-bil-Tadbir: Regimental and Lifestyle Treatment

This can include appropriate attention to:

- exercise;
- sleep;
- stress;
- physical fitness;
- unhealthy habits;
- emotional well-being.

These principles overlap usefully with modern recommendations for risk-factor management in erectile dysfunction.

The theoretical explanations may differ, but clinically both systems recognize the importance of lifestyle.

Psychological Health in the Unani Approach

The traditional concept of **Izala-i-Awariz Nafsani**—addressing psychological disturbances—is highly relevant today.

A man who is frightened of sexual failure may require:

reassurance, sexual education, stress reduction and couple counselling.

An aphrodisiac alone cannot resolve every psychologically mediated erection problem.

Ilaj-bil-Dawa: Individualized Traditional Pharmacotherapy

Unani pharmacotherapy can be used as part of individualized supportive treatment.

However, my principle is:

The medicine should follow the diagnosis. The diagnosis should not be created to fit the medicine.

A patient with diabetes-related vascular ED should not be treated identically to a patient with normal morning erections and performance anxiety.

A patient with PE should not automatically receive the same medicine as a patient with confirmed hypogonadism.

A man trying to father a child requires fertility-protective decisions.

Special Treatment Approach at Saira Health Care

The clinical research material prepared around Saira Health Care's treatment framework specifically discusses four formulations—**Dr. Qasmi's Nuskha No. 104 (Vitaflow Max), Nuskha No. 108, Nuskha No. 130 and Nuskha Khas**—within an integrative sexual-health programme.

For textbook-quality medical communication, I consider it important to describe each product according to its **current published formulation and evidence level**, rather than making assumptions from the product name.

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

The current Saira Health Care Pharmacy page identifies **Nuskha No. 104 (Vitaflow Max)** as an **external Unani oil**.

Its currently listed ingredients include:

Kharateen Mussaffa, Roghan Shersaf and Roghan Kunjad.

The page positions it for traditional support of stamina, male sexual wellness and erection-related concerns and specifically states that it is **for external use only**.

Within my preferred integrative framework, it may be considered as a **traditional external supportive therapy in selected patients**.

However, I would not describe an external oil as scientifically equivalent to sildenafil, tadalafil or established vascular ED therapy.

High-quality clinical trials demonstrating that this finished product restores nocturnal erections or reverses proven vascular ED are currently limited.

Dr. Qasmi's Nuskha No. 130

The current pharmacy listing describes **Nuskha No. 130 as an Unani herbal Majoon**.

Its listed ingredients include Khulanjan, Zanjabeel, Shaqqul, Piyaz, Doodh, Ghee, Qaranfal, Satawar, Pambadana, Qiwam Shakar, Zafran and Arq Gawzaban.

The pharmacy positions the formulation for:

male debility, energy/endurance, premature ejaculation and semen-quality support.

I consider this appropriately described as **traditional supportive pharmacotherapy**.

However, its role should be distinguished from guideline-established PE therapies, and improvement in semen quality should ideally be assessed with properly performed semen analyses rather than assumed from subjective sexual improvement.

Nuskha Khas

The current pharmacy page describes **Dr. Qasmi's Nuskha Khas as a dietary supplement** and lists a combination that includes Shudh Shilajeet, Makardwaj, Loh Bhasm, Jaiphal, Safed Musli, Kaunch seed, Akarkara, Kali Musli, Shatavari, Vang Bhasm and Kumkum.

The current page itself describes these ingredients largely through an **Ayurvedic rejuvenative framework**, so it is more academically accurate to describe the formulation as part of an **integrative traditional medicine programme** rather than call every component classical Unani medicine.

Because it contains traditional mineral preparations, manufacturing quality, appropriate dose and professional supervision are particularly important.

It should not be described as a substitute for testosterone replacement in a patient with properly diagnosed hypogonadism.

Nuskha No. 108

The supplied research material places Nuskha No. 108 within the wider therapeutic architecture, particularly around general vitality, renal and nervous-system support.

Its **current public pharmacy page**, however, primarily lists indications such as kidney and joint discomfort, urinary problems, general weakness, indigestion and appetite, rather than specifically presenting it as an evidence-established ED medicine.

For that reason, I would use it only according to individual clinical indication rather than presenting it universally as a morning-erection treatment.

An important safety consideration

The current published ingredient list includes an ingredient identified as **Zaravand Mudharij / Aristolochia**.

This deserves formal botanical and pharmaceutical verification because the International Agency for Research on Cancer states that aristolochic acids found in many *Aristolochia*

species are associated with severe nephropathy and urologic cancers, and plants containing aristolochic acid are classified as carcinogenic to humans.

For professional website publication, I recommend that any formulation carrying an *Aristolochia* species on its ingredient list be reviewed for **species identification, aristolochic-acid status and applicable regulatory/pharmacopoeial compliance** before it is promoted for long-term oral use.

This is not an argument against traditional medicine. It is an argument for **stronger quality control**, which is essential for responsible traditional medicine.

Traditional Medicines in Hypertension

The supplied research material also discusses patients with hypertension.

I would not describe any sexual-health formulation as **universally safe for every hypertensive patient**.

The patient may be taking several cardiovascular medicines and may have:

coronary artery disease, kidney disease or other complications.

Similarly, some natural ingredients can influence blood pressure or interact with medicines.

Therefore, treatment should follow a medication review.

Traditional Medicines in Thyroid Disease

The same principle applies to thyroid disorders.

A patient with hypothyroidism who is prescribed levothyroxine should not stop it because he begins Unani treatment.

A hyperthyroid patient with palpitations and PE requires proper endocrine management.

Traditional treatment may support general health but should not replace necessary thyroid therapy.

Why “Natural” Does Not Mean “No Side Effects”

One of the most damaging ideas in traditional medicine is:

“If it is natural, it cannot have side effects.”

This is not scientifically correct.

Herbs and minerals are biologically active.

Safety depends on:

- botanical identity;
- purity;
- dose;
- duration;
- kidney and liver health;
- other medicines;
- manufacturing standards.

The appropriate message is not “zero side effects.”

It is:

Use the correct medicine in the correct patient at the correct dose under appropriate supervision.

How I Integrate Modern and Unani Treatment at Saira Health Care

When I treat a patient with reduced morning erections or broader male sexual problems, my preferred clinical sequence is:

First: Define the actual problem

Morning erection?
Intercourse erection?
Libido?
Premature ejaculation?
Infertility?

Second: Identify reversible causes

Diabetes, obesity, hypertension, smoking, sleep problems, medications, stress and thyroid disease.

Third: Investigate when necessary

Glucose, lipids, testosterone and other selected tests.

Fourth: Assess fertility goals

If pregnancy is desired, semen analysis and reproductive evaluation may become important.

Fifth: Perform individualized Unani assessment

Mizaj, lifestyle, diet, sleep, physical health and psychological state.

Sixth: Select treatment according to the diagnosis

This may include lifestyle intervention, counselling, evidence-based ED or PE medicines, hormonal treatment for genuine hypogonadism, fertility-specific treatment and individually selected Unani supportive therapy.

Seventh: Reassess

Treatment should be judged by:

erection quality, sexual satisfaction, side effects, psychological confidence, metabolic control and—when fertility is involved—objective semen parameters.

Saira Health Care's current published ED pathway similarly emphasizes identification of the cause, correction of reversible risk factors and individualized use of counselling, guideline-supported medicine, devices, hormonal treatment, supervised traditional/Unani care and surgery in selected cases.

Why One Medicine Cannot Treat Every Man

Consider four patients.

Patient 1

A 29-year-old man with strong morning erections but erection loss during intercourse because of severe performance anxiety.

He primarily needs psychological and sexual-health management.

Patient 2

A 52-year-old man with diabetes, hypertension, obesity and gradually disappearing morning erections.

His cardiovascular and metabolic health may be central to the problem.

Patient 3

A 35-year-old man with reduced libido, reduced morning erections and repeatedly confirmed low morning testosterone.

He requires endocrine evaluation.

Patient 4

A 31-year-old man with normal erections but low sperm count and poor motility.

His problem is primarily male infertility, not ED.

Giving all four the same “sexual-strength medicine” would not be individualized clinical practice.

Does a Stronger Morning Erection Mean Fertility Has Improved?

No.

This is important when evaluating treatment.

A patient may report:

“My erection is much better now.”

That is a useful sexual outcome.

But it does **not** prove that:

sperm concentration, motility or morphology have improved.

If fertility is the treatment goal, semen analysis remains necessary.

Does Thicker Semen Mean Better Fertility?

No.

Semen appearance cannot reliably diagnose sperm count or fertility.

Semen normally changes consistency after ejaculation.

A thick-looking sample may contain few sperm.

A relatively thin-looking sample may have normal sperm parameters.

Therefore, laboratory semen analysis—not appearance—is the correct way to evaluate fertility.

Can Treatment Guarantee Better Sperm Count?

No medicine can responsibly guarantee improvement in every patient.

For example:

A hormonal deficiency may respond to appropriate hormonal treatment.

A varicocele may require specific management.

A genetic cause may not respond to general fertility supplements.

An obstruction requires a completely different approach.

This is why infertility treatment should be diagnosis-based.

Dr. Nizamuddin Qasmi: My Clinical Focus

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

My professional education and training listed for this article include:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Saira Health Care's public professional profile lists **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK**, and describes my clinical work as focused on sexual disorders and infertility.

MasterHealthPro publicly lists a **six-month Male Infertility Masters programme**, alongside other sexual-medicine and andrology programmes.

This combination of sexual-health and infertility training is particularly relevant because men frequently arrive with several concerns at the same time:

weak erection + PE + hormone worries + abnormal semen report + fertility anxiety.

These problems have to be separated before they can be treated properly.

Contribution of Saira Health Care to Sexual Disorders and Infertility

Saira Health Care describes its approach as providing a private, patient-centered environment for sexual and fertility concerns and integrating traditional knowledge, individualized treatment, lifestyle guidance and modern diagnostic understanding.

I believe one of the most valuable contributions a clinic can make is **correcting misconceptions**.

A patient should not be told:

“No morning erection means you are impotent.”

“Low testosterone causes every erection problem.”

“Thick semen means high sperm count.”

“Masturbation permanently weakens the penis.”

“Every natural medicine is completely safe.”

“One formulation can permanently cure every type of ED.”

Sexual-health treatment becomes much more effective when the patient understands what is actually happening.

Common Myths

“If morning erection disappears, testosterone must be low.”

No.

Reduced morning erections can occur with hypogonadism, but sleep, vascular disease, diabetes, psychological factors, medication and other conditions can also contribute.

“If I have morning erections, I cannot have ED.”

Not always.

Morning erections can suggest that the erectile system is capable of functioning, but some men still experience significant situational or mixed ED.

“ED means my sperm count is low.”

No.

Erectile function and sperm production are separate biological processes.

“Taking testosterone will increase sperm count.”

The opposite may occur. External testosterone can suppress spermatogenesis and is contraindicated as fertility treatment in men wishing to father children.

“PE is always caused by penile hypersensitivity.”

No.

Acquired PE may occur with ED, prostatitis, anxiety, thyroid disease and other factors.

“Masturbation causes permanent sexual weakness.”

Routine masturbation does not cause ED, penis shrinkage, low sperm count or infertility.

“Herbal medicine can never cause side effects.”

Incorrect.

Traditional medicines are biologically active and require attention to ingredients, quality, interactions and patient-specific risk.

Frequently Asked Questions

Is loss of morning erection dangerous?

Not usually by itself. Occasional absence is common. Persistent reduction together with ED, low libido or other symptoms deserves assessment.

How many days without morning erection should worry me?

There is no scientifically useful fixed number of days. The **persistent change from your normal pattern and the presence of other symptoms** are more important.

Can stress stop morning erections?

Stress, anxiety, depression and sleep disruption can influence sexual function and nocturnal erections.

Does low testosterone reduce morning erections?

It can. Decreased spontaneous/morning erections are among more specific sexual symptoms of hypogonadism. Diagnosis still requires appropriately confirmed low testosterone.

What testosterone test should I take?

Total testosterone is generally measured while fasting between **7 AM and 10 AM**, and a low value should be repeated before diagnosis or treatment.

Can tadalafil restore morning erections?

Tadalafil is an established ED treatment and may improve erectile function in suitable patients, but treatment should be directed at the diagnosed cause rather than judged only by morning erections.

Can Unani medicine help?

Yes, Unani medicine can offer valuable individualized supportive treatment through Mizaj assessment, dietotherapy, lifestyle/regimental management, psychological care and physician-selected pharmacotherapy.

However, important vascular, endocrine, neurological or fertility disorders should be appropriately diagnosed rather than treated blindly.

Is Nuskha No. 104 an oral medicine?

No. Its current Saira Health Care Pharmacy listing identifies Vitaflow Max as an **oil for external use**.

Is Nuskha No. 130 used for PE and semen health?

Its current product page describes it as an Unani herbal Majoon positioned for male debility, PE and semen-quality support. These are product/traditional-use descriptions rather than independent proof of universal clinical efficacy.

How soon should semen testing be repeated if my report is abnormal?

For infertility evaluation, the WHO 2025 guideline suggests repeating an abnormal semen analysis after at least **11 weeks**.

Prognosis

The outlook for reduced morning erections depends on the cause.

Performance anxiety

Can improve significantly with education, counselling and appropriate sexual therapy.

Lifestyle-related or metabolic ED

May improve with weight control, physical activity, diabetes management and appropriate ED treatment.

Hypogonadism

Sexual symptoms may improve when genuine testosterone deficiency is correctly diagnosed and treated.

Severe vascular or neurological ED

May require longer-term medication, devices, injections or other specialist treatment.

Male infertility

Prognosis depends on the specific sperm abnormality and underlying cause rather than erection quality.

The important message is:

Reduced morning erection is a clue—not a final diagnosis.

Conclusion

Morning erection is one useful window into male sexual physiology, but it should never be treated as the only measure of male health.

The current **2026 EAU Sexual and Reproductive Health Guidelines** recommend asking about both stimulated and morning erections during ED evaluation and recognize that erectile dysfunction may involve vascular, neurological, hormonal, psychological, medication-related and mixed mechanisms.

A persistent reduction in morning erections can sometimes accompany **male hypogonadism**, but low testosterone cannot be diagnosed from this symptom alone. The latest EAU guidance requires compatible symptoms together with consistently low fasting morning testosterone measurements, generally using about 12 nmol/L as a practical threshold in symptomatic men.

Premature ejaculation must also be understood separately. Men with ED may develop secondary PE because they rush intercourse out of fear of losing their erection, while acquired PE can also be associated with anxiety, prostatitis, lower urinary-tract symptoms and hyperthyroidism.

Male fertility is another distinct area.

WHO/EAU lower reference values include approximately **16 million sperm/mL concentration, 30% progressive motility and 4% normal morphology**, but no single semen parameter can diagnose fertility or infertility.

The new WHO 2025 infertility guideline further recommends repeating an abnormal semen analysis after a minimum of approximately **11 weeks** during male-factor infertility evaluation.

The **Unani system of medicine** offers an important complementary perspective through its individualized approach to *Zu'f-i-Bah*, traditionally considering penile flaccidity, general physical condition, semen-related concerns and psychological factors. CCRUM's treatment framework includes dietotherapy, regimental therapy, pharmacotherapy and surgery according to clinical need.

At **Saira Health Care**, the clinical framework discussed for this topic includes traditional formulations such as Nuskha No. 104, Nuskha No. 108, Nuskha No. 130 and Nuskha Khas.

However, my approach as **Dr. Nizamuddin Qasmi** is not to give every patient all of these medicines simply because he says his morning erection has decreased.

I first determine:

Is it true erectile dysfunction?

Is testosterone genuinely low?

Is diabetes or vascular disease involved?

Is sleep or anxiety the major factor?

Is premature ejaculation secondary to erection anxiety?

Is the patient also concerned about fertility?

Are sperm count and motility actually abnormal?

Only then should treatment be individualized.

My central message to patients is:

Do not judge your masculinity, fertility or testosterone from one morning without an erection. At the same time, do not ignore a persistent change. Reduced morning erection can be an early clue to sleep, metabolic, vascular, hormonal or psychological problems. Proper evaluation makes it possible to distinguish the cause and select the right treatment. Modern sexual medicine and responsibly practiced Unani medicine can complement one another when diagnosis, safety and individual patient needs remain at the centre of care.

Medical Disclaimer

This article is intended for **general medical education and awareness about male sexual and reproductive health**. It is not a substitute for individualized consultation, physical examination, laboratory testing or specialist advice.

Persistent erectile dysfunction may sometimes be associated with cardiovascular disease, diabetes, hormonal disorders, neurological disease or significant psychological conditions.

Do not begin testosterone treatment simply because morning erections have reduced. Testosterone therapy should be used only after appropriate diagnosis, and it can suppress sperm production in men seeking fertility.

Do not discontinue diabetes, blood-pressure, thyroid, antidepressant or other prescribed medicines because of sexual symptoms without discussing the problem with the treating clinician.

Traditional Unani, Ayurvedic, herbal and herbo-mineral medicines contain biologically active ingredients. Their safety depends on correct botanical identity, manufacturing quality, dose, duration, other medicines and the patient's kidney, liver and cardiovascular health.

The currently published Nuskha No. 108 ingredient list includes an *Aristolochia*-identified ingredient; products containing aristolochic acids are associated with serious kidney toxicity and carcinogenicity. Formal ingredient verification is therefore important before long-term oral use.

No conventional medicine, traditional formulation, supplement, oil, hormone treatment or fertility programme can responsibly guarantee permanent erection restoration, testosterone normalization, improvement in sperm parameters or pregnancy in every patient.