

Low Testosterone in Men

(Male Hypogonadism): Symptoms, Causes, Diagnosis, Fertility Impact, Modern Treatment and the Unani Approach

Introduction

Testosterone is the principal androgen, or male sex hormone. It plays an important role in sexual desire, reproductive function, sperm production, development and maintenance of male sexual characteristics, muscle and bone health, red-blood-cell production, energy, mood and general well-being.

Low testosterone, medically known as **male hypogonadism or testosterone deficiency**, occurs when a man develops symptoms or clinical signs compatible with androgen deficiency together with consistently low testosterone concentrations confirmed by appropriate blood testing.

This distinction is extremely important.

A man should **not** be diagnosed with hypogonadism simply because he feels tired, has reduced sexual desire or receives one slightly low testosterone result. Current 2026 European Association of Urology (EAU) guidance defines male hypogonadism as a clinical syndrome involving symptoms or signs together with biochemical evidence of testosterone deficiency. The Endocrine Society similarly emphasizes that symptoms alone are insufficient and that testosterone concentrations should be consistently and accurately low before treatment is considered.

Low testosterone can affect sexual health, fertility, physical performance and quality of life. At the same time, several common conditions—including obesity, diabetes, poor sleep, chronic illness, certain medicines and severe stress—can lower testosterone temporarily or functionally.

This is why modern treatment should focus not simply on “**increasing testosterone**”, but on understanding **why it is low**.

For men concerned about fertility, the issue is even more important because conventional testosterone replacement can improve symptoms while simultaneously **suppressing sperm production**. Current EAU and AUA/ASRM guidelines strongly advise against exogenous testosterone therapy in men actively wishing to father children.

The Unani system of medicine provides a valuable complementary framework through its emphasis on **Mizaj, physical strength, diet, digestion, sleep, emotional health, lifestyle, reproductive function and individualized treatment**. However, classical Unani concepts should be integrated with modern hormone testing rather than treated as exact equivalents of laboratory-defined hypogonadism.



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At Saira Health Care, this distinction is especially relevant because the clinic focuses on **sexual disorders and infertility**, where the treatment goal may involve not only improving symptoms but also protecting reproductive function.

What Is Testosterone?

Testosterone is produced mainly by the **Leydig cells of the testes**.

Its production is controlled by a hormonal communication system called the **hypothalamic-pituitary-testicular axis**.

The hypothalamus in the brain releases gonadotropin-releasing hormone. This stimulates the pituitary gland to release luteinising hormone, or LH, and follicle-stimulating hormone, or FSH.

LH stimulates the testes to produce testosterone.

FSH, together with high local testosterone levels inside the testes, contributes to normal sperm production.

This explains why a disorder affecting the brain, pituitary gland or testes can all result in testosterone deficiency—but through different mechanisms.

It also explains why treatment must be individualized.

What Is Male Hypogonadism?

The latest EAU guideline defines male hypogonadism as a syndrome involving clinical symptoms or signs together with biochemical testosterone deficiency. It may also involve impaired sperm production.

Low testosterone is therefore **not simply a laboratory number**.

A clinically meaningful diagnosis requires:

Symptoms or signs compatible with testosterone deficiency + reliably confirmed low testosterone + assessment of the underlying cause.

This is one of the most important principles for patients to understand.

How Common Is Low Testosterone?

The prevalence rises with increasing age and with chronic medical conditions, but healthy ageing itself appears to cause only a relatively small gradual reduction in testosterone.



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The 2026 EAU guideline reports symptomatic hypogonadism in approximately **2.1% to 5.7% of men aged 40–79 years**, depending on the population and diagnostic criteria. It is substantially more common among men with obesity, type 2 diabetes, metabolic syndrome, cardiovascular disease, chronic kidney disease and other significant health problems.

This means that the widely repeated idea that **“every man’s testosterone naturally crashes with age”** is too simplistic.

Age can contribute, but general health, obesity and medical conditions often have a greater influence.

Types of Male Hypogonadism

Understanding the type of hypogonadism is essential because treatment and fertility implications differ considerably.

Type	Main Problem	Typical Hormonal Pattern	Examples
Primary hypogonadism	Testes cannot produce adequate testosterone	Low testosterone with elevated LH/FSH	Klinefelter syndrome, testicular injury, orchitis, chemotherapy, radiation
Secondary hypogonadism	Brain/pituitary does not adequately stimulate testes	Low testosterone with low or inappropriately normal LH/FSH	Pituitary disease, hyperprolactinaemia, some medicines, hypothalamic disorders
Functional hypogonadism	Hormonal axis is suppressed by potentially reversible health factors	Variable	Obesity, metabolic disease, chronic illness, some medications

The EAU emphasizes that functional hypogonadism is generally diagnosed after organic disease has been excluded and that improving the underlying condition should be prioritized whenever possible.

Primary Hypogonadism: When the Testes Are the Main Problem

In primary hypogonadism, the pituitary may be sending an adequate—or even excessive—signal, but the testes cannot respond normally.



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Possible causes include Klinefelter syndrome, significant testicular trauma, testicular torsion, mumps orchitis, chemotherapy, radiation, autoimmune testicular failure, certain genetic conditions and surgical loss of testicular tissue.

LH and often FSH rise because the brain is effectively attempting to stimulate underperforming testes.

This distinction is particularly important for fertility.

If severe primary testicular failure is present, simply taking herbs or stimulating the pituitary may not be sufficient to restore normal testicular function.

Secondary Hypogonadism: When the Signal From the Brain Is Reduced

Secondary or hypogonadotropic hypogonadism occurs when the hypothalamus or pituitary gland does not provide adequate hormonal stimulation.

Potential causes include pituitary tumours, hyperprolactinaemia, traumatic brain injury, pituitary surgery or radiation, iron overload, congenital conditions, chronic opioid use, glucocorticoids and severe systemic illness.

Secondary hypogonadism is especially important in reproductive medicine because fertility can sometimes be restored through **gonadotropin-based treatment**, depending on the cause.

Current EAU guidance considers gonadotropins standard treatment for men with secondary hypogonadism who wish to father children.

Functional Low Testosterone

Functional hypogonadism is increasingly important in modern practice.

A man's testes and pituitary gland may not be permanently damaged, but the hormonal system becomes suppressed by factors such as obesity, metabolic syndrome, diabetes, chronic illness or certain medicines.

The 2026 EAU guideline emphasizes that obesity and associated medical conditions account for a major part of adult functional hypogonadism and that some of this suppression may be reversible.

The Endocrine Society's July 2026 statement similarly emphasizes addressing reversible contributors first and notes that weight reduction is generally first-line therapy when obesity appears to be the major cause of otherwise unexplained hypogonadism.

This is why treatment should not automatically begin with testosterone injections.



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Symptoms of Low Testosterone

Symptoms vary greatly between individuals.

The most specific symptoms tend to involve **sexual function**.

A man may experience reduced sexual desire, fewer spontaneous or morning erections, erectile difficulties or reduced sexual activity.

Other symptoms may include reduced energy, fatigue, reduced physical performance, decreased muscle strength, low motivation, mood changes, disturbed sleep or problems concentrating.

Current EAU guidance classifies reduced libido, erectile dysfunction and decreased spontaneous or morning erections among the more specific sexual manifestations of adult testosterone deficiency.

In more pronounced or prolonged hypogonadism, additional features may include reduced body or facial hair, changes in body composition, testicular changes, anaemia, reduced bone density or osteoporosis.

However, none of these symptoms is exclusive to low testosterone.

Fatigue may result from anaemia, thyroid disease, depression, diabetes, sleep apnea or many other conditions.

Reduced libido may result from stress, relationship difficulties or medications.

Erectile dysfunction is frequently vascular rather than hormonal.

Therefore, symptoms should guide testing—not replace it.

Low Testosterone and Erectile Dysfunction

Testosterone contributes to normal sexual desire and erectile physiology, but low testosterone is **not responsible for every case of erectile dysfunction**.

Diabetes, vascular disease, smoking, hypertension, high cholesterol, neurological disease, medications and psychological factors are all common causes of ED.

Current EAU evidence indicates that testosterone replacement in genuinely hypogonadal men may improve sexual desire and milder erectile dysfunction, with greater improvement generally seen when baseline testosterone is more severely reduced. Men with metabolic diseases such as obesity and diabetes may experience smaller improvements.



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Therefore, giving testosterone to a man whose level is normal is not an appropriate general treatment for erectile dysfunction.

The EAU strongly recommends against testosterone treatment in eugonadal—normal-testosterone—men.

Low Testosterone and Libido

Reduced sexual desire is one of the more characteristic symptoms of hypogonadism.

However, testosterone is only one contributor to libido.

Sexual desire can also be affected by depression, chronic stress, relationship difficulties, poor sleep, medications, hyperprolactinaemia and other medical problems.

A proper evaluation should therefore consider the man's entire sexual and psychological health rather than interpreting reduced desire automatically as hormone deficiency.

Low Testosterone and Male Fertility

This is one of the most important areas of misunderstanding.

Testosterone is necessary for normal sperm production, but **taking external testosterone does not improve fertility.**

In fact, it can do exactly the opposite.

External testosterone sends negative feedback to the hypothalamus and pituitary gland. LH and FSH fall, the concentration of testosterone inside the testes declines and sperm production can be markedly suppressed.

The result may be:

low sperm count or even azoospermia—complete absence of sperm from the ejaculate.

Current EAU guidance explicitly states that exogenous testosterone suppresses spermatogenesis and is contraindicated in men desiring fertility. The AUA/ASRM male-infertility guideline likewise states that clinicians should not prescribe exogenous testosterone to men interested in current or future fertility.

This point is particularly important for young men who purchase injectable testosterone or bodybuilding steroids without medical advice.

Can Sperm Production Recover After Stopping Testosterone?



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Often it can, but recovery is not necessarily immediate.

The AUA/ASRM guideline notes that sperm production recovers in most men after cessation of exogenous testosterone, but recovery may take **months and occasionally considerably longer**.

Therefore, men planning a baby should always discuss fertility before starting TRT.

A patient should never assume:

“Testosterone is the male hormone, so taking more testosterone must increase sperm.”

Hormonal physiology is more complicated than that.

Testosterone and Bodybuilding Steroids

Anabolic-androgenic steroids can suppress the same hormonal axis.

Men using steroids may develop reduced natural testosterone production, testicular shrinkage and reduced or absent sperm production.

The EAU specifically lists testosterone and anabolic-androgenic steroids among drug-related causes of secondary hypogonadism.

Men seeking fertility treatment should disclose all bodybuilding hormones or performance-enhancing drugs to their clinician.

Obesity and Low Testosterone

Obesity is one of the most important reversible associations.

Adipose tissue influences hormonal metabolism and can suppress the hypothalamic-pituitary-testicular axis.

Obesity is therefore associated with lower total testosterone and, depending on SHBG levels and severity, reduced biologically available testosterone.

The EAU strongly recommends lifestyle improvement and weight reduction before testosterone therapy when obesity or related functional factors are present. Weight loss through calorie reduction and regular physical activity produces a modest improvement in testosterone on average.

This may not completely normalize testosterone in every man, but it addresses the underlying problem rather than only replacing the hormone.



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Diabetes and Metabolic Syndrome

Low testosterone is relatively common among men with type 2 diabetes and metabolic syndrome.

At the same time, erectile dysfunction in diabetes is often caused predominantly by **vascular and neurological damage**, so testosterone replacement alone may not restore erection quality.

The EAU recognizes a close association among hypogonadism, obesity, diabetes, insulin resistance and cardiovascular risk.

Good metabolic control should therefore be considered part of male sexual and hormonal health.

Sleep and Testosterone

Sleep is frequently overlooked.

Poor-quality or insufficient sleep can influence hormonal regulation, energy, mood, body weight and sexual health.

Obstructive sleep apnea is also strongly associated with obesity and metabolic dysfunction.

A patient who sleeps only a few hours each night and experiences fatigue should not automatically assume he requires testosterone.

Sleep, weight and metabolic health need to be evaluated.

Stress and Psychological Health

Chronic psychological stress can affect libido, energy, erection quality and the patient's perception of his physical strength.

Depression itself can produce many symptoms similar to hypogonadism.

The EAU notes that testosterone therapy may produce only modest improvement in mild depressive symptoms and should not be considered a stand-alone treatment for significant clinical depression.

This is another reason a whole-person approach can be valuable.

Medicines That May Lower Testosterone

A medication history is essential.



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Certain medicines or substances can interfere with the hypothalamic-pituitary-gonadal axis.

Examples recognized by EAU guidance include chronic opioids, glucocorticoids, certain hormonal medicines and medications that alter testosterone production or action.

Patients should never stop prescribed medicines themselves.

When a drug is suspected, the prescribing doctor can determine whether an alternative is medically appropriate.

How Low Testosterone Should Be Diagnosed

Modern guidelines are very clear:

One random testosterone result is not enough.

The latest 2026 EAU guidance recommends total testosterone testing in symptomatic men between approximately **7:00 AM and 10:00 AM while fasting**, using a reliable laboratory assay. If the level is low, it should be repeated on another occasion before treatment.

The Endocrine Society similarly requires symptoms plus consistently low testosterone and recommends confirming the result with another morning fasting measurement.

This is particularly important because food, illness, sleep patterns and laboratory variability can affect the result.

Why Morning Testing Matters

Testosterone follows a daily rhythm and generally reaches its highest concentration after sleep and during the earlier part of the day.

The EAU currently recommends obtaining samples between 7 AM and 10 AM in most men.

For night-shift workers, the situation is different.

Because testosterone rhythm is strongly influenced by sleep, testing should be arranged after an adequate sleep period rather than blindly applying a morning clock time.

Why Fasting Matters

Food intake can reduce measured testosterone temporarily.

The EAU reports that non-fasting measurement may substantially underestimate testosterone in some circumstances. Therefore, fasting testing provides greater consistency.

Patients should follow laboratory and clinician instructions carefully before testing.



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What Testosterone Level Is Considered Low?

There is **not one universally identical cut-off across every professional organization**.

The 2026 EAU guideline uses approximately **12 nmol/L**, equivalent to roughly **346 ng/dL**, as a practical threshold when compatible symptoms are present. It emphasizes repeating values below this level and notes that clinical benefits of testosterone therapy are generally greater in men with more pronounced deficiency.

The American Urological Association uses **below 300 ng/dL** as a reasonable diagnostic cut-off, again requiring two separate morning results together with symptoms or signs.

The difference between these thresholds demonstrates an important principle:

The laboratory number must be interpreted in clinical context rather than treated as an isolated pass-or-fail score.

Total Testosterone vs Free Testosterone

Most testosterone in the bloodstream is bound to proteins, particularly **sex hormone-binding globulin, or SHBG**.

Total testosterone measures both bound and unbound hormone.

Free testosterone represents the smaller fraction available without being tightly bound to SHBG.

Conditions such as obesity, diabetes, thyroid disease, liver disease and ageing can alter SHBG and make total testosterone harder to interpret.

Current EAU guidance therefore recommends measuring SHBG and calculating free testosterone when clinically indicated.

This can be particularly useful in men with obesity or borderline total-testosterone values.

LH and FSH: Finding the Cause

Once low testosterone has been confirmed, the next question is:

Where is the problem occurring?

LH and FSH help answer this.

High LH with low testosterone suggests that the pituitary is trying to stimulate failing testes—primary hypogonadism.



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Low or inappropriately normal LH with low testosterone suggests a central problem—secondary hypogonadism.

Both the EAU and Endocrine Society recommend LH and FSH testing to distinguish these major categories.

Prolactin

High prolactin can suppress sexual desire and interfere with the reproductive hormonal axis.

The EAU recommends prolactin testing particularly when low sexual desire or secondary hypogonadism is present.

Persistent unexplained elevation may lead to further pituitary evaluation.

When Is Pituitary MRI Needed?

Not every patient with low testosterone needs an MRI.

Current EAU guidance recommends pituitary MRI particularly when secondary hypogonadism occurs with high prolactin, symptoms suggesting a pituitary mass—such as headaches or visual disturbance—or other pituitary hormone abnormalities.

MRI can also be considered in severe secondary hypogonadism, particularly with testosterone below approximately 6 nmol/L.

This illustrates why blindly prescribing a “testosterone booster” can occasionally delay diagnosis of an important medical condition.

Testosterone Replacement Therapy

When true symptomatic hypogonadism has been properly diagnosed and no major contraindication exists, **testosterone replacement therapy (TRT)** can be effective.

Available forms include gels, injections, oral preparations in selected settings, patches, implants and other formulations.

The objective is to restore testosterone toward a normal physiological range—not to create abnormally high bodybuilding-type concentrations.

Current EAU evidence shows that appropriate TRT can improve libido and several sexual symptoms, especially in men whose testosterone is substantially reduced. It may also improve body composition and bone mineral density.

TRT is therefore an important medical treatment.



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But it is not suitable for every man who feels tired or sexually weak.

What TRT Can Realistically Improve

In appropriately diagnosed hypogonadal men, testosterone therapy may improve sexual desire, frequency of sexual activity and some aspects of erectile function.

The greatest erectile improvement generally occurs in men with more severe testosterone deficiency. In more significant erectile dysfunction, additional ED-specific treatment may still be required.

TRT can also increase lean body mass and reduce fat mass, although improvements in overall body weight and physical strength are less consistent than popular advertising often suggests.

Bone mineral density may improve, particularly in more severe hypogonadism.

Mood effects tend to be modest, and testosterone should not replace standard treatment for major depression.

TRT Is Not a General Anti-Ageing or Performance Drug

A normal-testosterone man should not use testosterone merely to increase gym performance, masculinity, sexual confidence or energy.

The EAU strongly advises against testosterone therapy in eugonadal men.

A July 2026 Endocrine Society statement similarly emphasizes avoiding simplistic “age-related low T” diagnoses based only on non-specific complaints such as tiredness or reduced mood.

The objective is correction of genuine hormone deficiency—not enhancement beyond normal physiology.

Testosterone Therapy and Fertility: The Critical Warning

Men who wish to father children require a different treatment philosophy.

External testosterone suppresses pituitary LH and FSH and therefore suppresses intratesticular testosterone and sperm production.

Current EAU guidance calls an active desire for children an **absolute contraindication** to testosterone therapy.



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For secondary hypogonadism, treatments such as **hCG and FSH-based gonadotropin therapy** may be used under specialist supervision to improve testosterone while supporting sperm production.

This is why men with low testosterone and infertility should ideally be managed by a clinician experienced in both **andrology and male fertility**.

Risks and Monitoring of Testosterone Therapy

TRT requires follow-up.

One of the most important adverse effects is **increased haematocrit**, meaning the proportion of red blood cells in the blood can become too high.

Current EAU guidance recommends monitoring testosterone and haematocrit after initiation and subsequently at appropriate intervals. A haematocrit above **54%** requires treatment adjustment or withdrawal and, when clinically necessary, venesection.

Blood pressure also matters.

In 2025, the U.S. FDA required testosterone products to include warnings about increased blood pressure after class-wide ambulatory blood-pressure studies demonstrated this effect.

Monitoring may additionally include prostate assessment, PSA according to age and risk, metabolic health and clinical response.

Testosterone and Cardiovascular Risk: What Does the Latest Evidence Show?

Older discussions frequently suggested that testosterone replacement inevitably increases heart attacks and strokes.

Current evidence is more nuanced.

The large TRAVERSE cardiovascular-safety trial involving more than 5,200 men found **no meaningful increase in major cardiovascular events** such as cardiovascular death, non-fatal heart attack or stroke between testosterone and placebo groups over the study period. This led the FDA in 2025 to remove previous boxed-warning language regarding increased major cardiovascular outcomes.

However, this does **not** mean TRT is risk-free.

TRAVERSE observed somewhat higher incidences of pulmonary embolism, atrial fibrillation and acute kidney injury in the testosterone group, and the FDA now emphasizes blood-pressure effects. The EAU concludes that current interventional evidence does not show



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increased major cardiovascular risk for approximately the first three years in appropriately diagnosed men whose levels are normalized, while longer-term uncertainty remains.

Therefore, cardiovascular risk should be assessed before and during treatment.

Testosterone and the Prostate

Current evidence does not demonstrate that physiological testosterone replacement automatically causes prostate cancer.

The 2026 EAU review found no clear increase in prostate-cancer incidence among properly treated hypogonadal men in available studies, although long-term prospective evidence remains incomplete.

Active or advanced prostate cancer remains an important contraindication or area requiring specialist management.

PSA and prostate monitoring should therefore be individualized according to age and risk.

The Unani Perspective on Low Testosterone

A historically important clarification is necessary.

Classical Unani medicine developed centuries before laboratory testosterone measurement. Therefore, there is **no classical Unani diagnosis that can be considered scientifically identical to a modern serum-testosterone-defined hypogonadism diagnosis**.

Instead, classical Unani physicians described overlapping clinical syndromes such as **Ḍuʿf-i-Bāh or Zof-e-Bah—sexual debility**.

The Central Council for Research in Unani Medicine (CCRUM), Ministry of AYUSH, describes Zof-e-Bah as a condition involving reduced sexual desire and capacity and discusses contributing factors including reproductive weakness, penile flaccidity, general debility and psychological influences. Traditional treatment principles include improving general and reproductive strength and addressing psychological factors.

These traditional concepts may overlap with symptoms of hypogonadism, but they should **not be used as a substitute for hormone testing**.

This distinction makes the modern Unani approach stronger and more credible.

Why the Unani System Can Be Useful

Unani medicine's major strength is its **individualized whole-person approach**.



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A patient who reports fatigue, poor sexual desire and weakness is not considered only through one laboratory value. Unani assessment traditionally considers Mizaj, diet, digestion, sleep, physical activity, emotional state, sexual function and general physical strength.

This can be particularly useful in **functional low testosterone**, where obesity, inactivity, poor metabolic health, stress and lifestyle factors may be important contributors.

Interestingly, many modern guideline recommendations also emphasize treating obesity, comorbid disease, medications and lifestyle factors before automatically prescribing TRT.

This creates a practical area where evidence-based modern care and traditional Unani principles can complement each other.

Ilaj-bil-Ghiza: Dietotherapy

A balanced diet supports hormonal and metabolic health.

Instead of focusing on one so-called “testosterone food,” a responsible approach should provide adequate protein, vegetables, fruits, whole grains, nuts, seeds and appropriate healthy fats while avoiding excessive calorie intake and ultra-processed foods.

For overweight men, gradual sustainable weight reduction may improve functional testosterone suppression.

Patients with diabetes, fatty liver, kidney disease or other conditions require individualized dietary advice.

Ilaj-bil-Tadbeer: Lifestyle and Regimental Management

Lifestyle treatment is an especially important area of overlap between Unani medicine and contemporary endocrinology.

Management may emphasize regular physical activity, healthy body weight, adequate sleep, avoidance of tobacco and anabolic steroids, moderation of excessive alcohol and effective stress management.

The EAU strongly recommends improving lifestyle, reducing excess weight, treating comorbidities and modifying testosterone-suppressing medicines when possible before initiating TRT for functional hypogonadism.

Lifestyle treatment should therefore not be viewed as a minor addition.

In selected patients, it addresses the actual underlying cause.



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Ilaj-bil-Dawa: Traditional Pharmacotherapy

Unani practitioners may select traditional medicines according to the individual's constitution, symptoms and reproductive goals.

Such treatment may aim to support general vitality, sexual desire, reproductive health or traditionally defined sexual debility.

However, modern scientific evidence for herbal “testosterone boosters” remains substantially weaker than advertising often suggests.

A systematic review of 32 herbal studies found some evidence for certain standardized preparations—particularly ashwagandha and fenugreek—but only 9 studies demonstrated significant testosterone increases, study populations and preparations varied greatly and most participants were not men with established clinical hypogonadism.

A separate systematic review of commercially promoted testosterone-boosting ingredients concluded that **most did not reliably increase total testosterone**.

Traditional medicine should therefore be used with realistic expectations.

Ashwagandha and Testosterone: What Does Research Actually Show?

Ashwagandha is frequently discussed in traditional male wellness.

Some small randomized trials have reported modest increases in testosterone in selected healthy, stressed or lower-libido men. One earlier study found a significant increase after eight weeks, while a newer controlled study found that differences in total and free testosterone were **not statistically significant compared with placebo**.

The U.S. National Center for Complementary and Integrative Health currently describes the evidence as **limited**, suggesting that some ashwagandha preparations may increase testosterone or improve sperm quality over a few months but noting insufficient information on long-term safety.

Therefore, ashwagandha should not be described as equivalent to medical testosterone replacement in confirmed organic hypogonadism.

Kaunch Beej / Mucuna pruriens

Mucuna pruriens, or Kaunch, has also received scientific attention in male reproductive health.

Older clinical studies in infertile men reported improvements in reproductive hormones and semen parameters after Mucuna treatment.



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These findings are interesting for fertility research, but they do not establish Mucuna as a proven substitute for TRT in men with classical testicular or pituitary hypogonadism.

This distinction is particularly important when discussing traditional formulations containing Kaunch.

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

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

[View Dr. Qasmi's Nuskha No. 129 – Vitasem Max](#)

Within an individualized programme, such a formulation may be considered for selected patients presenting with general weakness or reproductive-health concerns.

However, the current product page does **not provide controlled clinical evidence establishing Nuskha No. 129 as a replacement for testosterone therapy in confirmed hypogonadism.**

That distinction should remain clear on a professional disease page.

Spermogenic Powder

Saira Health Care Pharmacy describes **Spermogenic Powder** as a multi-herbal formulation for male sexual and fertility concerns. Its ingredients include traditional substances such as Asgand Nagori, Kaunch, Musli Safed and other herbs.

[View Spermogenic Powder](#)

Some individual ingredients have been investigated scientifically for reproductive-health effects. For example, Mucuna pruriens has been studied in infertile men, and standardized ashwagandha extracts have undergone several small controlled trials.

However, evidence relating an individual herb to testosterone should not automatically be transferred to a multi-ingredient formulation.

Spermogenic may therefore be discussed as part of **individualized fertility and traditional reproductive-health support**, rather than advertised as a clinically proven TRT substitute.

Dr. Qasmi's Nuskha No. 156



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Saira Health Care Pharmacy currently lists **Dr. Qasmi's Nuskha No. 156** as a traditional polyherbal preparation for general health, libido and fertility, with Kaunch as a major component. The current pharmacy page describes it as an **Ayurvedic polyherbal formulation** rather than specifically documenting it as a clinical treatment for laboratory-confirmed hypogonadism.

[View Dr. Qasmi's Nuskha No. 156](#)

For textbook accuracy, its role should therefore be framed around physician-guided traditional wellness or reproductive support rather than asserting that it has been proven to normalize testosterone in men with primary or secondary hypogonadism.

Why One Medicine Cannot Treat Every Low-Testosterone Patient

Consider four men.

The first has obesity-related functional suppression and could potentially improve substantially through weight loss, exercise and management of metabolic disease.

The second has a pituitary tumour causing secondary hypogonadism.

The third has Klinefelter syndrome and primary testicular failure.

The fourth has low testosterone while trying to conceive and requires fertility-preserving hormonal management.

All four have "low testosterone."

But they should not receive the same treatment.

This is why **diagnosis is more important than the name of a supplement.**

The Saira Health Care Approach

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

Its official professional profile lists his qualifications as:

BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK. The profile describes his practice as including male and female sexual disorders, infertility, azoospermia, oligospermia, abnormalities of sperm motility and morphology, varicocele, hormonal imbalance and related reproductive-health conditions.



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According to additional professional credential information supplied by **Saira Health Care for publication**, Dr. Qasmi has also completed **Male Infertility Masters / Masters in Male Infertility through MasterHealthPro (HealthPro)**.

MasterHealthPro publicly lists a six-month **Male Infertility Masters** programme and describes advanced training in male infertility, reproductive physiology, diagnostic evaluation and related sexual dysfunction.

For formal publication, the wording should ideally reproduce the exact title printed on Dr. Qasmi's issued certificate.

Why Male Infertility Training Matters in Low Testosterone

Low testosterone becomes considerably more complicated when a patient wants children.

A clinician must understand that increasing the testosterone number is **not necessarily the same as improving fertility**.

External TRT may improve libido and energy but suppress sperm.

Secondary hypogonadism may sometimes require hCG/FSH treatment.

Infertility may coexist with varicocele, severe oligozoospermia, azoospermia, genetic disease or other testicular pathology.

This makes reproductive goals an essential part of treatment planning.

Current EAU guidance explicitly states that fertility should always be discussed during hypogonadism assessment.

Special Treatment Philosophy at Saira Health Care

A responsible integrative pathway for low testosterone can begin with confirmation of symptoms and appropriate hormone testing rather than immediately starting medicines.

The patient's testosterone should be confirmed with correctly timed testing. LH, FSH, prolactin, SHBG/free testosterone and additional investigations can be considered according to the clinical picture.

The physician can then determine whether the condition is primary, secondary or functional.

Weight, diabetes, sleep, stress, medicines and lifestyle should be addressed.

Fertility goals should be identified before testosterone therapy is considered.

Unani dietotherapy, lifestyle management and appropriately selected traditional formulations can then be incorporated where suitable.



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When a patient has classical organic hypogonadism requiring hormone replacement, pituitary disease requiring endocrine care or fertility-related hormonal disease requiring gonadotropin treatment, appropriate modern medical management should be integrated rather than delayed.

This approach makes Unani treatment **complementary, individualized and diagnosis-led.**

Contribution of Saira Health Care to Sexual Disorders and Infertility

Sexual symptoms frequently overlap.

A patient complaining of low desire may have testosterone deficiency, depression, relationship stress or medication effects.

A man with erectile dysfunction may have vascular disease rather than low testosterone.

A man seeking fertility treatment may have normal testosterone but poor sperm production.

A man using bodybuilding testosterone may have excellent serum testosterone while his sperm production is severely suppressed.

Specialized sexual and infertility services are therefore valuable because the condition needs to be interpreted within the patient's **complete reproductive and sexual-health picture.**

Saira Health Care's published materials describe an approach combining traditional Unani assessment with modern diagnostic information, individualized treatment, counselling and lifestyle guidance.

Common Myths About Low Testosterone

“Feeling tired means my testosterone is low.”

Not necessarily.

Fatigue has many causes. Diagnosis requires compatible symptoms plus confirmed low laboratory testosterone.

“One low test is enough.”

No.

Current guidelines recommend at least two appropriately timed measurements before diagnosing testosterone deficiency.

“Every man should take testosterone after age 40.”

No.



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Healthy ageing produces only a modest hormonal decline in many men, and treatment should be reserved for appropriately diagnosed hypogonadism rather than age alone.

“TRT increases sperm.”

The opposite may occur.

External testosterone can substantially suppress sperm production.

“More testosterone means better erections.”

Not necessarily.

Normal erection depends heavily on blood vessels, nerves, metabolic health and psychological arousal.

“Herbal means completely safe.”

No.

Herbal and traditional medicines can produce adverse effects and interactions. Even ashwagandha, for example, has been associated rarely with liver injury and can interact with several medicines.

“A testosterone booster can replace medical treatment.”

Not in all cases.

A pituitary tumour, Klinefelter syndrome or severe testicular failure cannot responsibly be managed solely with over-the-counter supplements.

When Should a Man Seek Professional Evaluation?

Testing is particularly appropriate when persistent symptoms include reduced libido, loss of spontaneous erections, erectile dysfunction, significant fatigue or reduced physical function, especially when accompanied by infertility, reduced testicular size, previous testicular injury, pituitary symptoms, diabetes, obesity or exposure to testosterone-suppressing medicines.

Headache combined with visual disturbance and confirmed secondary hypogonadism requires particular attention because pituitary disease may need to be excluded.

Men using anabolic steroids who experience infertility or testicular shrinkage should also seek professional evaluation.

Can Low Testosterone Be Reversed Naturally?

Sometimes—but it depends entirely on the cause.



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Functional suppression associated with obesity, poor metabolic health or certain medicines may improve when the underlying problem is corrected.

Weight loss and regular physical activity produce modest average increases in testosterone and are recommended in appropriate patients.

But a congenital genetic condition or severe irreversible testicular damage cannot be expected to normalize simply through diet, exercise or herbs.

The phrase “**naturally increase testosterone**” should therefore be used carefully.

Can Unani Medicine Treat Low Testosterone?

The answer requires distinction between **supporting a patient with symptoms associated with functional sexual debility** and replacing a hormone that the body can no longer adequately produce.

Unani medicine may be especially useful in individualized management of lifestyle, obesity, stress, sleep, digestion, sexual confidence, general debility and reproductive wellness.

Traditional formulations may provide supportive benefit for selected patients.

But confirmed organic hypogonadism may require endocrinological or urological treatment, and fertility-related hypogonadism may require specialized reproductive hormone therapy.

This integrated model respects both the strengths and limitations of each medical system.

Frequently Asked Questions

What is the best time to test testosterone?

For most men, current EAU guidance recommends fasting blood collection between approximately **7 AM and 10 AM**, followed by confirmation on another day if the result is low.

Does low testosterone always cause erectile dysfunction?

No. It can contribute, but vascular and neurological problems are extremely common causes of ED.

Can low testosterone cause infertility?

Depending on the underlying disorder, low testosterone can be associated with impaired sperm production. However, infertility requires its own reproductive evaluation.

Does testosterone injection improve fertility?



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Generally no. External testosterone can markedly suppress sperm production and should not be used as fertility treatment.

Can testosterone improve libido?

Yes, in genuinely hypogonadal men, sexual desire is one of the symptoms most likely to improve.

Does TRT cause heart attacks?

Current evidence does not demonstrate increased major cardiovascular events over approximately three years in appropriately diagnosed men treated to physiological levels, although blood pressure, haematocrit and individual cardiovascular risk still require monitoring.

Can low testosterone cause osteoporosis?

Severe and prolonged hypogonadism can contribute to reduced bone mineral density. Testosterone treatment can improve bone density in appropriately diagnosed men, although fracture prevention requires broader assessment.

Is low testosterone simply part of ageing?

Not necessarily. Age contributes modestly, but obesity and chronic illness account for much of the decline seen in many older men.

Prognosis

The outlook depends greatly on the cause.

Functional low testosterone associated with obesity and poor metabolic health may improve substantially when underlying factors are corrected.

Medication-related suppression may improve after an appropriate clinician-supervised change.

Pituitary disease may respond to targeted endocrine treatment.

Men with secondary hypogonadism seeking fertility may benefit from specialist gonadotropin therapy.

Primary testicular failure may require long-term testosterone replacement when fertility is not being pursued.

The key is to treat **the cause and the patient—not simply the laboratory number.**

Conclusion



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Low testosterone is a medically important condition, but it is also frequently misunderstood and overdiagnosed.

The most important lesson from current evidence is that **male hypogonadism cannot be diagnosed from symptoms alone or from one isolated low testosterone result.**

The latest 2026 EAU guidance requires compatible clinical symptoms together with consistently low morning fasting testosterone. The EAU uses approximately 12 nmol/L as a practical threshold in symptomatic men, whereas the AUA uses below 300 ng/dL, illustrating that interpretation must combine the laboratory result with the patient's clinical situation.

After deficiency is confirmed, LH, FSH, prolactin, SHBG/free testosterone and selected investigations can help determine whether the condition is primary, secondary or functional.

This distinction directly determines treatment.

TRT can provide meaningful benefits for appropriately selected hypogonadal men, particularly for libido and other sexual symptoms. But it should not be given to men with normal testosterone simply for performance enhancement, and it should **not be used as fertility treatment**. Exogenous testosterone can suppress spermatogenesis severely enough to cause oligozoospermia or azoospermia.

Current evidence also provides a more balanced understanding of TRT safety. The large TRAVERSE trial did not demonstrate increased major cardiovascular events, leading the FDA to remove previous boxed-warning language related to MACE; however, blood-pressure increases are now specifically warned about, haematocrit requires monitoring and long-term treatment still requires individualized follow-up.

The **Unani system of medicine** offers an important whole-person perspective through its traditional concepts of Mizaj, diet, general strength, psychological state, reproductive function and individualized treatment. CCRUM's traditional description of **Zof-e-Bah or sexual debility** overlaps with some symptoms seen in hypogonadism but is not scientifically identical to modern laboratory-defined testosterone deficiency.

This distinction creates a sensible integrative model.

Lifestyle and metabolic correction, Ilaj-bil-Ghiza, Ilaj-bil-Tadbeer and selected traditional formulations can be valuable supportive components, particularly where obesity, poor physical health, stress or general sexual debility are contributing factors.

At **Saira Health Care**, Dr. Nizamuddin Qasmi's work focuses on sexual disorders and infertility. His official Saira Health Care profile lists **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK**. According to professional credential information provided for publication, he has additionally completed **Masters in Male Infertility / Male Infertility Masters through MasterHealthPro (HealthPro)**, which publicly lists an advanced six-month Male Infertility Masters programme.



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Dr. Qasmi's Nuskha No. 129, Spermatogenic and Nuskha No. 156 may be considered within individualized traditional sexual and reproductive-health programmes according to a patient's symptoms and medical condition. Their product descriptions and the scientific literature surrounding some of their ingredients, however, should not be interpreted as proof that these formulations can replace testosterone therapy in every patient with confirmed organic hypogonadism.

The strongest approach to low testosterone is therefore:

Confirm the diagnosis correctly. Find the cause. Ask about fertility before treatment. Correct reversible lifestyle and medical factors. Use hormone therapy when truly indicated. Integrate Unani care responsibly where appropriate. Monitor the patient's long-term sexual, reproductive and general health.

That approach allows modern endocrinology, male reproductive medicine and individualized Unani principles to complement one another while maintaining scientific accuracy and patient safety.

About Saira Health Care

Saira Health Care provides consultation and educational services focused particularly on **sexual disorders, male and female infertility and reproductive health**, with an approach that combines individualized Unani care, lifestyle guidance and appropriate modern diagnostic assessment.

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Medical Disclaimer

This article is intended for **general medical education and health awareness**. It does not diagnose an individual patient and should not replace consultation, physical examination, hormonal testing or treatment by an appropriately qualified healthcare professional.

Do not start testosterone injections, gels, anabolic steroids, fertility hormones or “testosterone-boosting” supplements solely on the basis of symptoms or one laboratory result.

Men planning current or future fertility should specifically inform their clinician **before starting testosterone therapy**, because external testosterone can significantly suppress sperm production.

Unani, herbal, Ayurvedic and nutritional formulations contain biologically active ingredients and may cause adverse effects or interact with prescription medicines. “Natural” should not be interpreted as automatically safe, suitable for everyone or proven to normalize testosterone.



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No conventional medicine, hormone, herb, supplement or traditional formulation can responsibly guarantee normalization of testosterone, fertility, erection quality, sexual performance or pregnancy for every patient.



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