Diabetes and Sexual Health in Men: Diabetic Erectile Dysfunction, Causes, Diagnosis, Treatment and the Unani Perspective

Understanding How Diabetes Affects Erection, Sexual Desire, Nerves, Blood Vessels and Male Reproductive Health

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

Updated with medical literature available through September 2026

Introduction

When a man with diabetes comes to me and says:

“Doctor, my sugar is high and my erection has gradually become weak. Is diabetes really responsible?”

my answer is that diabetes can certainly contribute—but we should not simply assume that diabetes is the only cause.

Erectile dysfunction in a man with diabetes is often the result of several factors acting together. Persistently high blood glucose can gradually affect the **small blood vessels, larger arteries, peripheral nerves and autonomic nerves** needed for a normal erection. Diabetes is also commonly associated with high blood pressure, abnormal cholesterol, obesity, cardiovascular disease, low testosterone in some men and emotional stress. Each of these can further influence sexual function.

The background material supplied for this article correctly emphasizes that diabetic erectile dysfunction is multifactorial, involving vascular, neurological and erectile-tissue mechanisms rather than being merely a problem of “sexual weakness.”

The American Diabetes Association's **2026 Standards of Care** now specifically recommends asking men with diabetes or prediabetes about sexual health, including erectile dysfunction

and low libido. It cites an estimated ED prevalence of about **52.5% among men with diabetes**.

For Indian patients, the burden may be especially important. A 2025 meta-analysis of Indian studies estimated erectile dysfunction in approximately **60.6% of men with type 2 diabetes** included in the analyzed studies.

So, if you have diabetes and erectile difficulty, you are not alone—and the problem deserves medical attention rather than embarrassment.

What Is Diabetic Erectile Dysfunction?

Erectile dysfunction (ED) means a persistent difficulty obtaining or maintaining an erection firm enough for satisfactory sexual activity.

A man may experience:

- erection beginning but not becoming sufficiently firm;
- erection becoming weak shortly after penetration;
- difficulty obtaining an erection despite sexual desire;
- erections becoming less reliable than previously;
- reduced morning erections;
- or complete inability to achieve an erection in more advanced cases.

Diabetes is one of the most important chronic medical conditions associated with ED. NIDDK explains that diabetes can damage the nerves and blood vessels necessary for sexual function. Men with diabetes are more than three times as likely to develop ED as men without diabetes, and diabetic ED may appear approximately **10–15 years earlier**.

This is why I tell my patients:

“Weak erection in diabetes should not be ignored, but neither should you lose hope. We first need to understand what has been affected and what can still be improved.”

How Common Is Erectile Dysfunction in Diabetes?

Different studies provide different numbers because populations, age groups and definitions vary.

A large historical meta-analysis involving more than 88,000 men estimated overall ED prevalence among men with diabetes at approximately **52.5%**, with significantly greater odds compared with men without diabetes.

A more recent umbrella review involving more than 108,000 men with diabetes estimated a pooled global prevalence of approximately **65.8%**, although prevalence differed substantially among populations and studies. Important associated factors included older age, longer diabetes duration, peripheral vascular disease and obesity.

The ADA's 2026 Standards of Care continues to use an estimated prevalence of 52.5% and identifies important predictors including age, cardiovascular disease, diabetes, hypertension, obesity, dyslipidaemia, metabolic syndrome, hypogonadism, smoking and depression.

The practical message is more important than the exact percentage:

Erectile dysfunction is common enough in diabetes that sexual health should be part of routine diabetes care.

Why Does Diabetes Affect Erection?

A normal erection requires several systems to function together:

brain → nerves → nitric oxide release → relaxation of penile smooth muscle → increased arterial blood flow → trapping of blood inside the penis → erection.

Diabetes can interfere with several steps in this process simultaneously.

---

1. Damage to Blood Vessels: Diabetic Vasculopathy

An erection is fundamentally dependent on blood flow.

During sexual stimulation, signals from nerves and blood-vessel cells lead to the release of **nitric oxide**, commonly abbreviated as NO.

Nitric oxide stimulates the production of **cyclic guanosine monophosphate (cGMP)**.

cGMP helps smooth muscle inside the penis relax.

The penile arteries widen, blood enters the erectile chambers and the penis becomes firm.

Chronically elevated blood glucose can damage the vascular endothelium—the inner lining of blood vessels—and reduce normal endothelial function.

Diabetes is also strongly associated with atherosclerosis, hypertension and abnormal cholesterol.

The result may be inadequate arterial blood flow to the penis.

Current European Association of Urology guidelines recognize diabetes as both a **vasculogenic and neurogenic risk factor** for erectile dysfunction.

2. Reduced Nitric Oxide Availability

Nitric oxide is essential for normal erectile physiology.

Long-term hyperglycaemia can contribute to:

- oxidative stress;
- endothelial dysfunction;
- impaired nitric oxide signalling;
- abnormal smooth-muscle relaxation.

If penile tissue does not relax sufficiently, blood cannot enter and remain inside the erectile chambers efficiently.

The detailed source supplied for this article also emphasizes endothelial injury and impaired nitric-oxide signalling as central mechanisms in diabetic erectile dysfunction.

---

3. Diabetic Neuropathy: Damage to Sexual Nerves

Diabetes does not only affect blood vessels.

It can also damage nerves.

This is known as **diabetic neuropathy**.

An erection requires signals to travel from the brain and spinal cord through autonomic and peripheral nerves to the genital region.

When diabetes damages these pathways, a man may notice:

- reduced penile sensation;
- reduced response to sexual stimulation;
- slower development of erection;
- difficulty maintaining erection;
- altered orgasm;
- ejaculation problems.

NIDDK specifically explains that diabetic nerve damage can affect the genital and urinary systems and contribute to sexual dysfunction.

---

4. Changes in Penile Smooth Muscle

The corpora cavernosa—the erectile chambers of the penis—contain specialised smooth muscle.

For erection to occur, this tissue must relax and expand.

Long-standing diabetes may be associated with structural and functional changes in cavernosal tissue.

When smooth-muscle function deteriorates, erection may become increasingly difficult even when sexual desire remains normal.

This is one reason diabetic ED can sometimes be more difficult to treat than temporary performance-anxiety-related ED.

It does **not**, however, mean that every man with diabetes has irreversible erectile damage.

Severity varies greatly according to:

- duration of diabetes;
- glucose control;
- blood pressure;
- cholesterol;
- smoking;
- body weight;
- cardiovascular health;
- neuropathy;
- age;
- and other individual factors.

---

5. Diabetes, Atherosclerosis and Cardiovascular Disease

Diabetes accelerates cardiovascular disease in many patients.

The arteries supplying the penis are relatively small.

This means that vascular problems may sometimes become clinically noticeable through erectile dysfunction.

Current EAU guidelines regard ED as an important **marker and risk enhancer for cardiovascular disease**, and state that erectile dysfunction can improve detection of otherwise asymptomatic cardiovascular disease, including in men with diabetes.

This is a very important point.

A man who tells me:

"Doctor, erection has gradually become weak over the last year,"

may not simply need an erection tablet.

He may also need assessment of:

- blood pressure;
- blood glucose;
- HbA1c;
- cholesterol;
- weight;
- smoking history;
- cardiovascular symptoms;
- overall cardiovascular risk.

Sexual health can sometimes provide an early warning about general vascular health.

---

6. Testosterone and Diabetes

Not every diabetic man with ED has low testosterone.

But diabetes—especially when associated with obesity and increasing age—is associated with a greater likelihood of testosterone deficiency.

Possible symptoms include:

- reduced sexual desire;
- low energy;
- reduced spontaneous erections;
- fatigue;
- reduced motivation;
- sometimes loss of muscle mass.

The ADA's 2026 Standards recommend asking men with diabetes about low libido and ED, and obtaining a **morning total testosterone level when symptoms or signs suggest hypogonadism**.

European guidelines similarly recommend early-morning testosterone as part of the basic laboratory work-up for ED.

Testosterone should **not** be prescribed simply because an erection is weak.

A genuine deficiency should first be demonstrated and interpreted in the appropriate clinical context.

---

7. Psychological Effects of Diabetes

Diabetic erectile dysfunction is not purely a physical problem.

Suppose a man has one episode of erection loss because vascular or neurological function has become slightly impaired.

During his next sexual encounter he thinks:

“Will it happen again?”

That creates anxiety.

He monitors his erection.

The erection becomes slightly softer.

He panics.

Now the psychological response makes the physical problem worse.

This creates:

mild diabetic ED → performance anxiety → worse erection → fear → further performance difficulty.

Diabetes may therefore cause an organic problem that later develops an additional psychological component.

NIDDK recognizes anxiety, depression and stress as factors that can cause or worsen ED.

This is why some patients benefit from counselling or psychosexual therapy in addition to physical treatment.

---

8. Medicines Can Also Affect Sexual Function

Some medicines used by people with chronic health problems can contribute to ED.

These may include certain:

- antihypertensives;
- antidepressants;
- sedatives;
- hormonal medicines;
- pain medicines.

Do **not** stop prescribed diabetes, blood-pressure or heart medicine yourself.

Instead, show the doctor your complete medication list and ask whether any medication could be contributing.

NIDDK specifically recommends medication review as part of ED treatment.

Other Sexual Problems Associated With Diabetes

Diabetes can affect more than erection.

Reduced Sexual Desire

Low libido can result from:

- low testosterone;
- depression;
- chronic fatigue;
- relationship problems;
- poor glucose control;
- chronic illness;
- medication effects.

Retrograde Ejaculation

Diabetes-related autonomic neuropathy can occasionally cause **retrograde ejaculation**.

Normally, semen travels outward through the penis.

In retrograde ejaculation, some or all semen enters the bladder instead.

A man may notice:

- little or no semen at orgasm;
- cloudy urine afterwards.

NIDDK recognizes retrograde ejaculation as an uncommon sexual complication of diabetes.

It is usually not dangerous, but it can affect fertility.

Diabetes and Peyronie's Disease

Men with diabetes may also have an increased likelihood of **Peyronie's disease**, in which fibrous plaque inside the penis causes abnormal curvature.

The curvature may:

- make intercourse difficult;
- produce pain;
- coexist with erectile dysfunction.

NIDDK specifically notes the relationship between diabetes, Peyronie's disease and ED.

Diabetes, ED and Fertility Are Not the Same Thing

This distinction is extremely important.

Erectile dysfunction is not the same as male infertility.

A diabetic man may have:

- weak erection with normal sperm;
- normal erection with abnormal sperm;
- both erectile dysfunction and impaired semen quality;
- or neither problem.

Likewise, low semen volume, sperm count, motility and morphology require appropriate fertility evaluation.

If a couple is having difficulty conceiving, merely treating the erection is not enough.

At Saira Health Care, where my clinical focus includes both sexual disorders and infertility, I consider these two areas separately and then examine how they may interact in the individual patient.

Who Is at Greater Risk of Diabetic Erectile Dysfunction?

Risk tends to increase with:

- longer duration of diabetes;
- poor blood-glucose control;
- increasing age;
- diabetic neuropathy;
- cardiovascular disease;
- high blood pressure;
- abnormal cholesterol;
- obesity;
- smoking;
- physical inactivity;
- kidney disease;
- microvascular complications;
- low testosterone;
- depression;
- certain medicines.

A 2024 systematic review and meta-analysis of risk factors in men with diabetes further supports the relationship between ED and multiple metabolic and vascular factors rather than a single isolated cause.

For type 1 diabetes specifically, a 2024 meta-analysis involving 3,788 men estimated ED prevalence at approximately 42.5%, with age, diabetes duration, BMI, HbA1c, retinopathy and smoking among identified risk factors.

Symptoms That Should Not Be Ignored

Consult a qualified healthcare professional when:

- erections become repeatedly weak;
- you cannot maintain erection until desired sexual activity is completed;

- erection has progressively deteriorated;
- morning erections have substantially reduced;
- sexual desire becomes persistently low;
- there is penile curvature or pain;
- ejaculation becomes abnormal;
- ED develops along with poorly controlled diabetes;
- ED occurs with chest discomfort, breathlessness or exercise intolerance;
- you are also experiencing infertility.

Do not wait for ED to become severe before discussing it.

How I Evaluate Diabetic Erectile Dysfunction

When a patient with diabetes consults me for sexual weakness, I do not begin by asking:

“Which medicine should I give?”

I begin by asking:

“Why is the erection becoming weak?”

Modern EAU guidance strongly recommends comprehensive medical and sexual history, focused examination and relevant metabolic and hormonal investigations for men with ED.

Medical History

I want to know:

- How long have you had diabetes?
- Is it type 1 or type 2?
- What was your recent HbA1c?
- When did erectile difficulty begin?
- Was onset gradual or sudden?
- Do you still have morning erections?
- Is sexual desire normal?
- Is erection normal during masturbation?

- Does erection become weak only with a partner?
- Do you have premature ejaculation?
- Are there symptoms of neuropathy?
- Do you smoke?
- Do you drink alcohol?
- Do you have hypertension or cholesterol problems?
- Are you taking nitrate medication for angina?
- Are you taking antidepressants?
- Are you trying to conceive?
- Is anxiety now affecting sexual performance?

These details help separate predominantly vascular, neurological, hormonal and psychological components.

Physical Examination

Depending on the individual, examination may assess:

- blood pressure;
- heart rate;
- weight and BMI;
- waist circumference;
- genital anatomy;
- penile plaques or curvature;
- testicular size;
- signs suggesting testosterone deficiency;
- vascular status;
- neurological findings.

EAU guidelines recommend focused genitourinary, endocrine, vascular and neurological examination in men presenting with ED.

Blood Tests

Depending on what has already been checked, useful tests may include:

HbA1c or fasting glucose

To understand diabetes control.

Lipid profile

Because high cholesterol and atherosclerosis can impair penile circulation.

Morning total testosterone

Especially where low libido or other symptoms suggest testosterone deficiency.

Additional tests

Thyroid function, prolactin, kidney function and other investigations may be useful in selected patients.

Current EAU guidance specifically recommends glucose/HbA1c, lipid profile and early-morning testosterone as part of the basic ED evaluation when not recently assessed.

International Index of Erectile Function

Doctors may use the **International Index of Erectile Function (IIEF)** or shorter IIEF-5/SHIM questionnaires.

These help assess:

- erection quality;
- ability to maintain erection;
- intercourse success;
- sexual satisfaction.

They also provide an objective method of monitoring treatment response.

Penile Doppler Ultrasound

Not every diabetic man needs penile Doppler testing.

It can be useful in selected patients when significant vascular ED is suspected, particularly:

- patients with multiple cardiovascular risk factors;
- severe diabetes-related ED;
- poor response to correctly used oral therapy;

- suspected arterial insufficiency.

EAU guidelines identify diabetes as one clinical situation in which penile duplex ultrasound may be considered when vasculogenic ED is suspected.

Treating Diabetic Erectile Dysfunction

Successful management usually has two parallel objectives:

1. Improve the underlying metabolic and cardiovascular health.

2. Treat the erectile problem itself.

A patient gets the best long-term benefit when both are addressed.

The First Treatment: Control the Diabetes

No sexual medicine can compensate indefinitely for poorly controlled diabetes.

Better glucose control helps reduce ongoing damage to blood vessels and nerves.

NIDDK emphasizes keeping blood glucose in the target range as an important way of reducing diabetes-related nerve and blood-vessel complications affecting sexual function.

This does not mean that lowering HbA1c today will restore every damaged nerve tomorrow.

It means that good metabolic management remains part of protecting future sexual function.

Control Blood Pressure and Cholesterol

Blood pressure and cholesterol management should not be considered unrelated to sexual treatment.

The same blood vessels supplying the heart, brain and legs are part of the same vascular system affecting penile circulation.

Current guidelines recommend controlling metabolic and cardiovascular conditions as part of ED management.

Exercise

Physical activity can improve:

- cardiovascular fitness;

- insulin sensitivity;
- body weight;
- vascular health;
- psychological wellbeing.

EAU guidelines conclude that lifestyle modifications including physical activity and weight reduction can improve erectile function in appropriate populations.

NIDDK likewise recommends increasing physical activity as part of ED treatment.

Maintain a Healthy Weight

Obesity is closely connected with:

- insulin resistance;
- hypertension;
- dyslipidaemia;
- inflammation;
- low testosterone;
- cardiovascular disease.

All can influence erection.

Weight management is therefore part of sexual healthcare, not simply cosmetic advice.

Stop Smoking

Smoking directly damages blood vessels.

For a diabetic man already vulnerable to vascular disease, smoking adds another major risk.

Stopping smoking is one of the most important lifestyle steps for both erectile and cardiovascular health.

Reduce Excessive Alcohol

Excess alcohol can worsen:

- erection;
- neuropathy;

- glucose control;
- liver health;
- testosterone;
- relationship problems.

Moderation is particularly important where diabetes and ED coexist.

Healthy Diet

A healthy diet supporting diabetes, cardiovascular health and appropriate body weight may also support erectile health.

NIDDK notes that dietary patterns associated with lower risks of diabetes, cardiovascular disease and obesity are also associated with lower ED risk or improved ED symptoms.

There is no single “sexual power food” that reverses diabetic neuropathy.

The dietary goal should be metabolic health.

PDE5 Inhibitors: Sildenafil, Tadalafil and Related Medicines

Common oral medicines for ED include:

- sildenafil;
- tadalafil;
- vardenafil;
- avanafil.

These are called **PDE5 inhibitors**.

They do not create sexual desire automatically.

Instead, they strengthen the natural nitric oxide–cGMP erection pathway during sexual stimulation.

Are PDE5 Inhibitors Dangerous for Every Diabetic Patient?

No.

This is an important point where current evidence differs from some claims in the supplied background material.

The source material characterizes PDE5 inhibitors as broadly dangerous for men with diabetes and suggests that Unani therapy is inherently safer and superior.

That claim is **not supported by current major clinical guidelines**.

The EAU guideline concludes that PDE5 inhibitors produce significant improvement in erectile function with a **good overall safety profile** and recommends them as **first-line therapy for ED**.

A 2025 systematic review and meta-analysis specifically studying diabetic ED also concluded that PDE5 inhibitors can safely and effectively improve erectile dysfunction in men with diabetes, although adverse effects and individual differences must be considered.

This distinction is essential for a scientifically accurate article.

The Important Exception: Nitrates

PDE5 inhibitors can be dangerous when combined with **nitrate medicines** used for angina or certain heart conditions.

Examples can include nitroglycerin and other organic nitrates.

Combining a PDE5 inhibitor with a nitrate may cause a dangerous fall in blood pressure.

EAU guidelines identify concurrent nitrate or nitric-oxide-donor use as an **absolute contraindication** to PDE5 inhibitors.

Therefore, never use erectile-dysfunction medicine secretly if you are receiving heart treatment.

Tell the doctor exactly which medicines you take.

Cardiovascular Assessment Before ED Treatment

Because diabetic men with ED may have increased cardiovascular risk, the clinical question is not simply:

“Is sildenafil dangerous?”

The correct question is:

“Is this individual patient's cardiovascular health stable enough for sexual activity and appropriate ED treatment?”

Current EAU guidance incorporates the Princeton IV cardiovascular recommendations and treats ED as an opportunity to assess cardiovascular risk.

Patients with unstable or significant cardiovascular symptoms require appropriate medical evaluation.

What if Sildenafil or Tadalafil Does Not Work?

A poor response does not automatically mean the penis is permanently damaged.

The doctor should first check:

- Was the medication genuine and properly prescribed?
- Was the correct dose used?
- Was timing correct?
- Was adequate sexual stimulation present?
- Was a heavy meal interfering with absorption?
- Is severe anxiety present?
- Is testosterone genuinely deficient?
- Has diabetic vascular disease become advanced?

EAU guidance specifically notes that incorrect use and inadequate patient education are important causes of apparent PDE5 failure.

Vacuum Erection Device

A vacuum erection device draws blood into the penis mechanically.

It may be useful for men who:

- cannot take oral medicines;
- do not respond adequately;
- prefer a non-drug option.

EAU guidelines report good overall effectiveness, although satisfaction varies and bruising, numbness and discomfort may occur.

Intracavernosal Injection Therapy

Medicines such as alprostadil can be injected directly into the erectile tissue.

These treatments may work when tablets are inadequate.

Proper medical training is essential because incorrect use can cause:

- pain;
- prolonged erection;
- fibrosis;
- other complications.

They should never be self-administered without instruction.

Penile Prosthesis

For severe ED that does not respond satisfactorily to less invasive therapies, penile prosthesis surgery may be considered.

This is generally reserved for carefully selected patients after discussing:

- benefits;
- risks;
- infection;
- mechanical complications;
- expectations.

Diabetes can increase certain surgical risks, which makes careful metabolic control particularly important.

Psychological and Relationship Treatment

Diabetic ED can produce:

- shame;
- avoidance of sex;
- relationship conflict;
- fear of rejection;
- depression;
- performance anxiety.

Counselling can be valuable even when the ED has a clear physical cause.

EAU guidelines recommend cognitive-behavioural and psychosexual interventions where appropriate and note that combining psychological and medical treatment can maximize outcomes.

Testosterone Treatment

Testosterone therapy is **not an erection tonic for every diabetic man**.

It should generally be considered when a clinically relevant testosterone deficiency has been appropriately demonstrated.

Men with normal testosterone usually should not expect testosterone replacement to solve vascular diabetic ED.

Where hypogonadism is confirmed, treatment may improve libido and can sometimes improve response to ED therapy.

The Unani Perspective on Diabetic Sexual Dysfunction

As a physician trained in Unani medicine, I consider its greatest strength to be its traditionally **whole-patient approach**.

Unani medicine does not historically view health only as a single isolated organ problem.

Its framework considers:

- **Mizaj** – individual temperament;
- **Akhlat** – the classical humours;
- function of vital organs;
- diet;
- digestion;
- sleep;
- physical activity;
- psychological wellbeing;
- environmental and lifestyle influences.

Official Ministry of Ayush material describes Unani medicine as emphasizing prevention and health promotion through the **six essential factors of life—Asbab-e-Sitta Zarooriyah**.

The Four Humours in Classical Unani Medicine

Classical Unani theory describes:

Dam – blood
Balgham – phlegm
Safra – yellow bile
Sauda – black bile

Health is traditionally understood in relation to the appropriate balance of these humours and the individual's Mizaj.

These are **traditional explanatory concepts**.

They should not be treated as laboratory measurements equivalent to blood glucose, HbA1c, testosterone or nitric oxide.

In contemporary responsible practice, I believe Unani assessment should complement appropriate modern investigations rather than replace them.

Zuf-i-Bah: Sexual Debility in Unani Literature

The Central Council for Research in Unani Medicine (CCRUM), under India's Ministry of Ayush, discusses sexual debility under the traditional term **Zuf-i-Bah**.

Its treatment guideline recognizes several traditional contributors, including **Istirkha-i-Qazib**, or penile flaccidity, as well as **Umur Wahmiyya—psychological factors**.

This is important because the Unani framework itself acknowledges that sexual dysfunction can involve both body and mind.

CCRUM also lists metabolic and hormonal investigations including:

- blood glucose;
- lipid profile;
- kidney function;
- testosterone;
- prolactin;
- gonadotropins

within its evaluation framework for sexual debility.

This provides an important bridge between traditional Unani care and contemporary medical assessment.

The Six Essential Factors and Diabetic Sexual Health

The Unani concept of **Asbab-e-Sitta Zarooriya** can be particularly helpful in chronic metabolic disease.

It includes:

Air and environment

Healthy surroundings and environmental conditions.

Food and drink

Particularly relevant in diabetes because diet directly affects glucose, body weight and cardiovascular health.

Physical movement and rest

Regular physical activity supports circulation and metabolic health.

Psychological movement and repose

Chronic stress, anxiety and depression can worsen diabetes management and sexual function.

Sleep and wakefulness

Poor sleep may worsen metabolic control, fatigue and sexual desire.

Retention and elimination

Part of the classical Unani framework concerning normal physiological balance.

These factors create a useful structured conversation about the patient's whole lifestyle.

How Unani Medicine May Contribute to Diabetic ED

In my view, responsible Unani care may contribute in several ways.

1. Lifestyle Regulation

This is one of the most important areas.

A patient with:

- irregular meals;
- obesity;
- physical inactivity;

- poor sleep;
- chronic stress

cannot expect one sexual medicine to solve everything.

Unani emphasis on regulating daily living is compatible with modern recommendations for metabolic and cardiovascular health.

---

2. Dietotherapy – Ilaj bil Ghiza

Unani medicine traditionally uses diet as part of treatment.

For a diabetic patient, however, diet must respect modern diabetes requirements.

I do **not** advise patients to consume large amounts of:

- honey;
- dates;
- sweet Majun preparations;
- sugar-rich tonics

simply because they are traditionally considered strengthening.

A food or medicine can be traditional and still raise blood glucose.

The patient's diabetes comes first.

---

3. Regimenal Therapy – Ilaj bit Tadbir

Unani regimenal principles can help organize:

- physical activity;
- rest;
- stress reduction;
- sleep;
- healthy routine.

These should be individualized according to the patient's age, cardiovascular health and diabetes-related complications.

---

4. Pharmacotherapy – Ilaj bid Dawa

CCRUM's official treatment guideline for sexual debility lists several traditional Unani formulations, including preparations such as **Labub Kabir, Majun Jalali and other compound medicines**.

However, an important clinical principle applies:

A traditional indication is not the same thing as high-quality proof of effectiveness specifically for diabetic erectile dysfunction.

These medicines should be selected only after considering:

- diabetes control;
- kidney function;
- liver function;
- cardiovascular disease;
- existing medicines;
- formulation ingredients;
- sugar content;
- potential interactions.

What About Labub Kabir and Traditional Tonics?

Traditional Unani literature uses Labub formulations as nutritive or nervine preparations in certain sexual-debility presentations.

The supplied source describes Labub Kabir very strongly and attributes nerve regeneration, tissue restoration and cardiovascular superiority to it.

These claims need to be moderated for a medically responsible website.

At present, there is **not sufficient high-quality clinical evidence to claim that Labub Kabir regenerates diabetic nerves, reverses cavernosal fibrosis or is safer and more effective than established ED medicines**.

Traditional use may justify further research, but it should not be presented as proven cellular regeneration.

This distinction strengthens, rather than weakens, responsible Unani medicine.

Sugar-Free Unani Formulations in Diabetes

This is an important practical subject.

Traditional:

- Majun;
- Khamira;
- Labub;
- Halwa

preparations may use substantial amounts of sugar, honey or sweet bases.

For a patient with diabetes, that can be unsuitable.

Sugar-free alternatives may sometimes be preferable, but the words **"sugar-free" do not automatically mean medically safe**.

Patients should still check:

- carbohydrate content;
- full ingredients;
- dosage;
- kidney and liver considerations;
- drug interactions;
- product quality.

I would not advise a diabetic patient to begin a traditional strengthening formulation without reviewing these issues.

Herbs and Erectile Dysfunction: What Does Research Actually Show?

Traditional plant medicines deserve scientific study.

But I prefer discussing evidence accurately rather than calling every herb a proven cure.

Tribulus terrestris – Khare Khasak / Gokhru

Tribulus terrestris is traditionally used in several systems of medicine for sexual and reproductive health.

A recent systematic review and meta-analysis of randomized trials published for 2026 found improvements in erectile-function scores compared with placebo in the included studies, while finding **no significant increase in total testosterone**.

Another 2025 systematic review found that some trials reported benefit but also highlighted variable methodological quality.

This means:

Tribulus may deserve consideration and further study, but it should not be claimed to reliably raise testosterone or reverse diabetic neuropathy.

Herbal Treatments More Broadly

A 2025/2026 systematic review and meta-analysis of 14 randomized trials involving 1,227 men found that some herbal supplements improved erectile-function measures, with evidence particularly noted for agents such as saffron and ginseng. However, study duration was relatively short and evidence differed considerably between products.

Most importantly for this article:

Evidence for an herb in general ED is not automatically evidence for treating diabetic ED.

Diabetic ED has unique vascular, neurological and metabolic components.

Ashwagandha – Asgandh

Ashwagandha is traditionally used in South Asian systems as a restorative or adaptogenic plant.

Research has investigated possible effects on:

- stress;
- sleep;
- sexual wellbeing;
- reproductive parameters.

However, claims that it has been clinically proven to **regenerate diabetic myelin sheaths or reverse advanced diabetic autonomic neuropathy in humans** go beyond current evidence.

I would therefore describe Asgandh as a potential component of individualized traditional care—not a replacement for diabetes control or established ED treatment.

Paneer Dodi, Satawar, Ginger and Other Herbs

The source material also discusses:

- *Withania coagulans*;
- *Asparagus racemosus*;
- ginger;
- garlic;
- *Commiphora mukul*;
- watermelon-derived citrulline.

Many have interesting laboratory, animal or preliminary clinical research.

But statements such as:

“repairs pancreatic beta cells permanently,”

“regenerates nerves,”

or

“reverses diabetic erectile damage”

should not currently be presented to patients as established clinical facts.

The difference between **biological plausibility** and **proven patient benefit** is extremely important in medical writing.

A 2025 Clinical Study of Unani Treatment for ED

Unani research is developing.

A randomized open-label clinical study published in 2025 compared oral and topical Unani polyherbal formulations with another herbal treatment regimen for erectile dysfunction.

The study supports continued investigation into Unani approaches, but it was relatively small and was **not a definitive diabetes-specific placebo-controlled trial**.

Therefore, the appropriate conclusion is:

Unani therapy for ED has promising areas for research, but stronger and larger controlled trials—especially specifically in diabetic ED—are still required.

Why I Prefer Integrative Rather Than Competitive Medicine

Patients sometimes ask me:

“Doctor, should I choose Unani or modern medicine?”

I do not believe sexual healthcare should become a competition between systems.

A diabetic man may need:

modern laboratory testing to understand HbA1c, cholesterol and testosterone;

cardiovascular assessment when vascular risk is high;

modern ED medicines where appropriate;

psychological support where anxiety is contributing;

and an **individualized Unani approach** to lifestyle, diet, general wellbeing and carefully selected traditional medicines.

These approaches can coexist when used responsibly.

The objective is the patient's health—not proving that one system must defeat another.

Special Clinical Approach at Saira Health Care

At **Saira Health Care**, my focused practice includes sexual disorders and infertility.

When a diabetic patient consults me for erectile dysfunction, I consider several questions before planning treatment:

Is blood glucose adequately controlled?

Without controlling diabetes, progressive vascular and neurological damage may continue.

Is the ED predominantly vascular?

We assess metabolic and cardiovascular risk.

Is neuropathy present?

Symptoms in the feet, legs, bladder or penis may provide important clues.

Is testosterone genuinely low?

Testing should guide hormonal decisions.

Is performance anxiety now making the problem worse?

Physical and psychological ED commonly coexist.

Is premature ejaculation also present?

It requires a separate assessment.

Is there infertility?

Erection and sperm quality should not be confused.

Which medicines is the patient already taking?

This is especially important for nitrate medication and cardiovascular drugs.

Is Unani treatment appropriate?

If so, I consider the patient's diabetes, temperament, general condition, diet, sleep, physical activity, existing medicines and treatment objectives rather than automatically prescribing the same strengthening tonic to everyone.

Why Saira Health Care Emphasizes Patient Education

Sexual disorders remain surrounded by misinformation.

Diabetic men may be told:

“Your sexual power is permanently finished.”

or:

“Take this one herbal medicine and diabetes-related nerve damage will completely disappear.”

or:

“Never take modern ED medicine because it causes heart attacks.”

None of these statements is a responsible universal conclusion.

At Saira Health Care, an important contribution to sexual and reproductive healthcare is helping patients understand:

- why diabetes affects erection;
- why cardiovascular health matters;
- why ED may sometimes be an early health warning;
- how anxiety can worsen diabetic ED;
- when laboratory testing is necessary;
- when Unani care may complement treatment;
- and when modern medical or specialist management is appropriate.

I believe that an informed patient is much less vulnerable to dangerous sexual-health advertising.

A Practical Treatment Plan for a Man With Diabetes and ED

In clinical practice, I prefer a stepwise approach.

Step 1: Measure diabetes control

Review:

- HbA1c;
- fasting/postprandial glucose;
- medication adherence.

Step 2: Assess cardiovascular risk

Check:

- blood pressure;
- cholesterol;
- smoking;
- obesity;
- cardiovascular symptoms;
- exercise tolerance where clinically appropriate.

Step 3: Review erection pattern

Determine:

- onset;
- severity;
- morning erection;
- masturbation-associated erection;
- penetration and maintenance;
- psychological factors.

Step 4: Check hormones where appropriate

Particularly morning total testosterone when symptoms suggest deficiency.

Step 5: Improve lifestyle

Address:

- exercise;
- weight;
- diet;
- smoking;
- alcohol;
- sleep;
- stress.

Step 6: Treat ED appropriately

Options may include:

- PDE5 inhibitors;
- vacuum device;
- alprostadil;
- injection therapy;
- psychological treatment;
- penile prosthesis in selected severe cases.

The appropriate option depends on the individual.

Step 7: Add individualized Unani support when suitable

This may include:

- Ilaj bil Ghiza;
- Ilaj bit Tadbir;

- stress and sleep regulation;
- qualified Unani pharmacotherapy;
- general constitutional and lifestyle assessment.

It should support—not interfere with—safe diabetes management.

Step 8: Review the outcome

Ask:

- Is erection harder?
- Can it be maintained longer?
- Has anxiety reduced?
- Is sexual satisfaction better?
- Has glycaemic control improved?
- Have medicines caused side effects?
- Does treatment remain necessary or need modification?

A treatment plan should evolve according to the patient's response.

Frequently Asked Questions

Does diabetes permanently cause impotence?

No.

Diabetes increases the risk of ED, and long-standing poorly controlled diabetes can cause significant vascular and neurological damage.

But severity differs greatly.

Many men improve with better risk-factor control and appropriate ED treatment. Effective treatment options are available.

Can ED be the first sign of diabetes?

Sometimes sexual dysfunction can occur before diabetes has been diagnosed.

If a man develops unexplained ED—particularly with obesity, excessive thirst, frequent urination or family history of diabetes—blood-glucose assessment may be appropriate.

Why is my erection worse when my sugar is high?

Poor glucose control over time contributes to vascular and nerve damage, while acute fluctuations can also influence energy and wellbeing.

Long-term glucose management is particularly important in reducing complications.

Can diabetes damage penile nerves?

Yes.

Diabetic neuropathy can affect autonomic and peripheral nerves involved in sexual response.

Does diabetes cause low testosterone?

Not every diabetic man has low testosterone.

However, diabetes—particularly with obesity—is associated with a greater likelihood of testosterone deficiency.

Testing should be performed when clinically indicated rather than automatically prescribing testosterone.

Is Viagra dangerous in diabetes?

Not simply because a person has diabetes.

PDE5 inhibitors are established first-line ED therapies with an overall good safety profile when prescribed appropriately.

However, they are **contraindicated with nitrate medicines**, and men with unstable cardiovascular disease may require additional assessment.

Can sildenafil cause a heart attack?

Current EAU guidance states that randomized and open-label studies have not demonstrated increased myocardial-infarction rates from PDE5 inhibitors themselves. The major concern is appropriate cardiovascular assessment and avoiding dangerous drug combinations, particularly nitrates.

Are PDE5 medicines effective in diabetic ED?

Yes, although response can be less robust in some men with advanced diabetic complications.

A 2025 meta-analysis of randomized trials found significant benefit of PDE5 inhibitors in diabetic ED.

Does better diabetes control improve sexual health?

Better diabetes management helps reduce ongoing vascular and nerve damage and is an important component of prevention and treatment.

NIDDK specifically recommends keeping blood glucose, blood pressure and cholesterol near individualized targets.

Can Unani medicine help diabetic ED?

Unani medicine can be valuable as part of an individualized holistic approach emphasizing diet, activity, sleep, psychological wellbeing and carefully selected traditional therapy.

However, present evidence does not establish that a particular Unani formulation can universally reverse diabetic neuropathy or permanently cure diabetic ED.

Can Gokhru increase testosterone?

Current evidence does not justify promising this.

A recent meta-analysis found improvement in some erectile-function outcomes with *Tribulus terrestris* but no significant difference in total testosterone.

Can I take Labub Kabir if I have diabetes?

Do not assume that every traditional Labub is appropriate for diabetes.

Some classical formulations may contain significant sugar or sweet bases, and other ingredients may require consideration of kidney, liver and cardiovascular health.

Use only after professional assessment.

Is a “sugar-free” Unani medicine automatically safe for diabetes?

No.

Sugar-free does not mean risk-free.

Ingredients, carbohydrates, interactions, dosage and individual medical conditions still need to be considered.

Does ED mean my sperm are weak?

No.

Erectile function and semen quality are separate issues.

If fertility is a concern, semen analysis and appropriate couple evaluation should be considered independently.

When to Seek Prompt or Emergency Care

Seek prompt medical evaluation if ED is accompanied by:

- unexplained chest discomfort;
- breathlessness with minor exertion;
- fainting;
- major cardiovascular symptoms;
- severe genital pain;
- sudden testicular pain;
- blood in urine;
- significant penile curvature with pain.

After taking an ED medicine, seek urgent care for an erection lasting approximately **four hours or longer** or significant sudden hearing or vision changes. NIDDK advises urgent evaluation for these uncommon but serious complications.

A Message From Dr. Nizamuddin Qasmi

If you have diabetes and your sexual performance has changed, please do not assume that your sexual life is finished.

At the same time, do not treat the problem casually.

Erection is closely connected with your **blood vessels, nerves, hormones, metabolic health, psychological wellbeing and cardiovascular system**.

That means erection problems can sometimes tell us something important about your overall health.

My approach is not simply:

“Take a power medicine.”

I want to know:

Why did the problem begin?

How well controlled is the diabetes?

Are the blood vessels healthy?

Is neuropathy present?

Is testosterone normal?

Is anxiety worsening the problem?

Is fertility also a concern?

And which combination of lifestyle management, Unani care, medical treatment or specialist support is most appropriate for this particular patient?

I believe Unani medicine can make a meaningful contribution when its holistic principles are applied intelligently and when traditional treatment is integrated with appropriate clinical investigations.

But traditional medicine becomes stronger—not weaker—when we distinguish what is historically used from what modern research has actually proven.

Similarly, modern ED medicines should neither be taken blindly nor feared unnecessarily.

The safest and most effective approach is individualized, evidence-informed and focused on the whole patient rather than only the erection.

About Dr. Nizamuddin Qasmi

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

At Saira Health Care, the clinical focus includes patient education, individualized assessment and integrative management of sexual and reproductive-health concerns, including erectile dysfunction and infertility.

Medical Disclaimer

This article is intended for **patient education and general medical information** and does not replace an individual consultation, examination, laboratory testing, diagnosis or treatment.

Diabetes-related erectile dysfunction may indicate vascular, neurological, hormonal, psychological or cardiovascular problems. Patients should not start or discontinue diabetes, blood-pressure, heart, hormonal or erectile-dysfunction medicines without appropriate medical advice.

PDE5 inhibitors must not be combined with organic nitrates or nitric-oxide donors. Herbal and Unani formulations can also cause adverse effects or interact with prescription medicines and should therefore be selected under qualified supervision.

The evidence supporting established conventional ED treatments is currently substantially stronger than the evidence supporting specific Unani preparations for **diabetes-induced erectile dysfunction**. Unani care is best presented as an individualized complementary and integrative approach while stronger diabetes-specific clinical trials continue to develop.