Medical and Age-Related Sexual Health Changes

Navigating Sexual Health After Prostate Treatment, Chronic Illness and Normal Aging

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

Sexual health changes with time. A man who had satisfactory erections in his forties may notice slower arousal in his sixties. A patient who undergoes prostate surgery may suddenly find that erections, ejaculation or orgasm feel different. Someone living with diabetes, heart disease, kidney disease, arthritis or another long-term illness may lose sexual confidence even though affection for the partner remains unchanged.

When patients come to me with these concerns, one of the first things I explain is that **a change in sexual function does not mean that a person's sexual life has ended**. Sexual health involves much more than erection or penetration. It includes desire, arousal, sensation, orgasm, comfort, emotional closeness, confidence, communication and the ability to enjoy intimacy in whatever form is appropriate for the individual or couple.

At the same time, I do not dismiss persistent sexual difficulties simply as “old age.” Erectile dysfunction, reduced desire, painful intercourse, vaginal dryness, loss of orgasm or major changes following prostate treatment may have identifiable medical causes that can often be evaluated and treated.

Current European Association of Urology guidance continues to emphasize individualized assessment of sexual dysfunction and was updated again in 2026, including revisions relevant to prostate cancer, hypogonadism, erectile dysfunction and survivorship.

This article explains these changes in simple language while also discussing modern evidence-based management, the supportive role of Unani medicine, and the integrative approach I follow at **Saira Health Care**.

Sexual Health Does Not Have an Expiry Date

A common misconception is that sexual interest should disappear after fifty, sixty or seventy years of age.

That is not medically correct.

Many older adults continue to value sexuality, touch, companionship and intimacy. The National Institute on Aging notes that some older couples actually report greater satisfaction later in life because they have more privacy, communication and understanding of their partners. What does change is the body's response: arousal may take longer, erections may be less firm, vaginal lubrication may decrease and chronic illness may influence comfort and stamina.

Therefore, I tell patients:

Aging changes sexuality; it does not automatically eliminate sexuality.

There is also an important distinction between **normal age-related change and disease**. Erectile dysfunction becomes more common with age, but persistent ED should not simply be accepted as an unavoidable consequence of aging. Diabetes, cardiovascular disease, obesity, medicines, stress and other conditions may be contributing and should be assessed.

What Changes Normally With Aging?

Aging affects the nervous system, circulation, hormones, muscles and connective tissues. These changes can alter the sexual response cycle even in otherwise healthy people.

Changes commonly noticed by men

An older man may require more direct or prolonged stimulation before an erection develops. Erections may not become as hard as they once did, and recovery after orgasm may take longer. Ejaculatory force or semen volume can also decrease.

However, persistent inability to obtain or maintain an erection sufficient for satisfactory sexual activity meets the clinical definition of erectile dysfunction and deserves evaluation rather than automatic attribution to age. Current EAU guidance defines ED as a persistent inability to attain and maintain an erection sufficient for satisfactory sexual performance.

Changes commonly noticed by women

After menopause, lower estrogen levels may make vaginal tissues thinner, less elastic and less naturally lubricated. Some women therefore need more time for arousal or experience dryness, irritation or painful penetration. Libido may increase, decrease or remain unchanged.

The National Institute on Aging notes that the vagina may become somewhat shorter and narrower and lubrication may take longer, while menopause-related symptoms such as sleep disturbance, hot flashes and mood changes may also influence sexual interest.

These are medical and physiological changes—not personal failures.

Why Sexual Health Changes With Chronic Illness

Sexual response depends on several systems working together:

- healthy blood vessels,
- functioning nerves,
- appropriate hormone levels,
- physical energy,
- emotional well-being,
- adequate sleep,
- freedom from significant pain,
- and healthy communication with the partner.

A long-term disease can disturb one or several of these pathways.

This is why I often tell my patients that **sexual dysfunction can sometimes be a window into general health**.

Diabetes and Sexual Function

Diabetes is one of the most important examples.

Persistently high blood glucose can gradually damage small blood vessels and nerves. Because erections depend heavily on nerve signaling and blood flow, men with diabetes have a substantially increased risk of erectile dysfunction. Diabetes may also affect libido and ejaculation. In women, it can contribute to reduced arousal, vaginal dryness, diminished genital sensation and difficulty reaching orgasm.

The NIDDK reports that men with diabetes may develop ED around **10–15 years earlier** than men without diabetes, and good control of glucose, blood pressure and cholesterol forms an important part of prevention and management.

This illustrates why I do not consider erection treatment complete if the patient's diabetes remains uncontrolled.

Treating the erection while ignoring glucose, blood pressure, cholesterol, obesity or smoking would be incomplete medicine.

Heart Disease, Blood Circulation and Sexual Health

An erection is fundamentally a vascular event. Blood must flow properly into the erectile tissues and remain there long enough to produce adequate rigidity.

The same vascular risk factors that damage coronary arteries—high blood pressure, high cholesterol, diabetes, smoking and obesity—can impair penile circulation.

Modern cardiovascular-sexual medicine therefore considers ED an important cardiovascular risk marker in appropriate patients. The 2024 Princeton IV Consensus emphasizes the close relationship between erectile dysfunction and cardiovascular health and recommends cardiovascular risk assessment when appropriate.

For many people with stable cardiovascular disease, sexual activity is possible and safe after appropriate clinical assessment. People with unstable cardiac symptoms, poor exercise tolerance or recent serious cardiovascular events need individual clearance from their treating physician.

One medication warning is particularly important: **PDE5 erectile-dysfunction medicines such as sildenafil or tadalafil must not be combined with nitrate medicines or nitric-oxide donors**, because the combination can cause a dangerous fall in blood pressure. Current EAU guidance considers this an absolute contraindication.

Patients should therefore never take ED tablets supplied informally without disclosing their heart medicines.

Kidney Disease and Sexual Health

Chronic kidney disease and kidney failure can affect sexuality through several mechanisms at the same time.

Patients may experience:

- fatigue,
- anemia,
- hormonal disturbance,
- changes in nerve function,
- vascular disease,
- depression,
- medication effects,
- and reduced physical stamina.

The NIDDK notes that kidney failure can affect emotions, nerves, hormones and energy levels, all of which may change sexual relationships. Control of kidney disease, blood pressure and diabetes together with psychological support can improve some associated difficulties.

Any herbal or conventional sexual medicine in kidney disease must be selected carefully because reduced kidney function can alter how medicines are processed by the body.

Chronic Pain, Arthritis and Reduced Mobility

A patient may have completely normal sexual desire but avoid intimacy because movement hurts.

Arthritis, back pain and chronic pain syndromes can affect positioning, stamina, sleep and emotional well-being. Strong pain medicines can also affect libido, erection and orgasm.

The National Institute on Aging recommends addressing pain itself and considering practical adaptations such as timing sexual activity when symptoms are mild, changing positions, resting beforehand and discussing medication side effects with a clinician.

Intimacy sometimes needs adaptation rather than abandonment.

Depression, Anxiety and Long-Term Illness

Sexuality is not controlled only by hormones and circulation.

Depression may reduce sexual interest. Anxiety may interfere with erections or orgasm. After a heart attack, cancer diagnosis or major surgery, patients may become afraid that sexual activity will be dangerous. Their partners may have the same fear.

Cancer survivors may additionally experience worries about attractiveness, body image, pain, fertility and whether their partner still sees them in the same way. NCI guidance recognizes anxiety, depression, physical changes and treatment effects as important contributors to sexual difficulties after cancer treatment.

When anxiety becomes part of the problem, treating only the sexual organ is rarely enough.

Medicines Can Also Change Sexual Function

Many patients are surprised to learn that prescribed medication may affect sexuality.

Some blood-pressure drugs, antidepressants and other psychiatric medicines, sedatives, Parkinson's medicines, cancer therapies and several other drug classes can contribute to

reduced desire, erection problems, delayed ejaculation, difficulty reaching orgasm or vaginal dryness.

This does **not** mean that patients should stop essential medication themselves.

Instead, I recommend reviewing the complete medication list. Sometimes a treating physician can adjust the dose, timing or drug selection while still safely treating the original disease.

Prostate Disease and Sexual Function

The prostate sits below the bladder and surrounds part of the urethra. It contributes fluid to semen, so diseases and treatments involving the prostate can affect urinary as well as sexual function.

The sexual consequences depend greatly on whether the patient is being treated for:

- benign prostate enlargement,
- prostatitis,
- localized prostate cancer,
- advanced prostate cancer,
- or another pelvic condition.

The treatment itself also matters.

Sexual Changes After Radical Prostatectomy

Radical prostatectomy involves removal of the prostate for prostate cancer.

The nerves that control erections travel extremely close to the prostate. Although surgeons may use nerve-sparing techniques where oncologically appropriate, these nerves can still be stretched, inflamed or damaged during treatment.

As a result, erection difficulties may occur immediately after surgery.

Current EAU evidence reviews report a wide range—approximately **25% to 75% of men may experience erectile dysfunction after radical prostatectomy**, depending on factors such as age, erectile function before surgery, nerve preservation, surgical expertise and how outcomes are defined.

I would not use these percentages to predict one individual patient's future. They simply demonstrate why patients should receive counseling before treatment.

Nerve-sparing surgery

When it is oncologically safe, preserving the neurovascular bundles gives a patient a better chance of recovering erections.

However, “nerve sparing” does not mean erections will immediately remain normal.

Recovery may take months and sometimes much longer. Baseline erectile health and age are important predictors of recovery.

Orgasm after prostate removal

Patients often ask:

“Doctor, if my prostate is removed, will I still be able to have an orgasm?”

Many men can still experience orgasm even though ejaculation changes dramatically.

Because the prostate and seminal vesicles normally produce much of the ejaculatory fluid, prostate-cancer treatment can lead to **dry orgasm**, meaning orgasm without the normal release of semen. NCI notes that prostate surgery and pelvic treatments can alter erection and ejaculation while orgasmic sensation may remain possible.

This difference should be explained before treatment because otherwise men may become frightened when the first postoperative orgasm feels unfamiliar.

Sexual Changes After Radiation Therapy

Radiotherapy can affect small blood vessels, erectile tissues and nerves.

The pattern can differ from surgery.

After prostatectomy, erection difficulties often appear immediately and may improve over time. After radiation, erectile function may initially remain relatively preserved but deteriorate gradually over subsequent months or years.

The American Cancer Society describes this gradual pattern and notes that erection problems may become more likely with time, particularly when hormone therapy is given alongside radiation.

Current EAU evidence similarly recognizes erectile dysfunction after external-beam radiotherapy and brachytherapy.

Androgen Deprivation Therapy and Loss of Desire

Some prostate-cancer patients require androgen deprivation therapy, or ADT.

These treatments intentionally reduce testosterone production or block androgen activity because prostate-cancer cells often depend on androgen signaling.

A predictable consequence is that sexual desire may fall significantly. Erections may become difficult, energy levels may change and patients may experience hot flashes and other systemic effects.

The National Cancer Institute lists reduced sexual desire and impaired sexual function among recognized effects of prostate-cancer hormone therapy.

This is not psychological weakness. It is a biological effect of treatment.

Partners benefit from knowing this because otherwise reduced libido may incorrectly be interpreted as rejection.

Treatment of Benign Prostate Enlargement and Ejaculation

Not every prostate operation is cancer surgery.

Benign prostatic hyperplasia, commonly called BPH or enlarged prostate, may require medicines or surgical procedures.

After BPH surgery, sexual function may temporarily change. NIDDK notes that many men recover sexual function during follow-up, although the outcome depends on the procedure and the patient's baseline health.

After procedures such as TURP, ejaculation may sometimes become **retrograde**, meaning semen travels backward into the bladder instead of coming out through the penis during orgasm. This is generally not dangerous, but it can be important when fertility is desired.

Patients should therefore discuss not only urinary improvement but also ejaculation and fertility before prostate procedures.

Sexual Rehabilitation After Prostate Cancer Treatment

I prefer the phrase **sexual rehabilitation** rather than simply “ED treatment,” because recovery may involve erections, orgasm, urinary confidence, desire, relationship adjustment and psychological recovery.

Current EAU guidelines encourage clinicians to actively discuss sexual dysfunction after prostate surgery and recommend beginning pro-erectile treatment at an appropriate early stage following radical prostatectomy or other curative prostate treatment. However, they also state that evidence is insufficient to identify one universal “penile rehabilitation” regimen that restores spontaneous erections for everyone.

This distinction is important.

Rehabilitation can assist sexual activity and preserve confidence, but patients should not be promised that a particular tablet or device will guarantee complete natural erectile recovery.

Evidence-Based Treatment of Erectile Dysfunction

Modern ED management is stepwise and individualized.

1. Treat underlying disease and lifestyle risk

Current EAU recommendations strongly support lifestyle changes and risk-factor modification alongside specific ED treatment.

That may include:

- diabetes control,
- blood-pressure management,
- cholesterol management,
- smoking cessation,
- regular activity,
- weight reduction where appropriate,
- improved sleep,
- reduced excess alcohol,
- and management of depression or anxiety.

This is exactly where a holistic philosophy becomes clinically meaningful.

---

2. PDE5 inhibitor medicines

Medicines such as sildenafil and tadalafil are standard first-line treatments for many forms of erectile dysfunction when medically appropriate.

The EAU recommends PDE5 inhibitors as first-line therapy because they have strong evidence for improving erectile function.

They still require sexual stimulation to work.

They also do not treat every cause equally well, particularly when major nerve injury has occurred.

Again, nitrate users must not combine nitrates with PDE5 inhibitors.

---

3. Vacuum erection devices

A vacuum erection device draws blood into the penis mechanically and can provide a non-drug option for some patients.

EAU guidance considers vacuum devices an option for appropriately informed patients, including some older people who want non-invasive and drug-free management.

They may also be considered in selected men after prostate surgery.

---

4. Injectable or intraurethral treatment

When tablets do not work or cannot be used, medicines such as alprostadil may be administered locally.

Intracavernosal injection therapy can be highly effective, including in men with diabetes and vascular disease, but requires medical instruction because incorrect use can cause pain, prolonged erection or other complications.

These are specialist treatments, not medicines to experiment with independently.

---

5. Penile prosthesis

For men with severe ED who do not respond to less invasive treatments, penile-prosthesis surgery can provide a definitive option.

EAU guidelines recommend considering an implant when other therapies fail or when an appropriately counseled patient prefers it.

Pelvic-Floor Rehabilitation

Pelvic-floor exercises are commonly discussed after prostate surgery because pelvic muscles contribute to urinary control and aspects of sexual function.

Evidence reviewed by the EAU suggests that pelvic-floor muscle training with biofeedback may be helpful after prostatectomy, although more rigorous research is still needed to define its effect specifically on erectile recovery.

A trained pelvic-health professional is preferable to unsupervised excessive exercise, especially soon after surgery.

Psychological and Couple-Based Treatment

One of the most neglected parts of sexual medicine is what happens psychologically after illness.

A man may regain some erectile function yet remain afraid to initiate sex because of previous failures. His partner may become anxious about pressuring him. After months of avoidance, the couple can develop a pattern in which neither person starts intimacy.

Current EAU recommendations support psychosexual education, marital therapy and cognitive-behavioral approaches where psychological factors contribute to ED. Combining appropriate psychological therapy with medical treatment can improve outcomes.

I therefore encourage couples to move away from the idea that every intimate encounter must end in penetration.

Touch, affection, kissing, massage, communication and other mutually comfortable forms of intimacy can help restore confidence while medical recovery proceeds.

Erectile Dysfunction Can Be a Health Warning

An important clinical point deserves special emphasis.

ED is sometimes the first visible manifestation of vascular or metabolic disease.

A patient may come to a sexual-health clinic because his erection is weak, while the underlying issue is hypertension, diabetes, dyslipidemia, obesity or early vascular disease.

Both contemporary cardiovascular consensus guidance and EAU survivorship guidance recognize the relationship between ED and cardiovascular disease and the opportunity to assess cardiovascular risk factors.

That is one reason I tell patients:

Do not buy a sexual-performance medicine first and ask questions later. Find the cause.

Low Testosterone and Aging

Testosterone levels may decline with age, but age alone does not justify testosterone treatment.

Symptoms such as reduced desire, fatigue and reduced spontaneous erections can occur with testosterone deficiency, but similar complaints can also result from depression, diabetes, obesity, medication, sleep apnea or chronic illness.

A diagnosis of hypogonadism requires appropriate symptoms plus properly interpreted hormone testing.

Testosterone treatment becomes particularly complex in men with current or previous prostate cancer and must be decided with specialist involvement. The 2026 EAU guidelines specifically revised their prostate-cancer section in relation to male hypogonadism.

Patients should never self-administer testosterone, “testosterone boosters” or anabolic hormones simply because they are aging.

A Word About Herbal and “Natural” Sexual Medicines

Patients often believe that “natural” automatically means safe.

That is not always true.

Current EAU guidance states that although herbal products and supplements are widely marketed for erectile dysfunction, robust evidence for many products remains limited. Some supplements may produce only small improvements, and more research is needed to determine the clinical importance and safety of these effects.

This is particularly important for older patients because they may already take:

- blood-pressure medication,
- blood thinners,
- nitrates,
- diabetes treatment,
- prostate medicines,
- cancer therapies,
- antidepressants,
- or kidney and liver medicines.

Herbal substances can potentially interact with these treatments.

Therefore, responsible Unani medicine requires proper history taking, medication review and individualization—not indiscriminate use of “power medicines.”

The Role of Unani Medicine in Medical and Age-Related Sexual Health

As a physician trained in the Unani system, I consider its greatest strength to be its **whole-person approach**.

Unani medicine traditionally evaluates not only a named disease but also the patient's temperament, digestion, sleep, activity, psychological state, dietary pattern and broader lifestyle.

The classical concept of **Asbab-e-Sitta Zarooriya**, the essential determinants of health, includes important domains that remain relevant to modern preventive medicine:

- air and environment,
- food and drink,
- physical activity and rest,
- sleep and wakefulness,
- emotional or mental states,
- and appropriate elimination and retention.

For an aging patient with ED, diabetes, obesity, disturbed sleep and anxiety, these domains are highly relevant.

However, I make an important distinction between **supportive integrative care and claims of cure**.

No responsible practitioner should promise that Unani herbs can regenerate nerves removed during prostate cancer surgery, reverse radiation injury, replace necessary cardiovascular treatment or cure advanced diabetes.

In these circumstances, modern urology, oncology, endocrinology and evidence-based sexual medicine remain essential.

The role of Unani medicine is best understood as **complementary and supportive**, particularly in areas such as lifestyle regulation, nutrition, sleep, stress management, physical conditioning and selected symptom-oriented therapies where clinically appropriate.

Ilaj-bil-Ghiza — Dietotherapy

In Unani practice, food is considered an important therapeutic foundation.

In modern terms, this translates well into the management of many risk factors that influence sexuality.

For example, improving diet may assist with:

- obesity,
- type 2 diabetes,

- high cholesterol,
- hypertension,
- metabolic syndrome,
- fatigue,
- and cardiovascular risk.

Because vascular health and erectile health are closely connected, a heart-healthy dietary pattern indirectly supports sexual health.

I generally prefer sustainable dietary correction rather than exaggerated claims about one particular “sexual food.”

No date, seed, nut, herb or spice can compensate for uncontrolled diabetes, severe arterial disease or nerve injury.

Riyazat — Physical Activity

Appropriate regular exercise can contribute to:

- better circulation,
- improved cardiovascular fitness,
- weight control,
- insulin sensitivity,
- mood,
- sleep quality,
- mobility,
- self-confidence,
- and physical stamina.

EAU guidance recognizes lifestyle modification as part of evidence-based ED treatment.

For older patients or people with heart disease, exercise intensity should be appropriate for their medical condition.

Sleep and Sexual Health

Sleep is often ignored in sexual medicine.

Poor sleep contributes to fatigue, irritability, poor metabolic control and reduced interest in intimacy. Sleep apnea is also strongly associated with obesity, metabolic disease and cardiovascular problems.

From a Unani perspective, correction of sleep-wake routine is an important part of restoration of general health.

I often ask a patient with declining sexual performance a very simple question:

“How are you sleeping?”

Sometimes the answer explains more than the patient expected.

Mental and Emotional Regulation

Unani medicine recognizes the influence of psychological states on physical health.

Modern medicine confirms the same principle through research on depression, anxiety, stress and sexual dysfunction.

For patients facing prostate cancer, chronic illness or aging, treatment may therefore include:

- reassurance,
- realistic education,
- stress reduction,
- counseling,
- couple communication,
- relaxation strategies,
- and referral for formal psychological or psychiatric care when appropriate.

The mind and body should not be treated as separate patients.

Unani Medicines: A Responsible Position

Selected Unani formulations may be considered by a qualified practitioner for individual constitutional or associated complaints.

But I do not believe it is scientifically responsible to tell a post-prostatectomy patient:

“This herb will restore the removed nerves.”

Nor should a patient with severe vascular ED be promised a guaranteed cure from herbal medicine.

The evidence for most herbal ED products remains substantially weaker than the evidence supporting PDE5 inhibitors, vacuum devices, injections and established medical interventions.

At Saira Health Care, the more appropriate approach is to integrate traditional supportive measures with evidence-based treatment rather than place the two systems in unnecessary opposition.

My Clinical Approach at Saira Health Care

When a patient comes to me with age-related or post-treatment sexual problems, I prefer to ask:

What changed, when did it change, and what else changed at the same time?

I evaluate the situation in several layers.

First: the sexual complaint itself

Is the problem:

- erection,
- desire,
- ejaculation,
- orgasm,
- pain,
- arousal,
- lubrication,
- fertility,
- or a combination?

Second: medical causes

I review diabetes, blood pressure, cholesterol, cardiovascular disease, kidney disease, thyroid conditions, obesity, neurological illness, previous pelvic surgery, prostate disease and cancer treatment.

Third: medicines

A full medicine list is essential.

Fourth: hormones

Hormonal tests are considered when symptoms and history justify them rather than being ordered indiscriminately.

Fifth: emotional and relationship factors

Performance anxiety, depression, grief, partner conflict and fear following illness may contribute greatly.

Sixth: lifestyle and Unani assessment

Diet, activity, sleep, stress, digestion, constitutional factors and daily routine are considered for supportive correction.

The goal is an individualized plan rather than the same “sexual tonic” for every patient.

After Prostate Treatment: My Message to Patients

If you have undergone prostate surgery, radiation or hormone treatment and sexual function is different, please do not assume that your life as a husband or partner has ended.

Different treatments create different patterns.

After surgery, nerve recovery may take time.

After radiation, erection difficulties may develop gradually.

After hormone therapy, sexual desire itself may become much lower.

After certain BPH procedures, ejaculation may change even when erection remains possible.

Recovery should therefore be discussed according to **your procedure, age, baseline sexual function, cancer status, other illnesses and personal goals**.

Current EAU guidance specifically recommends discussing more than erection alone with prostate-cancer patients, including changes in desire, orgasm, ejaculation and penile changes.

This comprehensive conversation should ideally happen before treatment whenever possible.

Intimacy After Chronic Illness

Chronic illness can change what sexual activity looks like without eliminating intimacy.

A patient with severe arthritis may need a different position.

A patient with heart disease may need cardiovascular assessment and reassurance.

A diabetic patient may require vascular and metabolic treatment.

Someone with kidney failure may need management of fatigue, anemia, hormone changes and emotional distress.

A cancer survivor may need psychological support for body-image changes.

An older couple may need longer arousal time, lubricant or simply more communication.

Good sexual medicine asks:

"How can we adapt safely?"

rather than automatically saying:

"You are too old."

Partner Communication Is Part of Treatment

I frequently see a communication problem developing around a medical problem.

A man avoids intimacy because he fears losing his erection.

His wife interprets that avoidance as loss of attraction.

He notices her disappointment and becomes even more anxious.

Eventually both stop initiating affection.

The original issue was physical. The ongoing problem has become physical **and** psychological.

Open communication can interrupt this cycle.

The couple should discuss:

- what feels comfortable,
- what creates anxiety,
- what has changed physically,
- which forms of intimacy remain enjoyable,
- and what expectations need to change temporarily.

Where necessary, formal psychosexual or couple counseling can be very helpful. Current EAU guidance recommends psychological approaches, including CBT and partner involvement, when indicated.

What Patients Should Not Do

One of the most dangerous patterns I see in sexual-health practice is self-medication.

Patients may combine multiple supplements, sildenafil-type medicines, testosterone products and traditional remedies without telling their cardiologist or oncologist.

This is particularly risky after age fifty because a patient may simultaneously have hypertension, diabetes, heart disease or prostate treatment.

Never combine ED medication with nitrates.

Do not discontinue blood-pressure, antidepressant, prostate or cancer medication without consulting the prescribing physician.

Do not start testosterone simply because libido is reduced.

Do not assume that every herbal product is safe because its label says “natural.”

And do not delay medical evaluation when ED appears suddenly or becomes persistent.

Warning Signs That Need Medical Review

Sexual dysfunction should receive medical attention particularly when it is accompanied by:

- chest pain or breathlessness,
- newly diagnosed or poorly controlled diabetes,
- sudden erectile dysfunction,
- significant urinary symptoms,
- blood in urine or semen,
- persistent pelvic or prostate pain,
- neurological weakness or numbness,
- severe depression,
- loss of sexual desire with marked fatigue or hormonal symptoms,
- a new penile deformity,

- severe pain during sex,
- or symptoms developing after cancer treatment.

Persistent ED can sometimes be an early clue to vascular disease and should not be hidden because of embarrassment.

Can Sexual Health Improve in Older Age?

Yes.

The word “improvement” does not always mean returning the body exactly to how it functioned at age twenty-five.

For one man, improvement means reliable erections with medication.

For another, a vacuum device restores satisfactory intimacy after prostatectomy.

Another couple discovers that slowing down and removing performance pressure improves their relationship more than chasing a particular erection score.

A woman experiencing menopausal dryness may improve substantially with appropriate local treatment and lubrication.

A diabetic patient's function may improve after better glucose control, exercise and weight reduction.

A patient with anxiety may recover when the fear of failure is treated.

Sexual health should therefore be evaluated in terms of **satisfaction, safety, function, confidence and quality of life**, not simply youthful performance.

Contribution of Saira Health Care in Sexual Disorders & Infertility

At **Saira Health Care**, our work in the field of sexual disorders and infertility is based on a comprehensive approach to sensitive problems that patients are often reluctant to discuss elsewhere.

Sexual-health complaints are rarely isolated from the rest of a person's health.

An erection problem may reveal diabetes.

Low desire may be connected with hormonal treatment for prostate cancer.

Relationship difficulty may arise after infertility or chronic disease.

Ejaculatory changes may follow prostate surgery.

An older patient may have sexual difficulty caused by a combination of vascular disease, medication, anxiety and sleep problems.

Our objective is therefore not simply to prescribe a medicine.

It is to understand the patient.

As Founder and Chief Physician of Saira Health Care, my clinical interest is particularly focused on **sexual disorders and infertility**, and my training includes:

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

This background informs an integrative approach in which sexual symptoms are considered alongside reproductive health, urological concerns, chronic disease, emotional well-being and Unani principles of individualized care.

Integrative Treatment Philosophy of Dr. Nizamuddin Qasmi

I describe my approach in one sentence:

Use traditional wisdom where it is useful, modern evidence where it is strongest, and never allow either to prevent a patient from receiving necessary medical care.

For an older patient with metabolic disease, Unani lifestyle principles may complement modern risk-factor management.

For a post-prostatectomy patient, sexual rehabilitation may require PDE5 medication, vacuum therapy, counseling or other urological treatments.

For someone with cancer-related low libido, the oncology treatment cannot be ignored.

For a patient with cardiovascular disease, safety comes before sexual-performance medication.

For an anxious couple, communication may be as important as tablets.

This is what responsible integrative sexual medicine should look like.

Frequently Asked Questions

Is erectile dysfunction simply part of old age?

No. ED becomes more common as people grow older, but persistent erectile dysfunction often reflects medical, vascular, neurological, hormonal, medication-related or psychological factors that should be assessed.

Can erections return after prostate surgery?

They can improve in some patients, particularly when good erectile function existed beforehand and nerve-sparing was possible. Recovery differs greatly among individuals and may take considerable time.

Does prostate removal eliminate orgasm?

Not necessarily. Orgasm may remain possible, but ejaculation generally changes because prostate-cancer surgery alters the structures producing seminal fluid. Dry orgasm is common after prostate treatment.

Why did my erections worsen years after prostate radiation?

Radiation-related vascular and tissue changes can develop gradually; erection difficulties may therefore appear or worsen over time rather than immediately after treatment.

Why has prostate hormone therapy reduced my desire?

Androgen-deprivation treatment deliberately suppresses testosterone activity, and reduced libido and erectile difficulties are recognized consequences.

Can diabetes cause sexual problems?

Yes. Diabetes can damage nerves and blood vessels involved in sexual response and is strongly associated with ED in men and sexual dysfunction in women.

Can herbs replace ED treatment after prostate surgery?

Current scientific evidence does not support claiming that herbal medicines can reliably reverse nerve or vascular injury after prostate treatment. Herbal or Unani therapies may be considered as supportive care when appropriate, but established urological management should not be delayed.

Am I too old to discuss sex with my doctor?

No. Sexual health remains part of quality of life at every adult age. Older adults can continue to experience intimacy and sexual satisfaction, although adaptation may sometimes be needed.

Final Message From Dr. Nizamuddin Qasmi

When patients discuss aging or illness with me, I often notice that they are prepared to talk about blood pressure, sugar, prostate symptoms and joint pain—but not about sexual health.

Yet sexual health is also health.

If prostate treatment has changed your erection, ejaculation or desire, discuss it.

If diabetes has affected sexual function, do not hide it.

If heart disease has made you afraid of sexual activity, obtain proper cardiovascular advice.

If aging has changed intimacy, adapt rather than give up.

If medication is affecting libido or orgasm, review it professionally.

And if emotional distance has developed between you and your partner, communication should become part of the treatment.

I believe the best care is neither exaggerated promise nor unnecessary pessimism.

Modern medicine offers effective options for many sexual problems. Unani medicine can contribute valuable principles of individualized lifestyle, nutrition, physical activity, sleep and holistic well-being. Psychological and relationship support can restore confidence. And when these areas are integrated responsibly, many patients can achieve meaningful improvements in sexual health and quality of life even after major illness or advancing age.

Sexual health does not have to end because the body has changed. Sometimes the treatment is not about going backward—it is about learning how to move forward in a healthier, safer and more satisfying way.

Medical Disclaimer

This article is for professional health education and general patient information. It does not replace individual examination, laboratory testing, cardiovascular assessment, urological/oncological care or consultation with the treating physician. Treatment after prostate cancer must be coordinated with the patient's urologist or oncologist. Patients taking nitrate medicines must not use PDE5 erectile-dysfunction drugs unless their treating specialists have appropriately changed the cardiovascular regimen, because concurrent use can cause severe hypotension.