Medical Conditions & Illness and Sexual Health: Adapting Intimacy Around Chronic Pain, Cancer Recovery, Hysterectomy and Medicines Such as SSRIs

Understanding how illness, surgery, pain, medicines and emotional recovery can affect desire, arousal, comfort, orgasm and relationships—and how intimacy can be rebuilt safely

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

Introduction

One of the most important things I tell patients dealing with a long-term illness is:

Your sexual health does not become unimportant simply because another medical condition has entered your life.

A person may successfully undergo cancer treatment, major surgery or treatment for chronic pain and still feel that an important part of life has changed. Sexual desire may fall. Intercourse may become painful. Lubrication may decrease. Orgasm may take longer or become difficult. A person may feel exhausted, unattractive or frightened that sexual activity could worsen the illness.

Sometimes the problem comes directly from the disease. Sometimes it is produced by surgery, chemotherapy, radiotherapy or hormonal treatment. Sometimes it comes from pain, fatigue, anxiety or changes in body image. And sometimes a medicine that is essential for one aspect of health—such as an antidepressant—can affect sexual function.

These problems are medically real.

A major 2026 review from the Fifth International Consultation on Sexual Medicine emphasizes that chronic illness and cancer can affect sexual health through multiple

physical, psychological and relationship pathways and that sexual well-being should be addressed as part of comprehensive healthcare rather than ignored.

At **Saira Health Care**, I believe the first step is not to ask, "Which sexual medicine should this patient take?"

The first question should be:

"What has changed, and why?"

Only then can treatment become sensible, safe and personalized.

This Is Not One Disease

"Medical conditions and sexual health" is not a single disease diagnosis.

It is a broad clinical area involving changes in sexual function caused or influenced by another health condition, its treatment, a surgical procedure, medication or the psychological burden of illness.

ACOG notes that hormonal changes, cancer treatment, illnesses, medications, relationship problems and previous sexual experiences can all contribute to sexual difficulties.

That is why two patients with exactly the same diagnosis may experience very different sexual problems.

One woman with arthritis may have normal desire but pain with certain positions.

Another woman recovering from cancer may experience vaginal dryness and fear of intimacy.

A woman after hysterectomy may actually feel better sexually because pelvic pain or heavy bleeding has stopped.

Another woman whose ovaries were removed at the same time may experience sudden vaginal dryness because of surgical menopause.

A patient taking an SSRI antidepressant may love her partner and remain emotionally interested in intimacy but find that orgasm has become extremely difficult.

The treatment must therefore address the **actual mechanism**, not merely the label "sexual weakness."

Understanding the Different Parts of Sexual Function

Sexual function is not just libido.

When I assess a patient, I think about several different areas:

sexual desire, arousal, genital response and lubrication, comfort, orgasm, satisfaction, body confidence, emotional connection and relationship quality.

A patient may have difficulty in only one of these areas.

For example, a woman may retain normal desire but experience vaginal pain.

Another may have no pain but little desire.

Another may become aroused but cannot reach orgasm after starting medication.

Another may be physically capable of sexual activity but avoids intimacy because she feels unattractive following surgery.

This distinction matters because the treatments are completely different.

How Chronic Illness Can Affect Sexual Function

A chronic illness can affect sexuality directly and indirectly.

Direct effects may include pain, impaired blood flow, hormonal changes, nerve damage, fatigue, muscle weakness and changes in genital sensation.

Indirect effects can include depression, anxiety, poor sleep, medication side effects, reduced mobility, concerns about appearance and relationship stress.

ACOG specifically identifies conditions such as **arthritis, diabetes, cancer and thyroid disease** among medical problems that may interfere with sexual response. It also notes that medications and pain treatments can affect desire.

Recent research continues to support these connections. For example, a 2024 review describes multiple pathways through which thyroid disorders may influence female sexual function, while a meta-analysis published subsequently found a significant burden of sexual dysfunction among women with thyroid disease.

This is why a sexual problem sometimes becomes the first reason we discover an underlying general-health problem.

Chronic Pain and Intimacy

Chronic pain can be one of the strongest barriers to a satisfying sexual life.

The problem may arise from:

arthritis, back or neck disorders, fibromyalgia, pelvic pain, nerve pain, joint disease, migraine, cancer-related pain or postoperative pain.

Pain can interfere with intimacy in several ways.

A person may want sexual closeness but fear that movement will worsen symptoms.

A painful hip may make familiar positions difficult.

Back pain may worsen with bending or weight-bearing.

Pelvic pain may create fear of penetration.

Fatigue caused by chronic pain may leave little energy for intimacy.

Pain medicines themselves may also affect alertness, desire or sexual response.

This is why a patient with chronic pain should not automatically be diagnosed with a primary “low libido disorder.”

Sometimes the desire is still present; the person simply does not want to experience more pain.

Adapting Sexual Activity Around Chronic Pain

A healthy sexual life does not have to follow one fixed pattern.

The body may require adaptation.

For patients with musculoskeletal pain, it may be helpful to choose times when pain and fatigue are naturally lower, use pillows or supports, reduce pressure on affected joints and select positions requiring less physical strain.

If movement is uncomfortable, intimacy can temporarily focus more on touch, affection and other mutually comfortable forms of sexual expression rather than penetrative intercourse.

A patient should never feel required to “push through” significant pain in order to prove that sexual function is normal.

Pain is information.

It should be understood rather than ignored.

Painful Intercourse Is Not Something to Simply Tolerate

Pain during intercourse is medically known as **dyspareunia**.

ACOG notes that painful sex may originate from several areas, including the vulva, vaginal opening, vagina, pelvis, lower back, uterus or bladder, and recommends professional evaluation when pain is frequent or severe.

Causes can include hormonal dryness, pelvic-floor dysfunction, vulvar conditions, endometriosis, previous surgery, infection, cancer treatment, pelvic disorders or insufficient arousal.

Repeated painful intercourse can also create a vicious cycle:

pain → fear of pain → pelvic muscle tightening → reduced arousal → more pain.

Once this cycle develops, simply recommending more frequent intercourse is inappropriate.

Treatment should first restore comfort.

Pelvic-Floor Health

The pelvic floor contributes to bladder function, bowel function, genital support and sexual response.

Some patients develop pelvic-floor weakness.

Others develop excessive tightness.

These two conditions should not be treated in the same way.

A person with a weak pelvic floor may benefit from appropriate strengthening.

A person with painful, overactive muscles may need relaxation, coordination training, manual therapy or other approaches from a qualified pelvic-health physiotherapist.

This becomes especially relevant after pelvic surgery, cancer treatment, painful intercourse or chronic pelvic pain.

Cancer Recovery and Sexual Health

Sexual concerns during and after cancer treatment are extremely common but frequently under-discussed.

The National Cancer Institute explains that cancer treatment can affect sexual health temporarily or long-term and that the effect depends on the cancer type, treatment, dose, duration, age and other health factors.

Cancer can change sexual health through several mechanisms.

Chemotherapy may affect ovarian hormone production and contribute to hot flushes, vaginal dryness or premature ovarian insufficiency.

Hormone therapy used for some breast cancers can reduce estrogen activity and contribute to vaginal dryness, fatigue or reduced sexual interest.

Pelvic radiotherapy can cause vaginal dryness, inflammation, reduced elasticity, tissue changes or vaginal narrowing.

Surgery may change anatomy or body image.

Cancer itself and its treatment may cause severe fatigue.

Fear, anxiety and concerns about recurrence may make sexual activity difficult even after the body has physically healed.

Cancer Survivorship Should Include Sexual Health

I believe a major mistake in cancer survivorship is to behave as though sexual health becomes irrelevant once cancer has been treated.

Survival is the first priority—but quality of life also matters.

ASCO recommends that healthcare professionals initiate discussions about sexual health with people affected by cancer and reassess sexual concerns during treatment and follow-up. Psychosexual or psychosocial counselling may be offered to women experiencing problems with desire, arousal or orgasm.

This is important because patients often hesitate to raise the subject themselves.

A woman may be grateful that her cancer has been successfully treated and therefore feel guilty mentioning painful intercourse.

She may think:

“I survived cancer. Should I really complain about sex?”

Yes—she should discuss it.

Sexual health is part of health.

Vaginal Changes After Cancer Treatment

Some cancer treatments reduce estrogen levels or directly affect vaginal tissues.

The National Cancer Institute reports that chemotherapy, endocrine therapy and pelvic radiation can contribute to vaginal dryness and painful intercourse. Pelvic radiation may also cause vaginal stenosis, reduced elasticity, inflammation and tissue changes.

Treatment depends on the cancer history.

Lubricants and vaginal moisturizers may help some patients.

Pelvic-floor rehabilitation may help where muscle dysfunction or pelvic pain is present.

Vaginal dilators may be used in selected patients after pelvic radiation to help manage or prevent narrowing and scarring.

Hormonal vaginal treatments require particular caution in people with hormone-sensitive cancers and should be discussed with the oncology and gynecology teams.

Cancer Treatment and Body Image

Cancer can change how someone sees their body.

A mastectomy, hysterectomy, abdominal scar, ostomy, hair loss or weight change may affect confidence.

The National Cancer Institute recognizes that changes in body image, fear of performance, depression, pain and cancer medicines can all affect sexual interest and intimacy.

This can happen even when sexual organs themselves function normally.

For example, a woman after breast surgery may avoid intimacy because she no longer feels attractive.

A patient with an ostomy may fear leakage.

Another person may be worried that a partner will see a surgical scar.

These are not trivial concerns.

Compassionate counselling can be as important as medication.

Sexual Intimacy During Active Cancer Treatment

Many patients can remain sexually active during cancer treatment, but this must be individualized.

There are times when intercourse may temporarily be discouraged because of bleeding risk, infection risk, surgery, severe tissue irritation or treatment-specific precautions.

The National Cancer Institute advises discussing sexual activity with the treating cancer team because recommendations can depend on the specific therapy.

Do not assume either that sex is always unsafe during treatment or that it is always safe.

Ask the treating team.

Hysterectomy and Sexual Function

Another common question I hear is:

“Doctor, if my uterus has been removed, will my sexual life be permanently damaged?”

Not necessarily.

A hysterectomy is surgery to remove the uterus. Depending on the indication and surgical approach, the cervix may or may not be removed, and the ovaries may be preserved or removed separately.

Modern evidence does **not** support the belief that hysterectomy automatically destroys sexual function.

A 2026 systematic review and meta-analysis of 34 studies found that overall changes in sexual function after hysterectomy were small and not clinically significant, and preservation of the cervix did not provide a measurable sexual-function advantage.

ACOG similarly notes that some women report no long-term change after hysterectomy, while others report improvement—sometimes because pain or abnormal bleeding that previously interfered with sexual activity is removed.

Hysterectomy Is Not the Same as Removal of the Ovaries

This difference is extremely important.

The uterus and ovaries do different jobs.

If a woman has a hysterectomy but her ovaries remain, ovarian hormone production may continue.

If both ovaries are removed before natural menopause, estrogen production falls abruptly and **surgical menopause** begins.

ACOG explains that women whose ovaries are removed with hysterectomy can experience menopausal symptoms immediately, including hot flushes, mood changes and vaginal dryness.

A large systematic review has also found that hysterectomy without removal of both ovaries was associated with better outcomes in some domains, including lubrication and orgasm, compared with hysterectomy combined with removal of both ovaries.

The sexual effects of "hysterectomy" therefore cannot be discussed accurately without knowing whether the ovaries were preserved.

Recovery After Hysterectomy

Immediately after surgery, healing must come first.

Sexual intercourse should not be resumed until the surgical tissues have healed sufficiently and the operating clinician considers it safe.

After recovery, persistent pain, bleeding, deep pelvic discomfort or difficulty with penetration should be investigated.

ACOG specifically recommends continued gynecological follow-up after hysterectomy and notes that clinicians can help manage pelvic pain, menopausal symptoms and sexual problems.

A patient should not assume that postoperative sexual pain is simply something she must accept permanently.

SSRIs and Sexual Function

Selective serotonin reuptake inhibitors, or **SSRIs**, are widely prescribed for depression, anxiety and several other psychiatric conditions.

These medicines can be extremely valuable and sometimes lifesaving.

However, sexual side effects are real.

A 2026 systematic review and meta-analysis of randomized trials found that SSRI treatment was associated with a substantially increased risk of orgasmic dysfunction and reduced sexual satisfaction compared with placebo. Specifically, the pooled relative risk for orgasmic dysfunction was **3.28**, while the relative risk for reduced sexual satisfaction was **1.21**. The evidence for reduced desire showed a trend but was less certain.

Patients may describe:

difficulty reaching orgasm, delayed orgasm, reduced genital sensation, reduced arousal, decreased interest in sex or a sense that sexual response has become "muted."

However, there is another important complication:

depression itself can also reduce sexual function.

Therefore, the clinician must separate the effects of the illness from the effects of the medicine.

Never Stop an SSRI Suddenly Because of Sexual Side Effects

This is one of the most important safety messages in this article.

Do **not** abruptly stop an antidepressant simply because sexual function has changed.

Sudden discontinuation can cause withdrawal symptoms, return of anxiety or depression, and in some cases significant deterioration in mental health.

The correct approach is to discuss the problem openly with the prescribing clinician.

Depending on the patient's diagnosis and response to treatment, the clinician may consider waiting to see whether the side effect improves, adjusting the dose, switching medication or considering an additional treatment.

A 2025 systematic review examining pharmacological treatments for antidepressant-induced sexual dysfunction in women found potential benefit from some strategies, including bupropion in certain studies, but concluded that the overall evidence remains limited and of variable quality.

There is no universal solution.

Persistent Sexual Problems After Stopping SSRIs

Some patients report sexual symptoms that continue after an SSRI has been discontinued.

This has been described in the literature as possible **post-SSRI sexual dysfunction**.

However, the evidence remains uncertain.

A systematic review found that persistent sexual problems after stopping SSRIs have been reported, but current research cannot reliably determine how common the condition is or definitively establish causation in every case.

Patients experiencing persistent symptoms should therefore be taken seriously and assessed comprehensively rather than dismissed—but the limitations of current evidence should also be acknowledged.

Other Medicines Can Affect Sexual Health

SSRIs are only one example.

Some opioid pain medicines, antihypertensive drugs, hormone treatments and medicines affecting the nervous system can alter sexual desire or response.

The National Cancer Institute also notes that opioids and some antidepressants can reduce sexual interest in women, while other medications and health conditions can affect sexual function in men.

Whenever sexual symptoms begin after starting or increasing a medication, the timing should be discussed with the prescribing clinician.

But medication should not be changed without supervision.

Diabetes, Cardiovascular Disease and Sexual Function

Blood vessels and nerves play important roles in sexual arousal.

Conditions that damage circulation or nerves—including diabetes and vascular disease—can therefore affect sexual response.

For women, this may contribute to reduced genital sensation, lubrication or arousal.

For men, vascular and neurological problems may contribute to erectile dysfunction.

The appearance of sexual dysfunction should sometimes be viewed as part of broader health assessment rather than treated in isolation.

Managing blood glucose, blood pressure, weight, physical activity and cardiovascular risk may improve overall health and can support sexual health as well.

Neurological Illness

Neurological disorders can influence genital sensation, orgasm, erection, bladder function, mobility and fatigue.

Peripheral nerve damage may also alter sexual response.

The National Cancer Institute notes, for example, that autonomic nerve damage from cancer treatment can interfere with erection in men and orgasm in women.

Patients with neurological illness may require coordinated care involving neurology, urology, gynecology, rehabilitation medicine or sexual-health specialists.

Fatigue Is Often Mistaken for Low Libido

A person living with cancer, chronic pain, autoimmune disease or another long-term illness may be exhausted.

Fatigue can be profound.

Someone who spends the day coping with pain, appointments, medication and poor sleep may have very little energy remaining for sex.

This does not necessarily mean emotional attraction has disappeared.

Sometimes the most effective “sexual intervention” is better symptom control, sleep, pain management and practical support.

Sexual desire rarely exists independently of the rest of the body.

Mental Health and Sexual Health Are Closely Connected

Depression, anxiety, fear of recurrence, health anxiety and loss of confidence can all affect intimacy.

A patient may think:

“What if sex causes pain?”

“What if my illness returns?”

“Will my partner still find me attractive?”

“What if I cannot perform as before?”

These thoughts can interfere with arousal before physical contact has even started.

This is why psychosexual counselling, psychotherapy or couples counselling can be valuable in selected patients.

Treating the body while ignoring the mind can leave half the problem untreated.

Redefining Sexual Success

One of the most useful changes a couple can make is to stop defining successful sex only as intercourse.

During recovery from illness or surgery, intimacy may need to become broader.

Touch, affection, closeness, massage, kissing, conversation and non-penetrative sexual activity can maintain emotional and physical connection while the body heals.

This is not a “lesser” form of intimacy.

In some patients, temporarily removing the expectation of penetration dramatically reduces anxiety.

When the body is ready, intercourse can be reintroduced gradually if both partners want it.

Communication Between Partners

A partner cannot know what hurts unless the patient says so.

The person experiencing illness should feel comfortable saying:

“I want intimacy, but that position hurts.”

“I need more time.”

“I am exhausted today.”

“I want affection without intercourse tonight.”

Equally, partners need space to discuss their own fears and uncertainty.

After cancer or major surgery, the healthy partner sometimes becomes so afraid of causing harm that they stop initiating any physical affection.

The patient may interpret this as loss of attraction.

Simple communication can prevent these misunderstandings from becoming relationship problems.

Practical Ways to Adapt Intimacy During Illness

The following principles can be useful, depending on the individual's condition:

- Treat significant pain, vaginal dryness, infection or other physical symptoms before repeatedly attempting intercourse; choose a time when energy and pain control are better, use appropriate lubrication when dryness contributes, and modify positions or use pillows/supports when mobility is limited.
- Allow longer arousal time and do not make penetration the automatic goal of every intimate encounter.
- Ask the treating clinician about temporary restrictions after surgery, chemotherapy or radiotherapy; some treatments require precautions because of bleeding, infection or drug exposure.

- Consider pelvic-floor physiotherapy when pelvic pain, painful penetration, urinary symptoms or muscle dysfunction are present.
- Review medications when a sexual change begins after a new prescription, but never stop antidepressants, pain medicines or other essential treatments without medical supervision.
- Seek psychosexual or psychological support when fear, depression, body-image concerns or relationship distress are major contributors.
- Treat sexual health as part of overall health: sleep, physical activity, diabetes control, cardiovascular health, thyroid disorders, nutrition, pain management and mental health can all influence sexual response.

The Unani Perspective: Treating the Person, Not Only the Symptom

As a physician trained in the **Unani system of medicine**, I consider one of its greatest strengths to be its whole-person view of health.

Unani medicine traditionally emphasizes the **Asbāb Sitta Darūriyya**, or Six Essential Factors, which include air and environment, food and drink, physical movement and rest, psychological activity and repose, sleep and wakefulness, and evacuation and retention.

CCRUM, under India's Ministry of Ayush, describes these factors as central to maintaining health and explains that dietotherapy, regimenal therapy and pharmacotherapy are used to restore balance when health is disturbed.

This way of thinking is particularly relevant in chronic illness.

A patient may simultaneously have pain, poor sleep, constipation, anxiety, low physical activity, fatigue and reduced sexual desire.

Treating only “libido” misses the larger picture.

Ilāj bil-Ghidhā: Dietotherapy

Ilāj bil-Ghidhā, or dietotherapy, is an established therapeutic method in Unani medicine.

CCRUM describes diet as an important tool both for health promotion and treatment.

In modern clinical practice, this principle should be applied sensibly.

Good nutrition supports energy, muscle mass, recovery, bowel health and general metabolic health.

A cancer survivor recovering from weight loss will have different nutritional needs from a patient with diabetes or obesity.

A patient with chronic constipation and pelvic discomfort may require a different dietary plan from a person with inflammatory bowel disease.

Diet therefore needs to be individualized rather than reduced to a single “sexual-strength food.”

Ilāj bil-Tadbīr: Regimenal Therapy and Lifestyle

Unani medicine also uses **Ilāj bil-Tadbīr**, or regimenal therapy.

CCRUM officially lists regimenal therapy, dietotherapy, pharmacotherapy and surgery among the recognized modes of Unani treatment.

In chronic illness, an appropriate regimen may involve gradual physical activity, sleep optimization, relaxation, mobility work and other individualized measures according to the person's condition.

Exercise can support cardiovascular health, mood, mobility and sleep.

For someone with chronic pain, exercise may need to be adapted or supervised.

For someone recovering from major cancer treatment, rehabilitation should be coordinated with the medical team.

The Unani principle is not that every patient should perform the same activity.

It is that lifestyle should be adjusted according to the person's health status.

Ilāj Nafsānī: Psychological Care

Emotional and psychological factors have always been important in whole-person medicine.

CCRUM's official training material for women's healthcare includes **Ilāj Nafsānī**, or psychological approaches, among the Unani modalities used in the care of older women and also includes psychological problems as part of the clinical assessment.

This has direct relevance to sexual medicine.

A patient recovering from cancer may require counselling for body-image concerns.

A person taking an antidepressant may be experiencing both medication side effects and the sexual effects of depression itself.

A woman following hysterectomy may need reassurance that removal of the uterus has not removed her femininity.

Psychological care is therefore not an optional extra.

It may be part of the treatment.

Ilāj bil-Dawā: Unani Pharmacotherapy

Unani medicines may be considered as part of individualized supportive care where appropriate.

However, this area requires professional caution.

There is **not yet strong modern clinical evidence showing that a specific Unani formulation can reliably reverse sexual dysfunction caused by cancer treatment, nerve injury, hysterectomy or SSRIs**.

Therefore, I do not believe responsible Unani practice should make claims such as:

“this herb reverses chemotherapy-related sexual dysfunction,” or “this formulation cancels SSRI sexual side effects.”

Those statements would go beyond the current evidence.

Instead, Unani treatment can be used where appropriate to support broader health factors—such as digestion, sleep, general vitality, nutrition and individualized constitutional care—while the primary medical problem is treated appropriately.

This is an important distinction.

Unani Medicine as Part of Integrative Chronic-Disease Care

CCRUM has also participated in government programmes integrating Unani medicine into services addressing chronic diseases such as diabetes, cardiovascular disease and other lifestyle-related disorders, using diet therapy, regimenal measures and Unani treatment alongside broader healthcare.

This model illustrates the approach I favour:

integration rather than competition between systems of medicine.

A cancer patient should continue oncological care.

A person with diabetes needs proper metabolic management.

A patient taking an SSRI needs psychiatric or prescribing-clinician supervision.

A woman after hysterectomy needs appropriate postoperative gynecological follow-up.

Unani medicine can then be used thoughtfully as a complementary component where clinically appropriate.

My Clinical Approach at Saira Health Care

When a patient comes to me at **Saira Health Care** saying,

“Doctor, my sex life has changed since my illness,”

I do not immediately assume the patient needs an aphrodisiac.

I want to know:

When did the problem begin?

Did it start before or after the illness?

Did it begin after surgery?

Was there chemotherapy or pelvic radiotherapy?

Were the ovaries removed?

Is intercourse painful?

Is vaginal dryness present?

Has orgasm become difficult?

Is the patient taking an SSRI or another medicine?

Is there diabetes, thyroid disease, cardiovascular disease or neurological illness?

How severe is fatigue?

How is sleep?

Is there anxiety, depression or fear of intimacy?

Has the relationship itself changed?

This is the type of assessment that allows sexual medicine to become individualized rather than promotional.

The Saira Health Care Approach to Sexual Disorders & Infertility

At **Saira Health Care**, the objective is to create an environment in which intimate health concerns can be discussed professionally and without unnecessary embarrassment.

The approach is based on identifying the cause and then combining appropriate health education, lifestyle correction, individualized Unani principles and referral or coordination with other disciplines when required.

Depending on the condition, a patient may need gynecology, urology, oncology, psychiatry, endocrinology, pelvic-floor physiotherapy, pain medicine or counselling.

There is no contradiction in referring a patient appropriately.

On the contrary, it is one of the foundations of responsible clinical care.

Dr. Nizamuddin Qasmi's professional training includes **BUMS from Hamdard University, Delhi; MD; CGO; Certificate in Infertility from MGBIMS, Delhi; Certificate in Urology – London, UK; Masters in Male Infertility through MasterHealthPro (HealthPro); and Integrated Sexual and Reproductive Health training through ISRH, UNFPA**, alongside a focused practice in sexual disorders and infertility.

The purpose of this background should be to improve careful assessment and patient education—not to promise unrealistic or universal results.

When a Patient Should Seek Medical Evaluation

Sexual changes deserve professional evaluation particularly when there is persistent or severe pain during intercourse, bleeding after intercourse or after menopause, unexplained genital sores or discharge, fever, new pelvic or abdominal pain, recurrent urinary problems, sudden loss of sexual function, symptoms following cancer treatment or pelvic surgery, significant erectile or orgasmic dysfunction, severe depression or anxiety, or thoughts of stopping an essential medicine because of sexual side effects.

Patients receiving cancer therapy should also ask their oncology team whether there are periods when sexual activity should temporarily be avoided because of infection, bleeding or treatment-specific precautions.

Frequently Asked Questions

Can chronic illness really reduce sexual desire?

Yes.

Pain, fatigue, poor sleep, depression, hormonal changes, reduced mobility and medications can all influence desire. Sometimes the underlying illness affects sexual response directly; sometimes the effect is indirect.

Does chronic pain mean sexual activity should stop completely?

Usually not, but the activity may need to change.

The priority is to avoid worsening pain and to identify the cause of painful sexual activity. Different positions, support, pacing and non-penetrative forms of intimacy can be useful while medical or rehabilitation treatment addresses the underlying condition.

Can cancer treatment permanently affect sexual function?

Some effects are temporary and others may persist.

The outcome depends on the cancer, treatment type, radiation field, surgery, hormonal therapy and individual health. Chemotherapy and pelvic radiation can affect ovarian function and vaginal health, while surgery may alter anatomy or body image.

Does hysterectomy usually destroy sexual function?

No.

The latest 2026 systematic review did not find a clinically meaningful overall deterioration in sexual function after hysterectomy. Individual experiences vary, and removal of the ovaries is especially important because it can trigger surgical menopause.

Is the cervix necessary for sexual satisfaction after hysterectomy?

Current evidence does not show a clear sexual-function advantage from retaining the cervix. The 2026 systematic review found no measurable benefit of subtotal hysterectomy over total hysterectomy for sexual function overall.

Can SSRIs cause difficulty reaching orgasm?

Yes.

A 2026 meta-analysis found significantly increased orgasmic dysfunction among adults taking SSRIs compared with placebo.

However, depression itself can also affect sexual function, which is why individual assessment is necessary.

Should I stop my antidepressant if sexual side effects occur?

No—not without speaking to the clinician who prescribed it.

The treatment can often be reviewed, but abrupt discontinuation may cause withdrawal or relapse of depression or anxiety.

Can sexual function recover after cancer?

Yes, improvement is possible for many patients, but recovery varies.

Treatment may involve symptom management, pelvic rehabilitation, psychological support, communication with the partner and treatment of hormonal or anatomical changes.

ASCO specifically recommends incorporating sexual-health discussion and support into cancer survivorship care.

Can Unani medicine help sexual problems caused by chronic illness?

Unani medicine can provide a useful **supportive whole-person framework**, particularly through dietotherapy, regimenal therapy, psychological care and carefully selected pharmacotherapy. Official CCRUM materials recognize these as established Unani treatment modalities.

However, serious medical causes should first be properly diagnosed. Specific Unani medicines should not be presented as proven substitutes for cancer care, antidepressant management, postoperative care or treatment of structural and neurological disorders when such treatment is required.

A Message to Patients Living With Chronic Illness

I want patients to remember this:

Having a chronic illness does not mean you must stop being an intimate person.

Your sexual life may change.

You may need more time.

You may need different positions.

You may need lubrication.

You may need treatment for pain.

You may need counselling.

You may need your medication reviewed.

You may need pelvic rehabilitation.

You may temporarily prefer affection and touch rather than intercourse.

These adaptations are not evidence of failure.

They are examples of listening to the body.

A Message to Cancer Survivors

Cancer changes life.

But surviving cancer does not mean that concerns about intimacy suddenly become superficial.

If treatment has caused pain, dryness, loss of confidence, reduced desire or changes in orgasm, discuss them.

Do not assume there is nothing that can be done.

Modern survivorship care increasingly recognizes sexuality as part of quality of life.

A Message to Patients After Hysterectomy

Your uterus is not the source of your identity, femininity or capacity for emotional intimacy.

Many women have unchanged or even improved sexual lives after hysterectomy, particularly when painful bleeding or pelvic disease has been successfully treated.

Recovery should be allowed to occur properly.

If the ovaries were also removed, symptoms of surgical menopause should be discussed with the treating clinician.

Persistent pain should be evaluated.

A Message to People Taking SSRIs

Your mental health treatment matters.

Your sexual health also matters.

You should not have to choose silently between the two.

Tell your clinician if you develop reduced sexual satisfaction, difficulty reaching orgasm or another unwanted change after starting treatment.

There may be ways to adjust management safely.

But do not stop treatment on your own.

A Message to Partners

A medical condition can change sexual response without changing love.

Your partner may want closeness but be afraid of pain.

They may feel desire but be physically exhausted.

They may have difficulty reaching orgasm because of medication.

They may avoid being seen naked after surgery.

Patience matters.

Affection without pressure matters.

Asking **“What feels comfortable?”** is often more helpful than asking **“Why don't you want sex anymore?”**

Sexual Rehabilitation Is Real Rehabilitation

After illness or surgery, nobody expects a damaged knee to perform normally on the first day.

Yet people often expect sexual function to return immediately.

Sexual recovery may also require rehabilitation.

That may mean treating tissue changes, rebuilding muscle function, improving stamina, restoring confidence and gradually returning to intimacy.

A patient should be allowed the same patience with sexual recovery that we routinely give other parts of the body.

Conclusion

Medical illness can affect sexual health through many pathways.

Chronic pain can make movement and touch uncomfortable.

Cancer and its treatment can alter hormones, anatomy, genital tissues, energy and body image.

Hysterectomy may change recovery and pelvic sensations, although current evidence does not show that it generally causes major deterioration in sexual function; removal of the ovaries is a separate and important consideration.

SSRIs can interfere particularly with orgasm and sexual satisfaction, but depression itself must also be considered.

Other chronic conditions—including diabetes, thyroid disorders, cardiovascular disease and neurological illness—can also influence sexual response.

For this reason, effective treatment should be **biological, psychological, relationship-based and individualized**.

Unani medicine can contribute to this approach through its traditional emphasis on diet, physical activity and rest, sleep, psychological balance, regimenal therapy and individualized pharmacotherapy. Official CCRUM resources recognize these principles as central components of Unani care.

At the same time, responsible integrative medicine must recognize the boundaries of available evidence.

A cancer survivor needs oncological follow-up.

A woman with post-surgical pain may need gynecological or pelvic-floor assessment.

A person with medication-induced sexual dysfunction needs supervised medication review.

Traditional treatment should support good medical care—not delay it.

At **Saira Health Care**, the guiding principle is therefore simple:

Find the cause. Treat the whole person. Protect the underlying health condition. Adapt intimacy to the patient's present abilities. And never dismiss sexual well-being merely because someone is living with a chronic illness.

About the Author

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

Saira Health Care
www.sairahealthcare.com

Medical Disclaimer

This article is intended for general education and health awareness. It does not replace an individualized medical examination, diagnosis or treatment plan. Cancer treatment, hormone therapy, antidepressants, pain medication and other prescription medicines should not be started, stopped or changed without the appropriate treating clinician. Unani and herbal medicines can also have adverse effects and drug interactions and should be selected with attention to the patient's medical condition and ongoing treatments.

Sexual health is part of overall health—and living with illness does not make it unimportant.