

Sexual Health After a Heart Diagnosis

Returning Safely to Intimacy, Understanding Erectile Difficulties and Protecting Both Heart and Sexual Health

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Introduction

After receiving a diagnosis of heart disease, many patients ask questions about medicines, diet, walking and exercise.

But there is another question that many are afraid to ask:

“Doctor, is it safe for me to have sex?”

Some patients have recently experienced a heart attack.

Some have undergone angioplasty and stent placement.

Some have had bypass surgery.

Others are living with high blood pressure, coronary artery disease, heart failure, an abnormal heart rhythm, a pacemaker, an implanted defibrillator or heart-valve disease.

After such a diagnosis, it is very natural for a patient—and often the patient's partner—to worry that sexual activity might place too much stress on the heart.

Men may additionally develop erectile difficulties.

A patient may tell me:

“Before my heart problem my erections were normal, but since the diagnosis everything has changed.”

Sometimes there is a physical reason.

Sometimes medicines contribute.



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Sometimes vascular disease affecting the heart is also affecting the penile circulation.

Sometimes anxiety becomes the major problem.

And quite often several of these factors are present together.

My first message to patients is reassuring but medically important:

For many people with stable and appropriately treated cardiovascular disease, sexual activity can be resumed safely.

However, this statement does **not** apply automatically to every heart patient.

Patients with unstable chest pain, uncontrolled symptoms, severe heart failure, dangerous arrhythmias or another unstable cardiovascular condition require proper evaluation and stabilisation before resuming sexual activity.

Current European and American cardiovascular guidance supports an individual assessment based on symptoms, exercise capacity, the cardiac condition and recovery from any recent procedure.

This article is intended to help patients understand this subject without embarrassment and without unnecessary fear.

Sexual Health Is Part of Heart Health

Sexual health is sometimes treated as though it is separate from general medicine.

It is not.

The same blood vessels, nerves, hormones, metabolic health and psychological wellbeing that influence cardiovascular health can also influence sexual function.

Conditions frequently associated with both cardiovascular disease and erectile dysfunction include:

high blood pressure, diabetes, abnormal cholesterol, obesity, smoking, metabolic syndrome and physical inactivity.

Current European Association of Urology guidance recognises cardiovascular disease, hypertension, diabetes, dyslipidaemia, obesity, metabolic syndrome, smoking and lack of exercise among important risk factors associated with erectile dysfunction.

This relationship works in both directions.

A man who already has cardiovascular disease may develop erectile dysfunction.



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But a man presenting with erectile dysfunction—particularly gradual, apparently vascular ED—may also be showing an early sign of cardiovascular disease that has not yet become clinically obvious.

That is why I do not consider erectile dysfunction merely a private sexual inconvenience.

Sometimes it is a cardiovascular warning sign.

Erectile Dysfunction Can Be an Early Warning Sign of Heart Disease

This is one of the most important developments in modern sexual medicine.

The **Princeton IV Consensus** on erectile dysfunction and cardiovascular disease emphasises that ED should be considered a cardiovascular risk marker and risk-enhancing factor.

Research reviewed by the consensus indicates that erectile symptoms can precede clinically apparent cardiovascular disease by approximately **two to five years** in some men.

Why can this happen?

The penile arteries are relatively small.

Atherosclerosis and endothelial dysfunction can therefore interfere with penile blood flow before narrowing in larger coronary arteries produces obvious symptoms such as angina.

This does not mean:

“Every man with ED has blocked heart arteries.”

It means:

“Persistent unexplained ED deserves proper medical assessment, particularly when cardiovascular risk factors are present.”

The 2026 EAU Sexual and Reproductive Health guideline similarly states that erectile dysfunction significantly increases the observed risk of cardiovascular disease, coronary heart disease, stroke and cardiovascular mortality, and that more severe or longer-standing ED may indicate greater cardiovascular risk.

For me, this is one of the strongest reasons sexual medicine and general medical evaluation should work together.

Why Can a Heart Diagnosis Affect Sexual Function?

Sexual difficulties after a cardiovascular diagnosis may arise from several different mechanisms.

The heart condition itself can reduce exercise capacity and circulation.

The vascular disease responsible for coronary disease may also affect penile blood flow.

Diabetes, hypertension and abnormal cholesterol may damage blood vessels.

Some medicines may influence sexual function.

Fatigue may reduce sexual desire.

Depression or anxiety following a cardiac event may reduce libido.

Fear of another heart attack may make both partners avoid intimacy.

A patient may therefore develop ED even when no single severe abnormality is present.

This is why I prefer to evaluate the complete patient rather than immediately prescribing a sexual-performance medicine.

“Will Sex Put Too Much Pressure on My Heart?”

This is one of the most common fears.

For most people, ordinary sexual activity represents a **mild-to-moderate level of physical exertion**, often estimated at approximately **3 to 5 metabolic equivalents, or METs**.

Modern American chronic-coronary-disease guidance notes that if a patient can tolerate this degree of activity without chest pain, excessive breathlessness or evidence of ischemia, the cardiovascular risk associated with sexual activity is generally low.

The Princeton IV recommendations give patients a useful practical idea.

If someone can comfortably perform moderate everyday exercise—often compared with brisk walking or climbing approximately two flights of stairs—without chest pain, severe breathlessness, dizziness or another cardiac symptom, sexual activity is often tolerated similarly.

This is only a general guide.

It does not replace medical clearance in an individual with recent or unstable heart disease.



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How Often Does Sexual Activity Actually Cause a Heart Attack?

The fear is usually much greater than the actual risk.

The American Heart Association has reported that sexual activity accounts for **less than approximately 1% of acute myocardial infarctions**.

In patients whose cardiovascular disease is stable, cardiovascular events during sexual activity are uncommon.

That is reassuring.

But the key word is:

Stable.

A patient with uncontrolled or unstable cardiovascular disease should not apply statistics from stable patients to himself.

Who Is Usually Considered at Lower Cardiovascular Risk for Sexual Activity?

Contemporary Princeton and EAU frameworks classify patients according to cardiovascular risk.

Lower-risk patients generally include appropriately treated people who can perform moderate exercise without symptoms, such as patients with successfully treated coronary disease, controlled hypertension, mild valve disease or stable mild heart failure with adequate exercise capacity.

These patients can often resume sexual activity without specialised cardiac testing once their treating clinician considers the underlying condition stable.

Who Needs Further Evaluation Before Resuming Sexual Activity?

Some patients fall into an intermediate or uncertain category.

This may include individuals recovering from a relatively recent myocardial infarction, people with moderate angina, some patients with symptomatic heart failure, or patients whose ability to tolerate physical exertion is uncertain.

In these situations, exercise stress testing or another cardiovascular assessment may help determine whether the patient can safely tolerate the physical demand of sexual activity.

The principle is simple:



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If we do not know whether the heart can tolerate moderate activity, we should assess the heart rather than guess.

When Should Sexual Activity Be Deferred?

Sexual activity should generally be postponed when a cardiovascular condition is unstable.

Current guidance identifies situations such as unstable or refractory angina, uncontrolled hypertension, advanced or decompensated heart failure, recent untreated myocardial infarction and certain poorly controlled or high-risk arrhythmias as higher-risk circumstances in which sexual activity should wait until the cardiac condition has been stabilised.

This is not intended to frighten patients.

It is simply the same principle we use for exercise.

If climbing stairs produces dangerous symptoms, sexual activity should not be treated as though it places no demand on the cardiovascular system.

Sexual Activity After a Heart Attack

After a heart attack, both patient and partner frequently become frightened.

Sometimes the partner is actually more afraid than the patient.

The thought is:

“His heart attack happened once. What if sex triggers another one?”

For uncomplicated myocardial infarction in a patient who has recovered, has no ongoing ischemic symptoms and can tolerate mild-to-moderate physical exertion, older AHA-derived guidance has allowed resumption of sexual activity as early as approximately one week in selected patients.

However, current chronic-coronary-disease guidance appropriately emphasises **individualising the decision** according to symptoms, exercise capacity, treatment and recovery.

So I do not advise every patient:

“Seven days have passed, therefore sex is safe.”

The correct question is:



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“Has your cardiovascular condition become stable enough for moderate physical activity?”

Sexual Activity After Angioplasty and Stent Placement

After successful PCI—angioplasty with coronary stenting—sexual activity may sometimes be resumed within several days if blood flow has been successfully restored, there are no significant ongoing symptoms and the catheter-entry site has healed adequately.

Again, timing should be confirmed by the treating cardiologist because the original cardiac event, access site and completeness of revascularisation all matter.

A patient who continues to experience chest pain after a stent should not simply assume that the procedure has made all exertion safe.

Sexual Activity After Bypass Surgery

Coronary artery bypass grafting is different because the heart may be stable while the chest wall is still healing.

When CABG has been performed through a sternotomy, traditional guidance commonly recommends waiting approximately **six to eight weeks**, provided the sternum and surgical wound are healing normally.

Minimally invasive procedures may have different recovery requirements.

During early recovery, positions that place excessive strain on the chest should be avoided.

Your cardiac surgical team should give individual advice.

Sexual Activity With Heart Failure

Sexual problems are common among patients with heart failure.

Possible reasons include:

reduced exercise capacity, breathlessness, fatigue, reduced circulation, depression, medication effects and fear.

Sexual activity is generally considered reasonable in patients with **stable, compensated or mild heart failure** who can perform moderate physical activity without significant symptoms.

It should generally be deferred during **decompensated or advanced symptomatic heart failure** until treatment has restored stability.

If sexual activity consistently causes:

severe breathlessness, chest pain, dizziness or prolonged palpitations,

the patient should be reassessed.

Sexual Activity With Heart-Valve Disease

People with mild or moderate valve disease and no significant symptoms can often engage in sexual activity safely.

Patients with a successfully repaired valve or appropriately functioning prosthetic valve may also return to sexual activity after adequate recovery.

Severe symptomatic valve disease requires specialist assessment and stabilisation first.

The underlying principle remains exercise tolerance.

Arrhythmias, Pacemakers and ICDs

A pacemaker does not normally mean that sexual activity must stop permanently.

The American Heart Association advises patients with pacemakers to ask their healthcare professional when they may resume sexual activity, particularly during the period immediately after implantation when the wound and lead position are still healing.

Most people with an implanted cardioverter-defibrillator, or ICD, can also resume sexual activity when their cardiac condition is stable.

The device is designed to recognise dangerous rhythms rather than ordinary increases in heart rate associated with physical activity.

If an ICD is delivering repeated or inappropriate shocks, however, sexual activity should be postponed until the arrhythmia and device function have been evaluated and stabilised.

Partners sometimes fear that they will receive a dangerous shock from an implanted ICD during physical contact.

For implanted devices, the partner may occasionally feel something if a shock occurs, but it is generally not dangerous to the partner.



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Anxiety After a Cardiac Diagnosis Can Become a Sexual Problem

I see another important pattern.

A man has a heart attack.

He recovers physically.

His cardiologist tells him that his condition is stable.

But when he approaches sexual activity, he begins thinking:

“What if my heart rate goes up?”

“What if I get chest pain?”

“What if I die during intercourse?”

Immediately the body enters an anxious state.

Sexual arousal decreases.

The erection weakens.

The man then thinks:

“My heart disease has made me impotent.”

During the next attempt, he monitors every heartbeat.

That creates even more anxiety.

Eventually the original cardiac event has produced a secondary **performance-anxiety cycle**.

The partner may also contribute unintentionally.

If she repeatedly asks:

“Are you sure your heart can handle this?”

the patient may feel even more frightened.

Cardiac sexual counselling can therefore be very valuable.

AHA guidance specifically recognises psychological assessment, patient education and partner counselling as helpful when people are returning to sexual activity after cardiovascular illness.

Erectile Dysfunction After a Heart Diagnosis



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Many men assume their ED started because the cardiologist prescribed medication.

Sometimes medicines do contribute.

But we should not immediately blame the prescription.

The same vascular disease that produced hypertension or coronary disease can itself impair erections.

Diabetes may contribute.

Smoking may contribute.

Obesity and metabolic syndrome may contribute.

Fear, depression and reduced physical activity may contribute.

Therefore, a careful assessment is necessary.

Do Heart Medicines Cause Erectile Dysfunction?

Some cardiovascular medicines have historically been associated with sexual side effects, particularly some older beta-blockers, centrally acting antihypertensive medicines and certain diuretics.

However, the relationship is much less simple than patients are sometimes told.

A modern review found that evidence regarding beta-blockers and ED is mixed, and different medicines within the same drug family may have different sexual effects. ACE inhibitors, angiotensin-receptor blockers and calcium-channel blockers generally have neutral or sometimes favourable sexual-function profiles.

The most important message is:

Never stop a heart medicine yourself because you think it is affecting your erection.

Stopping an essential beta-blocker, antiplatelet medicine, anticoagulant or blood-pressure treatment can be far more dangerous than the sexual side effect.

Instead, tell the cardiologist.

Sometimes the medicine can be adjusted or substituted safely.

Sometimes the medication is not actually the main cause.

ED Medicines and Heart Disease



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Medicines such as:

sildenafil, tadalafil, vardenafil and avanafil

belong to a class called **phosphodiesterase type-5 inhibitors**, or PDE5 inhibitors.

These are well-established treatments for erectile dysfunction.

Importantly, modern evidence does **not** support the old idea that every patient with heart disease must avoid them.

The Princeton IV Consensus and EAU guidance consider PDE5 inhibitors generally cardiovascularly safe in appropriately selected patients with stable cardiovascular disease.

But there is one critical exception.

The Most Important Drug Interaction: PDE5 Inhibitors and Nitrates

A patient taking nitrate medication should **not** combine it with sildenafil, tadalafil, vardenafil, avanafil or another PDE5 inhibitor.

The combination can cause a dangerous fall in blood pressure.

Nitrate medicines include preparations containing nitroglycerin or isosorbide, and similar nitrate therapy used for angina.

Current EAU guidance also identifies nitrate donors and nicorandil as incompatible with PDE5 inhibitors.

Princeton IV guidance maintains the following separation:

sildenafil, vardenafil and avanafil — avoid nitrates within 24 hours;

tadalafil — avoid nitrates within 48 hours.

These intervals reflect differences in how long the medicines remain active.

This is not a minor precaution.

It is a potentially life-threatening interaction.

What If Chest Pain Occurs After Taking an ED Medicine?

This is very important.

Suppose a patient has taken sildenafil or tadalafil and then develops chest pain during sexual activity.



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He should stop sexual activity immediately and seek urgent medical attention if symptoms are significant or persistent.

He must tell the emergency team that he has recently taken an ED medicine.

He should **not simply take nitrate medication** during the contraindicated period because the combination can cause severe hypotension.

Emergency medical professionals can then choose an appropriate alternative approach.

Every heart patient considering ED medication should understand this before the first dose.

Can ED Treatment Actually Be Helpful in Cardiovascular Patients?

Yes, when prescribed appropriately.

Current evidence does not show an increased myocardial-infarction rate from PDE5 inhibitors in appropriately selected patients with stable cardiovascular disease.

Observational studies have even reported associations between PDE5-inhibitor use and lower cardiovascular event rates, although these studies cannot prove that the medicines themselves produce cardiovascular protection.

Therefore, I would not describe sildenafil or tadalafil as “heart medicines.”

But neither should patients automatically fear them because they have a stable heart diagnosis.

The decision should be individualised.

Why Exercise and Cardiac Rehabilitation Help Sexual Recovery

Cardiac rehabilitation is not only about walking on a treadmill.

It helps restore confidence.

A patient begins exercising under appropriate guidance.

He notices:

“My heart rate increased and I was fine.”

He walks farther.

His stamina improves.



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Fear reduces.

This confidence can transfer to sexual activity.

The 2023 American chronic coronary disease guideline states that cardiac rehabilitation and regular exercise can reduce cardiovascular complications associated with sexual activity, while the AHA has long recognised rehabilitation as a useful component of returning safely to intimacy.

Regular exercise also helps several underlying causes of erectile dysfunction, including vascular health, obesity, diabetes and cardiovascular risk.

Heart Health and Erectile Health Share the Same Lifestyle Foundations

I often tell patients:

“What is good for your arteries is usually good for your erections.”

If smoking damages blood vessels supplying the heart, it can damage penile vessels.

If uncontrolled diabetes affects coronary circulation, it can damage penile nerves and circulation.

If obesity and inactivity worsen vascular function, sexual function may also suffer.

Current EAU guidance reports that lifestyle modification—including physical activity, weight reduction when appropriate and management of cardiovascular risk factors—can improve erectile function in some men.

So treating ED after a heart diagnosis should not mean prescribing a tablet while ignoring:

blood pressure, glucose, cholesterol, smoking, weight, sleep and physical activity.

Smoking and Sexual Function

Smoking is one of the most important modifiable vascular risk factors.

It damages the endothelium—the delicate inner lining of blood vessels—and contributes to atherosclerosis.

The penile circulation is particularly dependent upon healthy endothelial function.

Therefore, stopping smoking is simultaneously a cardiovascular intervention and a sexual-health intervention.

Patients sometimes ask me:



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“Doctor, which medicine will improve blood flow?”

while continuing to smoke several cigarettes each day.

The most important treatment may first be removing something that is damaging the blood vessels continuously.

Diabetes, Heart Disease and ED

Diabetes deserves particular attention because it can affect sexual function through several mechanisms at once.

It may damage:

blood vessels, nerves and hormonal/metabolic health.

A patient with diabetes and coronary artery disease who develops ED should therefore not be managed as though the penis alone is the problem.

Good diabetes management is part of sexual-health treatment.

Testosterone and Heart Disease

Some men with heart disease and reduced libido immediately assume:

“My testosterone must be low.”

Sometimes it is.

But low sexual desire can also result from:

depression, fatigue, anxiety, medication, relationship factors, obesity, diabetes, sleep disorders or chronic disease.

Testosterone therapy should therefore only be considered after proper clinical and biochemical evaluation.

Patients should not purchase testosterone injections or “testosterone boosters” from gyms, online sellers or unqualified sources merely because sexual desire has decreased.

Sexual Health Is Not Only About Men

Although erectile dysfunction creates a particularly strong link between cardiovascular and sexual medicine, women with heart disease also experience sexual difficulties.



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These may include:

reduced desire, reduced arousal, difficulty with lubrication, discomfort during intercourse, fatigue, anxiety and fear that sexual activity could trigger a cardiac event.

A partner may also avoid intimacy because of fear of harming the patient.

The American Heart Association considers sexual health an important quality-of-life issue for both men and women living with cardiovascular disease.

This is why couples should be encouraged to ask about sexual activity openly rather than waiting for the doctor to raise the subject.

How Couples Can Restart Intimacy

After a serious cardiac diagnosis, I do not advise couples to treat the first sexual encounter as a test of whether everything has returned to normal.

Restart gradually.

Choose a familiar, comfortable environment.

Avoid intimacy immediately after an unusually heavy meal, excessive alcohol intake or exhausting physical activity.

Allow enough time so neither partner feels rushed.

Begin with affection and physical closeness rather than making penetrative intercourse the compulsory objective.

If the patient becomes excessively breathless, develops chest pressure, marked dizziness or significant palpitations, stop.

This gradual approach is consistent with cardiovascular sexual-counselling principles, which emphasise education, comfortable surroundings, partner communication and lower-exertion intimacy during recovery.

Intimacy Is More Than an Erection

After a heart diagnosis, some couples stop all affection because the man is experiencing ED.

This can create unnecessary emotional distance.

Sexual intimacy can include:



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touch, kissing, affectionate physical contact, sensual stimulation, emotional closeness and other mutually comfortable expressions of intimacy.

The point is not to ignore erectile dysfunction.

The point is to prevent ED from convincing the couple that every form of intimacy has disappeared.

When Sexual Activity Causes Symptoms

Patients should not hide symptoms because they feel embarrassed about explaining what they were doing when the symptoms appeared.

A cardiologist needs to know whether exertion produces symptoms.

If sexual activity repeatedly causes chest pain, severe breathlessness, faintness, marked dizziness or sustained palpitations, the patient should stop and obtain medical assessment.

If chest pain is severe, prolonged, associated with sweating, breathlessness, fainting or other features suggesting an acute cardiac event, urgent emergency evaluation is required.

The medical team does not need to judge how symptoms began.

They need accurate information to treat the patient.

The Unani Perspective on Heart Health and Sexual Health

As a physician trained in the **Unani system of medicine**, I find this subject particularly interesting because classical Unani medicine has traditionally viewed sexual strength within the broader health of the individual.

Sexual function is not considered independent from:

general vitality, cardiovascular strength, nutrition, digestion, physical activity, sleep and psychological wellbeing.

The Unani concept of **Asbab-e-Sitta Zarooriya**, or the six essential factors required for preservation of health, gives importance to:

environmental air, food and drink, physical movement and rest, psychological activity and rest, sleep and wakefulness, and appropriate elimination and retention.

Modern reviews of this classical framework have highlighted obvious parallels with contemporary lifestyle medicine, particularly regarding physical activity, diet, sleep,

stress and prevention of lifestyle-related disorders including cardiovascular disease and metabolic disease.

This is an area where traditional health principles and modern preventive cardiology can complement one another conceptually.

Unani Understanding of Sexual Weakness

Classical Unani literature discusses male sexual weakness under concepts such as **Zu'f-e-Bah**.

The traditional assessment is broader than simply asking:

“Can the penis become erect?”

It may consider:

Mizaj or temperament, general vitality, nutritional condition, digestion, sleep, physical activity, psychological state, reproductive health and associated systemic illness.

From a patient-care perspective, I find this broad view valuable.

A man who has recently experienced a heart attack may have:

vascular ED,

plus fatigue,

plus fear,

plus sleep disturbance,

plus depression,

plus medication concerns.

Giving the same sexual medicine to every such patient does not address this complexity.

How Can Unani Medicine Be Useful After a Heart Diagnosis?

This requires balance and medical responsibility.

Unani medicine can make a useful contribution through **individualised supportive care**, particularly in lifestyle regulation, general wellbeing, stress, sleep, nutrition and selected sexual-health complaints.



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In suitable patients, treatment may be directed towards improving overall health and vitality while the primary cardiovascular condition remains under the supervision of the treating cardiologist.

However, I want to state something very clearly:

Unani treatment should not replace essential cardiovascular treatment.

A patient should not stop:

antiplatelet treatment after a stent,

anticoagulation for an important rhythm disorder,

statins,

heart-failure medicines,

blood-pressure treatment,

or other cardiologist-prescribed therapy

simply because he wishes to use Unani treatment.

This would be medically unsafe.

What Does Research Say About Unani Treatment for Erectile Dysfunction?

There is emerging clinical research, but the evidence must be interpreted honestly.

A randomized open-label clinical study published in 2025 evaluated polyherbal oral and topical Unani formulations in men with erectile dysfunction and reported improvement in erectile-function measures.

However, only 36 participants were included, and the study was not specifically designed for men with coronary disease or patients recovering from a cardiac event.

Therefore, this research is encouraging for future investigation but is **not sufficient to claim that Unani medicine has been proven to treat cardiovascular-associated ED in all patients.**

This distinction is essential.

At Saira Health Care, I believe traditional treatment should become stronger through appropriate clinical evaluation and research—not through exaggerated claims.

“Herbal” Does Not Automatically Mean Safe for a Heart Patient



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This warning is especially important in cardiovascular patients.

Many over-the-counter products are marketed as:

“herbal Viagra,”

“natural sex power,”

“instant erection medicine,”

or “100% natural stamina capsules.”

The US National Center for Complementary and Integrative Health warns that some products marketed for sexual enhancement have been found to contain undeclared pharmaceutical ingredients, and such products may interact dangerously with nitrate medicines.

Therefore, a heart patient should never take an unknown sexual-performance product simply because the label says **herbal**.

A clinically prescribed Unani formulation from a qualified physician and an unidentified internet supplement are not the same thing.

All medicines and supplements should be disclosed to the cardiologist when significant heart disease is present.

My Approach at Saira Health Care

When a man with a cardiovascular diagnosis visits me because of a sexual problem, my first question is not:

“Which sexual medicine should I prescribe?”

I want to understand the complete situation.

I ask about:

the cardiovascular diagnosis, previous heart attack, angioplasty or bypass surgery, chest pain, exercise capacity, heart failure, blood pressure, rhythm disorders, current medicines, nitrate use, diabetes, cholesterol, smoking, body weight, erection quality, morning erections, libido, ejaculation, testosterone-related symptoms, psychological stress and relationship factors.

This is particularly important because prescribing an ED medicine without identifying nitrate treatment could be dangerous.

Why Collaboration With the Cardiologist Matters



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Sexual medicine and cardiology should not work against each other.

If the patient has stable cardiovascular disease, sexual function can often be treated effectively.

If his cardiovascular condition is unstable, cardiovascular stabilisation comes first.

If he uses nitrates regularly, we must consider ED treatments that do not create a dangerous interaction.

If he believes a heart medicine is damaging sexual function, the cardiologist can review whether an appropriate alternative exists.

If exercise tolerance is uncertain, cardiovascular testing may help determine sexual-activity safety.

This is the model of care I consider responsible.

Saira Health Care's Contribution in Sexual Disorders & Infertility

At **Saira Health Care**, our work has focused particularly on conditions that many patients hesitate to discuss openly.

These include erectile difficulties, ejaculation disorders, sexual-performance anxiety, libido concerns, male infertility, semen abnormalities and reproductive-health problems.

An important part of this work is patient education.

A man with ED should not simply be told:

“Take this medicine.”

He should understand why the condition has developed.

A man with heart disease should understand that the erection problem may reflect:

vascular health,

medication,

metabolic disease,

psychological factors,

or several of these together.

This makes treatment safer and more rational.



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A Special Message for Men With New Erectile Dysfunction

If you have developed erectile dysfunction but have never been diagnosed with heart disease, particularly if the problem appeared gradually and you also have:

high blood pressure, diabetes, high cholesterol, obesity, smoking history or a family history of cardiovascular disease,

please do not consider ED only a sexual problem.

The Princeton IV Consensus and contemporary EAU guidance recommend cardiovascular-risk assessment for men presenting with predominantly vascular erectile dysfunction.

Sometimes discussing an erection problem with a doctor gives us an opportunity to detect cardiovascular risk earlier.

That can be much more important than simply restoring an erection.

A Special Message for Men Already Diagnosed With Heart Disease

Do not assume:

“I have a heart problem, therefore my sexual life is over.”

That is usually not true.

Instead ask:

Is my cardiovascular condition stable?

Can I tolerate moderate activity without symptoms?

Do I take nitrate medication?

Is my erectile problem vascular, medication-related, psychological or mixed?

Can my treatment be safely adjusted?

Once these questions are answered, many patients can return to satisfying intimacy.

Warning Signs That Need Medical Attention

Stop sexual activity and seek appropriate medical evaluation if you develop significant chest pressure or pain, severe or unusual shortness of breath, fainting or near-fainting, sustained or severe palpitations, marked dizziness, or another symptom suggesting that your cardiovascular condition is not tolerating the activity normally.



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Patients with unstable angina, uncontrolled hypertension, advanced decompensated heart failure, recent untreated myocardial infarction or high-risk uncontrolled arrhythmia should obtain cardiovascular assessment before resuming sexual activity.

Frequently Asked Questions

Can a heart patient have sex?

In many cases, yes.

Sexual activity is generally considered safe when cardiovascular disease is stable and the person can tolerate mild-to-moderate physical exertion without significant symptoms.

Patients with unstable or severe symptoms need assessment first.

Can sex cause a heart attack?

Sexual activity temporarily increases heart rate and blood pressure, but cardiovascular events during sex are uncommon.

AHA guidance has estimated that sexual activity accounts for less than approximately 1% of acute heart attacks.

Individual risk depends on the stability of the underlying heart disease.

How soon can I have sex after a heart attack?

There is no single correct number for every patient.

Selected patients recovering from an uncomplicated heart attack may resume sexual activity relatively early when symptom-free and able to tolerate moderate exercise.

Current guidelines favour individualising the decision according to cardiac stability, treatment and exercise capacity.

Can I have sex after a heart stent?

Often, yes.

After uncomplicated successful PCI, some patients may resume sexual activity within several days once clinically stable and the catheter-entry site has healed.

Ask the treating cardiologist for individual advice.



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How long after bypass surgery?

Following conventional sternotomy CABG, approximately six to eight weeks is commonly allowed for adequate chest-wall healing before normal sexual activity, although individual recovery differs.

Is erectile dysfunction common in heart disease?

Yes.

Erectile dysfunction and cardiovascular disease share several underlying vascular and metabolic risk factors.

ED may also occasionally appear years before clinically obvious cardiovascular disease.

Can I take sildenafil if I have heart disease?

Possibly.

PDE5 inhibitors are generally considered safe in appropriately selected patients with stable cardiovascular disease.

But they must **not** be combined with nitrate medicines.

Can I take tadalafil if I use nitroglycerin?

No.

Combining tadalafil with nitrates can cause dangerous hypotension.

Current guidance recommends avoiding nitrate administration for at least 48 hours following tadalafil.

What about sildenafil?

Nitrates should generally be avoided for at least 24 hours following sildenafil.

Vardenafil and avanafil have a similar 24-hour separation in Princeton IV guidance.

What if I have angina but rarely use nitrate tablets?

Do not stop nitrate treatment yourself simply so that you can take an ED medicine.

The cardiologist should determine whether nitrate therapy remains medically necessary or whether an alternative anti-anginal strategy is appropriate.

Princeton IV specifically supports a patient-centred review of nitrate requirements rather than unsupervised discontinuation.

Can blood-pressure tablets cause ED?

Some medicines may contribute in certain patients, but cardiovascular disease itself is also an important cause.

Modern evidence regarding beta-blockers and diuretics is mixed, and sexual effects vary among individual medications.

Never stop blood-pressure medication without medical advice.

Can I use herbal sexual medicines if I have heart disease?

Only after appropriate professional review.

Some sexual-enhancement supplements marketed as herbal have been found to contain undeclared drug substances that can interact dangerously with nitrate medicines or cardiovascular treatment.

Can Unani medicine help?

Unani medicine may have a supportive role in appropriately selected patients, particularly through individualized attention to lifestyle, nutrition, sleep, stress, general vitality and sexual wellbeing.

A small 2025 clinical study also reported improvement in general ED with specific Unani formulations, but the evidence is not sufficient to claim a proven treatment for cardiovascular-associated erectile dysfunction.

Cardiac treatment must not be discontinued or replaced without the treating cardiologist's approval.

Can anxiety alone cause erection difficulty after a heart attack?

Yes.



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Fear of triggering another cardiac event can produce performance anxiety even when cardiovascular recovery is satisfactory.

Counselling, patient education and communication with the partner may help.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician – Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Qualifications & Professional Training

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

My focused clinical practice involves sexual disorders, male reproductive health and infertility, with particular attention to understanding the cause of a patient's symptoms rather than simply treating a laboratory number or a single complaint.

Through **Saira Health Care**, my aim is to provide patients with an environment where sexual-health concerns can be discussed professionally, respectfully and confidentially.

Sexual problems associated with cardiovascular disease require particular care because the treatment must protect both:

sexual function and cardiovascular safety.

My Message to Patients

If you have recently received a heart diagnosis, please remember:

A heart diagnosis does not automatically mean the end of your sexual life.

For many patients with stable cardiovascular disease, sexual activity can be resumed safely.

But the decision should be based on your actual cardiovascular condition—not fear and not guesswork.



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If you have erectile dysfunction, do not be embarrassed.

It may be connected to:

your circulation,

your diabetes,

your blood pressure,

your medication,

your psychological response to the cardiac diagnosis,

or several of these factors together.

And sometimes ED gives us useful information about cardiovascular health.

So please do not hide the symptom.

At the same time, do not purchase an unknown sexual-strength tablet simply because you want an immediate solution.

Particularly if you are taking nitrate medicines, the wrong combination can be dangerous.

A Balanced Approach: Heart First, Sexual Health Alongside It

When I see a patient with both cardiovascular disease and sexual dysfunction, my philosophy is straightforward:

Protect the heart first—but do not ignore the patient's sexual quality of life.

We should control the cardiovascular condition.

We should identify metabolic risk factors.

We should review medicines.

We should assess exercise tolerance.

We should address anxiety.

We should treat erectile dysfunction safely.

And where appropriate, individualized Unani supportive care may be incorporated without interfering with necessary cardiovascular treatment.

This is what responsible integrative care means to me.

It does not mean choosing Unani medicine instead of cardiology.



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It means using traditional principles responsibly while respecting modern cardiovascular diagnosis, evidence and lifesaving treatment.

Final Words From Dr. Nizamuddin Qasmi

There is something I want every heart patient to understand.

Sexual health is not an embarrassing luxury.

For many people it is an important part of:

confidence,

marriage,

emotional closeness,

quality of life,

and overall wellbeing.

A person who survives a heart attack should not then spend years unnecessarily afraid to touch his or her partner.

A man with a stent should not automatically believe that every erection will put his heart in danger.

A patient taking heart medication should not quietly stop lifesaving medicine because he believes it is causing sexual weakness.

And a man with new erectile dysfunction should not ignore the possibility that his sexual symptom may be telling us something about his blood vessels.

The right approach is:

evaluate, stabilise, communicate and treat safely.

Modern cardiology has made it possible for millions of people with cardiovascular disease to live active lives.

Modern sexual medicine gives us several effective ways to manage erectile dysfunction.

Traditional Unani principles can contribute to individualized attention to health, lifestyle, nutrition, sleep, psychological balance and general wellbeing when used responsibly.

At **Saira Health Care**, my goal is to bring these considerations together around the individual patient.

Because treating the heart should help a person return to life.



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And for many patients, intimacy is an important part of that life.

Medical Disclaimer

This article is intended for general health education and patient awareness. It is not a substitute for individual cardiology assessment, examination or treatment.

The safety of sexual activity depends upon the type and stability of cardiovascular disease, recent heart procedures, exercise tolerance, symptoms and medications.

Patients with unstable chest pain, significant breathlessness, poorly controlled blood pressure, decompensated heart failure, dangerous arrhythmias or another unstable cardiovascular condition should obtain appropriate cardiovascular evaluation before sexual activity.

Never discontinue prescribed cardiovascular medicines without the approval of the treating physician.

PDE5 inhibitors such as sildenafil and tadalafil must not be combined with nitrate medicines or other contraindicated nitric-oxide-donor treatments because severe hypotension can occur.

Unani medicines, herbal preparations and supplements should also be disclosed to the treating physician, particularly when a patient has significant cardiovascular disease or takes multiple cardiovascular medicines.

Unani medicine may contribute to supportive and individualized care, but it should not replace emergency treatment, cardiology follow-up, medically indicated cardiovascular medicines or necessary cardiovascular procedures.



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