Erectile Dysfunction in Men With High Blood Pressure

A Complete Modern and Unani Understanding of Hypertension-Related Erectile Dysfunction, Cardiovascular Risk, Medicines, Treatment, Lifestyle, Sexual Health and Integrative Care

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Introduction

One of the important questions I hear from men with high blood pressure is:

"Doctor, my blood pressure is under treatment, but my erection has become weak. Is this because of hypertension, because of my medicines, or because I am getting older?"

The answer may involve all of these factors—or none of them individually.

Erectile dysfunction and hypertension are closely connected because the penis depends heavily on healthy blood vessels. An erection requires arteries to dilate efficiently, erectile smooth muscle to relax and enough blood to enter and remain within the corpora cavernosa. The same conditions that damage blood vessels elsewhere in the body—hypertension, diabetes, smoking, abnormal cholesterol, obesity and atherosclerosis—can also interfere with penile circulation.

The background material supplied for this article correctly emphasizes that hypertension and erectile dysfunction should not be viewed as completely separate disorders and highlights the importance of vascular health and the possible influence of antihypertensive treatment on sexual function.

However, one scientific correction is essential: **not every case of erectile dysfunction is a vascular disease, and not every blood-pressure medicine causes ED**. Erectile dysfunction can be vascular, hormonal, neurological, psychological, medication-related or mixed. Current European urological guidance explicitly recognizes these multiple pathways.

Hypertension itself is extremely common. WHO estimated in its September 2025 update that approximately **1.4 billion adults aged 30–79 years worldwide had hypertension in 2024**, and only a minority had their blood pressure adequately controlled.

This makes sexual health in hypertensive men an important public-health issue rather than a minor quality-of-life complaint.

At **Saira Health Care**, I consider erectile dysfunction in a man with hypertension an opportunity to address **two goals together**:

protect the patient's cardiovascular health and restore sexual function as safely as possible.

My Unani training contributes another perspective. Classical Unani medicine evaluates sexual strength through concepts such as *Quwwat-e-Bah*, *Mizaj* and the health of the principal organs, while cardiovascular disturbance may be interpreted through traditional concepts such as *Imtila* and altered temperament. The supplied source discusses these frameworks in detail.

I find this holistic approach useful—but modern cardiovascular diagnosis must remain central. A traditional concept cannot replace a blood-pressure measurement, cardiovascular-risk assessment, glucose test, lipid profile or appropriate ED evaluation.

What Is Erectile Dysfunction?

Erectile dysfunction, commonly called **ED**, means persistent or recurrent difficulty obtaining or maintaining an erection sufficient for satisfactory sexual activity.

An occasional erection problem is not necessarily a disease.

Fatigue, stress, alcohol, relationship tension, inadequate stimulation or an unfamiliar sexual situation can temporarily affect erections.

ED becomes clinically important when the problem is persistent, recurrent or causes significant distress.

The erectile problem may involve difficulty becoming erect, inability to maintain rigidity during intercourse, an erection that is not firm enough for penetration or loss of erection before ejaculation.

Some men also have reduced sexual desire, premature ejaculation or anxiety about sexual performance.

These problems may coexist but are not the same condition.

Why Hypertension Can Affect Erections

A normal erection is primarily a **neurovascular event**.

Sexual stimulation activates nerves that release nitric oxide. Nitric oxide stimulates formation of cyclic guanosine monophosphate, or **cGMP**, inside the smooth muscle of the corpora cavernosa.

This causes smooth muscle relaxation.

The penile arteries widen.

Blood flow increases.

The erectile tissue expands and compresses the veins that would otherwise drain blood from the penis.

Rigidity is then maintained.

The source supplied for this article describes this nitric-oxide/cGMP pathway and how chronic hypertension may interfere with endothelial function.

This is broadly consistent with contemporary vascular medicine.

Endothelial Dysfunction: The Shared Link

The **endothelium** is the thin cellular lining inside blood vessels.

Healthy endothelium helps regulate vessel relaxation, blood flow, inflammation and clotting.

Chronic hypertension places mechanical and biological stress on this lining.

Over time, endothelial function may deteriorate, nitric-oxide availability may decrease and arteries may become less capable of relaxing appropriately.

The penis is particularly sensitive to these changes because erection depends on rapid, substantial changes in local blood flow.

This helps explain why erectile dysfunction and cardiovascular disease frequently share the same risk factors.

ED May Be an Early Cardiovascular Warning Sign

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

Erectile dysfunction should not always be viewed only as a sexual problem.

The latest Princeton IV cardiovascular-sexual medicine consensus considers ED a **risk marker and risk enhancer for cardiovascular disease**. In some men, particularly those with

predominantly vascular ED, erectile symptoms can precede clinically obvious cardiovascular disease by approximately **two to five years**.

The 2026 European Association of Urology guidance likewise states that ED can precede or predict cardiovascular disease and recommends cardiovascular-risk assessment in relevant men presenting with ED.

This does not mean every man with ED will have a heart attack.

It means persistent ED—especially when it develops gradually in a man with hypertension, diabetes, smoking, obesity or abnormal cholesterol—can provide an opportunity to identify cardiovascular risk earlier.

I therefore tell patients:

Do not be embarrassed about reporting erectile dysfunction. In some men, that conversation may protect much more than their sexual life.

Why Penile Arteries May Show Problems Before Coronary Arteries

One proposed explanation is called the **artery-size hypothesis**.

The penile arteries are much smaller than the major coronary arteries supplying the heart.

If systemic endothelial dysfunction or atherosclerosis affects the entire vascular system, a smaller artery may become functionally compromised before a larger artery produces obvious symptoms.

This helps explain why vasculogenic ED can sometimes appear before angina or another clinical manifestation of coronary artery disease.

It is an important concept, but it should not be interpreted to mean every erection problem is caused by blocked arteries.

Young men with sudden, situational ED may have a strong psychological component.

Others may have hormonal, neurological or medication-related causes.

Hypertension and Erectile Dysfunction Share Many Risk Factors

Sometimes hypertension itself contributes to ED.

Sometimes both conditions are manifestations of the same underlying health problems.

Diabetes, smoking, obesity, physical inactivity, dyslipidaemia, advancing age, metabolic syndrome, sleep disorders and cardiovascular disease can increase the likelihood of both hypertension and erectile dysfunction.

This is why treating only the penis without treating the rest of the patient is incomplete medicine.

Current EAU guidance strongly recommends beginning **lifestyle changes and cardiovascular-risk-factor modification either before or at the same time as ED treatment**.

Psychological Factors Still Matter

A man can have vascular ED and performance anxiety simultaneously.

Imagine that hypertension produces a mild reduction in erection quality.

The man loses his erection during intercourse once.

He becomes frightened.

Before the next sexual encounter he thinks:

“What if it happens again?”

The fear activates the sympathetic nervous system and makes erection more difficult.

Now a modest vascular problem has acquired an additional psychological component.

This is extremely common.

A complete treatment plan should therefore consider cardiovascular health **and** sexual confidence.

Does Blood-Pressure Medicine Cause Erectile Dysfunction?

This is one of the most complicated areas because patients often stop life-saving antihypertensive medicines after noticing sexual difficulties.

That can be dangerous.

The relationship between antihypertensive drugs and sexual function differs among drug classes and among individual patients.

The **2025 AHA/ACC High Blood Pressure Guideline** specifically includes a section on sexual dysfunction. It recognizes that hypertension itself and antihypertensive treatment may both contribute and notes that diuretics and beta-blockers—particularly older beta-blockers—have traditionally been most associated with male ED, while ARBs have a more favourable sexual-function profile.

However, newer research provides important nuance.

A 2024 review concluded that the evidence linking thiazide diuretics to ED is less consistent than previously believed, while beta-blockers remain the class most commonly associated with ED; nebivolol appears to have a more favourable profile than several older beta-blockers. ACE inhibitors, ARBs and calcium-channel blockers are generally neutral or relatively favourable.

Therefore, the correct message is not:

"Blood-pressure tablets cause impotence."

It is:

"Some antihypertensive medicines may influence sexual function in some men, and the medication regimen should be reviewed if symptoms appear."

Antihypertensive Medicines and Sexual Function

Medication group	General current evidence regarding erectile function
Older beta-blockers	May contribute to ED in some men
Nebivolol	Generally more erection-friendly than many older beta-blockers
Thiazide/thiazide-like diuretics	Possible association; modern evidence is mixed
ACE inhibitors	Usually neutral
ARBs	Generally neutral to favourable
Calcium-channel blockers	Usually neutral
Centrally acting agents such as clonidine	Can contribute to sedation, reduced libido or sexual dysfunction in some patients
Multiple-drug therapy	Individual effects depend on BP, vascular disease, medications and comorbid conditions

This table is an overview, not a reason for a patient to change medication independently.

Never Stop Blood-Pressure Medicine Because of ED

This deserves particular emphasis.

Do not stop an antihypertensive medicine on your own because your erection has become weaker.

Stopping treatment can expose the patient to stroke, heart attack, kidney damage and other complications.

Certain medicines, particularly beta-blockers and centrally acting agents such as clonidine, may also produce problems if abruptly discontinued.

The correct approach is to discuss the sexual side effect with the prescribing physician.

Sometimes another cause is identified.

Sometimes the ED can be treated while the antihypertensive medicine continues.

Sometimes a medication change is clinically reasonable.

But cardiovascular safety must remain the first priority.

Can the Blood-Pressure Medicine Be Changed?

Sometimes.

If ED began soon after introduction of a particular antihypertensive and no other obvious explanation exists, the clinician may review whether another drug can provide equivalent cardiovascular protection with a more favourable sexual profile.

However, antihypertensives are chosen for reasons beyond the BP number.

A beta-blocker may be needed after myocardial infarction, for arrhythmia or another cardiovascular indication.

A diuretic may be important for heart failure.

An ACE inhibitor or ARB may have kidney-protective indications.

The safest medicine is therefore not simply the medicine with the best sexual profile.

It is the medicine that gives the patient the **best overall risk-benefit balance**.

Controlled Hypertension and Sexual Activity

Many men become afraid that sexual intercourse itself will cause a heart attack because they have hypertension.

For most men with **well-controlled, stable hypertension**, sexual activity is generally considered low cardiovascular risk.

Princeton IV and current EAU guidance use cardiovascular-risk stratification to determine who can safely engage in sexual activity and receive ED treatment. Most men with controlled cardiovascular disease and reasonable exercise tolerance can remain sexually active.

Sexual activity is usually comparable to moderate physical exertion.

For a stable patient who can comfortably perform ordinary moderate activity without chest pain or major breathlessness, sexual activity is often safe.

Individual assessment is still required.

When Sexual Activity Should Be Deferred

The situation is very different when cardiovascular disease is unstable.

Current guidance considers men with conditions such as **uncontrolled hypertension, unstable or refractory angina, very recent myocardial infarction, high-risk arrhythmias or severe unstable heart failure** to be at high risk.

In these circumstances, sexual activity and ED treatment should generally be deferred until the cardiovascular condition is stabilized and appropriate medical clearance has been obtained.

If intercourse produces chest pain, severe breathlessness, faintness or another concerning cardiovascular symptom, medical evaluation is necessary.

How Erectile Dysfunction Should Be Evaluated in a Hypertensive Man

The evaluation should begin with conversation.

I want to know whether the ED appeared before or after hypertension.

Did it begin after starting a new medication?

Was onset sudden or gradual?

Are morning erections present?

Is erection normal during masturbation?

Is sexual desire reduced?

Is ejaculation normal?

Is there diabetes?

Does the patient smoke?

Is there chest pain or exercise intolerance?

Are there relationship or performance-anxiety concerns?

The answers often provide more useful information than an unnecessary large panel of laboratory tests.

Blood Pressure Must Be Properly Assessed

A single blood-pressure reading does not always diagnose chronic hypertension.

Definitions also vary among international guidelines.

WHO commonly defines hypertension as blood pressure **140/90 mmHg or higher**, while newer American and European strategies use additional risk-based categories and lower thresholds for intervention in selected high-risk patients.

What matters clinically is standardized measurement, repeat confirmation when appropriate, assessment of total cardiovascular risk and individualized treatment.

A patient should not diagnose or alter treatment solely from one home reading.

Physical Examination and Laboratory Assessment

Modern ED evaluation frequently includes assessment of blood pressure, body weight or waist circumference and examination for signs relevant to vascular, endocrine or genital health.

EAU guidance recommends considering metabolic and hormonal assessment, commonly including **glucose or HbA1c, lipid profile and early-morning total testosterone**, with additional tests selected according to symptoms and history.

In a hypertensive patient, kidney function and other investigations may also be important according to the broader medical picture.

The purpose is not simply to investigate the erection.

It is to identify potentially treatable diseases.

Testosterone Should Be Tested Appropriately, Not Assumed

Some men conclude that weak erections automatically mean low testosterone.

That is incorrect.

Testosterone deficiency is more likely to affect libido and may contribute to ED in selected men, but most hypertension-associated ED is not explained simply by testosterone.

Hormone replacement should only be considered after appropriate diagnosis.

This is particularly important in men who want children because **external testosterone can suppress sperm production**, sometimes severely.

At Saira Health Care, where infertility and sexual disorders frequently overlap, I consider this warning especially important.

PDE5 Inhibitors: First-Line Modern Treatment

Medicines known as **phosphodiesterase type-5 inhibitors**, or PDE5 inhibitors, are established first-line treatments for most men with ED.

They include medicines such as sildenafil and tadalafil.

They do not create sexual desire automatically.

Sexual stimulation is still required.

Their main action is to preserve cGMP within erectile smooth muscle so that the normal nitric-oxide pathway can produce better penile blood flow.

The 2026 EAU guideline strongly recommends PDE5 inhibitors as **first-line ED therapy**.

Can PDE5 Inhibitors Be Used With Blood-Pressure Medicines?

Often, yes.

This is another important correction to a common misconception.

Current EAU guidance states that PDE5 inhibitors used with antihypertensive medicines generally cause only a **small additional decrease in blood pressure**, and adverse effects are not substantially increased even in many patients taking several antihypertensives.

The 2025 AHA/ACC hypertension guideline likewise describes PDE5 inhibitors as safe and effective for ED in many patients receiving antihypertensive treatment.

However, this does not mean they are appropriate for every cardiovascular patient.

The Critical Warning: PDE5 Inhibitors and Nitrates

This is one of the most important safety rules in sexual medicine.

PDE5 inhibitors must not be combined with nitrate medicines or other nitric-oxide-donor drugs.

The combination can produce an unpredictable and potentially dangerous fall in blood pressure.

Current EAU and Princeton IV guidance consider concomitant nitrate use an **absolute contraindication**. Nicorandil is also contraindicated because of its nitric-oxide-donating action, and PDE5 inhibitors should not be combined with the guanylate-cyclase stimulator riociguat.

A patient with angina must tell the ED physician exactly which cardiac medicines he uses.

And a patient who has taken an ED medicine should inform emergency clinicians before treatment for chest pain.

PDE5 Medicines Are Not "Sex Power" Supplements

Prescription ED medicines should not be purchased blindly or combined with unknown herbal sexual products.

Princeton IV specifically discusses concerns about adulterated dietary supplements containing undeclared PDE5-like drugs.

This can be particularly dangerous in a hypertensive or cardiac patient because the person may unknowingly combine an undeclared vasodilator with nitrates or other cardiovascular medication.

If a product promises an immediate erection but does not clearly disclose its ingredients, I advise considerable caution.

What If PDE5 Inhibitors Do Not Work?

Before declaring treatment failure, the clinician should confirm that the medicine is being used correctly.

Some drugs are affected by food timing.

Adequate sexual stimulation is required.

Dose and timing matter.

Underlying severe vascular disease, diabetes, testosterone deficiency, anxiety or incorrect expectations may reduce response.

When appropriate oral treatment fails, evidence-based alternatives include **vacuum erection devices, intracavernosal injections, intraurethral or topical alprostadil in selected patients and penile prosthesis surgery for appropriately selected severe cases**. Current EAU guidance recognizes these options.

The treatment pathway should progress according to the individual patient rather than simply increasing unregulated aphrodisiacs.

Lifestyle Treatment Is Part of Erectile-Dysfunction Treatment

The same lifestyle changes that protect the heart frequently support erectile health.

Stopping tobacco is especially important.

Regular physical activity improves vascular and metabolic health.

Weight reduction can benefit appropriate overweight patients.

Diabetes and cholesterol should be controlled.

Excessive alcohol should be reduced.

The latest EAU patient guidance, updated in 2026, specifically recommends attention to physical activity, diet, weight, smoking, alcohol and recreational drugs in men with ED.

These measures should occur **alongside** ED treatment, not years before the patient is allowed to receive treatment.

Diet for a Hypertensive Man With ED

No single fruit, nut, spice or herb is a proven cure for erectile dysfunction.

A cardiovascularly healthy diet is more important than a so-called aphrodisiac diet.

A diet rich in vegetables, fruits, pulses, whole grains, nuts and appropriate healthy fats while limiting excessive sodium, highly processed food and excessive saturated fat supports cardiovascular health.

The newest hypertension guidelines continue to emphasize lifestyle and dietary measures as central components of blood-pressure treatment.

From a sexual-health perspective, the goal is to improve **the vascular system that supplies the penis**, not simply to consume foods marketed as sexual stimulants.

Smoking and Erectile Function

Smoking damages the vascular endothelium and is an important modifiable risk factor for cardiovascular disease and ED.

For a hypertensive smoker with ED, stopping tobacco can be more meaningful than adding another sexual-health supplement.

I tell patients:

If the arteries supplying the penis are being damaged every day by tobacco, a temporary erection medicine cannot substitute for vascular risk reduction.

Diabetes, Hypertension and ED: A Common Combination

Diabetes and hypertension frequently occur together and are both strongly associated with ED.

Diabetes may affect vascular function, peripheral nerves and endothelial nitric-oxide signalling.

When these conditions coexist, ED may become more severe and treatment response less predictable.

Therefore, erectile dysfunction in a diabetic hypertensive man should prompt attention to glucose control as well as blood-pressure control.

Again, ED becomes a window into overall men's health.

The Unani Understanding of Hypertension and Erectile Weakness

Classical Unani medicine predates the sphygmomanometer, so it does not describe modern hypertension in exactly the same biomedical language.

The supplied material interprets hypertension-like states through concepts such as **Imtila**, *Su-e-Mizaj Damwi* and *Salabat-e-Sharaayeen*, while male sexual weakness is discussed through *Zoaf-e-Bah* or *Zoaf-e-Istadgi* and the broader concept of *Quwwat-e-Bah*.

These are legitimate traditional concepts.

But they should not be presented as exact scientific synonyms.

Imtila is not a blood-pressure reading.

Salabat-e-Sharaayeen should not automatically be equated with a measured atherosclerotic plaque.

Zoaf-e-Bah is broader than modern vasculogenic ED.

Traditional assessment and modern cardiovascular diagnosis can complement one another, but they should not be confused.

Mizaj and Individualized Sexual-Health Care

Mizaj, or temperament, is central to Unani medicine.

CCRUM explains that modern research programmes are studying the physiological, biochemical, pathological and genetic correlates of different traditional temperaments rather than assuming that every classical theory already has a proven modern biological equivalent.

I consider this a useful and scientifically responsible position.

Mizaj can help structure an individualized traditional assessment.

But it cannot replace blood-pressure monitoring, cardiovascular-risk assessment or investigation for diabetes.

The patient's temperament and the patient's measurable cardiovascular disease are **different types of information**.

Quwwat-e-Bah and Male Sexual Function

Traditional Unani medicine uses *Quwwat-e-Bah* to describe sexual faculty or potency.

Sexual weakness may be considered in relation to general health, psychological state, nutrition and the functional condition of the body.

This broad perspective has practical value.

A hypertensive man may have ED because of vascular disease.

But another patient may also have stress, poor sleep, obesity, performance anxiety, low physical activity or medication side effects.

Unani medicine's whole-person emphasis can help ensure these factors are not overlooked.

The Four Major Unani Therapeutic Approaches

CCRUM formally identifies four principal therapeutic approaches within Unani medicine: **Ilaj-bil-Tadbir** or regimenal therapy, **Ilaj-bil-Ghiza** or dietotherapy, **Ilaj-bil-Dawa** or pharmacotherapy, and **Ilaj-bil-Yad** or surgery.

For hypertensive men with ED, I consider the greatest opportunity for responsible integration to lie in diet, lifestyle, psychological wellbeing, metabolic-health support and carefully reviewed pharmacotherapy.

The word **carefully** is particularly important because the patient is already taking cardiovascular medicines.

Ilaj-bil-Ghiza: Dietotherapy

Dietotherapy is one of the strongest areas for integration.

A diet designed to support cardiovascular health naturally benefits the vascular environment on which erection depends.

The supplied source discusses traditional foods such as pomegranate, nuts, garlic, onion, spices and other plant foods within the Unani cardioprotective framework.

Many of these foods can certainly form part of a healthy diet.

Pomegranate provides polyphenols.

Walnuts provide unsaturated fats.

Garlic and onion are useful foods.

But they should remain **foods**, not be advertised as substitutes for antihypertensive or established ED treatment.

Is Garlic a Natural Viagra?

No.

Garlic can be included in a cardiovascularly healthy diet and has biological effects worthy of study.

But eating garlic does not reliably produce an erection equivalent to a PDE5 inhibitor.

The same applies to pomegranate, walnuts, cinnamon, saffron and onions.

Nutrition supports vascular health over time.

That is different from treating established erectile dysfunction.

Khar-e-Khasak or Tribulus terrestris

The supplied document discusses **Khar-e-Khasak (*Tribulus terrestris*)** as a traditional Unani sexual-health medicine.

Recent evidence is interesting but should be interpreted cautiously.

A 2026 meta-analysis of randomized trials found improvements in erectile-function scores with Tribulus compared with placebo.

However, another 2025 systematic review concluded that the overall evidence remains **low quality** and found no robust evidence that Tribulus meaningfully increases testosterone.

Therefore, it would be premature to describe Tribulus as a proven replacement for PDE5 inhibitors or established cardiovascular management.

This is exactly the type of traditional medicine that may deserve further scientific research while being used cautiously in current practice.

Zafran or Saffron

Saffron has an important traditional place in Unani medicine and has been investigated for mood and sexual-function outcomes.

Earlier systematic reviews have suggested potentially favourable effects on sexual dysfunction, but the studies are relatively small and heterogeneous.

This means saffron is scientifically interesting, but we do not yet have evidence to recommend it as a proven treatment specifically for **hypertension-associated vasculogenic ED**.

Dose, product quality, cardiovascular medications and patient characteristics all matter.

Ginkgo: More Evidence Is Not Always Better Evidence

The supplied material presents Ginkgo biloba as useful for medication-related ED.

The evidence is considerably less convincing than that statement suggests.

A systematic review found only limited effects on sexual function and found no convincing benefit for antidepressant-associated sexual dysfunction.

Ginkgo can also influence platelet function and therefore deserves caution in patients taking anticoagulant or antiplatelet drugs.

This is why “natural circulation enhancer” is not an adequate safety assessment for a cardiovascular patient.

Laboob-e-Kabir and Traditional Compound Formulations

Traditional Unani medicine includes compound formulations such as **Laboob-e-Kabir** for general and sexual debility.

The supplied source describes its classical role and several of its ingredients.

Such formulations belong to the historical Unani pharmacopoeial tradition.

However, I would not describe any complex formulation as automatically **"hemodynamically safe"** for every hypertensive patient.

A hypertensive man may simultaneously be using an ACE inhibitor, ARB, calcium-channel blocker, beta-blocker, diuretic, antiplatelet drug, anticoagulant, nitrate or diabetes medication.

Potential herb-drug interactions therefore need to be considered individually.

Quality Control of Unani Medicines

This point is essential.

The Pharmacopoeia Commission for Indian Medicine & Homoeopathy states that the **Unani Pharmacopoeia of India and National Formulary of Unani Medicine constitute official quality standards** under India's Drugs and Cosmetics framework.

These standards address identity, purity and strength and include limits for **heavy/toxic metals, pesticide residues, aflatoxins and microbial contamination**.

CCRUM likewise maintains programmes for standardization of Unani drugs and testing for heavy metals, microbes, aflatoxins and pesticide residues.

For a cardiovascular patient, medicine quality is not optional.

Natural Does Not Mean Safe

The supplied material itself correctly raises concerns regarding herb-drug interactions and potent traditional ingredients.

This part deserves strong emphasis.

Some herbs may lower blood pressure.

Combining several such products with prescription antihypertensives and ED medicines may produce dizziness or symptomatic hypotension.

Other herbs may alter bleeding risk or drug metabolism.

Potent or toxic ingredients such as **Strychnos nux-vomica** should never be casually self-used, especially by cardiovascular patients.

A medicine should be judged according to pharmacology and quality—not according to whether the label says "herbal."

Hijama in Hypertension and Erectile Dysfunction

Hijama, or wet cupping, is an established traditional regimenal technique.

The supplied report describes it as a method intended within Unani theory to produce *Imala* and *Istifragh*.

There has been some clinical research on cupping for hypertension.

A systematic review found a small number of trials suggesting potential blood-pressure effects, but most studies had important methodological limitations and the authors concluded that **no firm clinical recommendation could be made**.

One small randomized study found a temporary reduction in systolic pressure that was no longer significantly different from control at eight weeks.

Therefore, Hijama should **not replace antihypertensive therapy**.

Hijama Is Not a Proven ED Treatment

There is currently no good clinical evidence showing that wet cupping reliably restores erections in hypertensive men or improves long-term penile arterial disease.

Claims that cupping creates penile angiogenesis, removes reproductive toxins or rebalances testosterone have not been established in high-quality human trials.

I would therefore describe Hijama, if selected, as a **traditional adjunctive regimenal therapy**, not as a proven treatment for vasculogenic ED.

It should never delay cardiovascular assessment or established ED treatment.

An Important Safety Correction About Cupping

Large-volume blood removal should **not** be used as a method of treating hypertension.

Claims that Hijama should remove hundreds of millilitres of “stagnant,” “deoxygenated” or “toxic” blood are not supported by modern physiology and could create anemia, fainting or hemodynamic instability.

Wet cupping also involves skin penetration and therefore requires appropriate sterility and infection-control procedures.

Patients with significant anemia, bleeding disorders or anticoagulant treatment require particular caution.

The purpose of integrative medicine should be to add safety—not introduce a new cardiovascular risk.

Dalak or Massage

Traditional **Dalak**, or massage, can provide relaxation and may help musculoskeletal wellbeing.

For a patient with performance anxiety, relaxation may indirectly help sexual confidence.

But massage does not reopen atherosclerotic penile arteries.

Likewise, topical oils should not be marketed as a method of permanently reversing hypertension-induced ED.

Unknown penile oils can also cause irritation, contact dermatitis or mucosal injury.

Any local treatment should therefore have known composition and an appropriate safety profile.

Psychological Treatment Still Matters in Hypertensive ED

Men with cardiovascular ED often develop performance anxiety.

The first erection failure may be vascular.

The second may be partly anxiety.

By the fifth episode, the man may be monitoring every sensation during sex.

Current ED guidelines support psychological or psychosexual interventions when clinically relevant, often alongside medical treatment.

This is especially important in couples attempting pregnancy, because ovulation-timed intercourse can produce substantial performance pressure.

At Saira Health Care, my work in sexual disorders and infertility allows me to consider both the vascular problem and the couple's sexual experience.

Hypertension, ED and Fertility

Erectile dysfunction is not the same as male infertility.

A hypertensive man may have poor erections but completely normal sperm.

Another man may have excellent erections and severely abnormal semen parameters.

However, ED can indirectly prevent pregnancy when vaginal intercourse or intravaginal ejaculation cannot occur reliably during the fertile period.

Treatment should therefore identify whether the patient's goal is sexual satisfaction, conception or both.

When infertility is also present, semen analysis may be required independently of the ED evaluation.

Testosterone Treatment in Men Trying to Conceive

This deserves another warning.

Some men with ED are given testosterone without a complete fertility history.

External testosterone may improve selected symptoms in genuinely hypogonadal men, but it can suppress the hormonal signals needed for testicular sperm production.

A man who wants a child therefore needs reproductive counselling before starting testosterone.

A stronger erection is not helpful if treatment simultaneously suppresses spermatogenesis.

A Responsible Integrated Treatment Strategy

For me, the most rational approach to hypertension-associated ED begins with **cardiovascular safety**.

Blood pressure should be assessed and controlled.

The medication list should be reviewed rather than stopped.

Cardiovascular risk should be considered, particularly in a man with gradual-onset vasculogenic ED.

Diabetes, cholesterol, smoking, weight and physical activity should be addressed.

Modern ED therapy such as a PDE5 inhibitor can then be considered when clinically appropriate and when contraindications such as nitrate treatment are absent.

Alongside this, Unani care can reasonably contribute through **Ilaj-bil-Ghiza, lifestyle modification, individualized Mizaj-based supportive care, psychological wellbeing and carefully selected standardized pharmacotherapy where appropriate**.

What it should not do is replace essential cardiovascular treatment.

Dr. Nizamuddin Qasmi's Specialized Approach to Hypertension-Related Erectile Dysfunction

When a hypertensive patient comes to me with erectile dysfunction, I do not begin by simply prescribing a “stronger sexual medicine.”

I first want to determine **why the erection is weak**.

Did the problem begin before or after hypertension?

Was a new medicine introduced?

Is blood pressure controlled?

Does the patient have diabetes?

Does he smoke?

Does he have high cholesterol?

Are morning erections present?

Is sexual desire normal?

Is the problem present during masturbation?

Is premature ejaculation or performance anxiety also present?

Does intercourse cause chest discomfort or unusual breathlessness?

Is the patient trying for pregnancy?

These questions allow the sexual problem to be treated as part of the man's overall health rather than as an isolated complaint.

Medication Review at Saira Health Care

I consider the existing prescription before adding anything.

A patient on nitrates cannot simply be given a PDE5 inhibitor.

A patient taking several antihypertensives may require attention to low blood pressure or dizziness.

A patient taking anticoagulants deserves extra caution with invasive regimenal procedures.

A patient using unknown sexual supplements may already be taking ingredients that interact with his prescription medicines.

A patient who believes his beta-blocker is causing ED should not discontinue it himself.

Instead, where appropriate, the cardiovascular physician can be involved in deciding whether an alternative treatment is possible.

This coordinated approach is much safer than asking patients to choose between blood-pressure control and sexual function.

What "Special Treatment" Means at Saira Health Care

For me, specialized treatment means **individualized treatment—not one medicine for every man**.

A hypertensive patient with predominantly vascular ED requires one strategy.

A patient whose blood pressure is controlled but whose problem is mainly performance anxiety requires another.

A man whose symptoms began after medication adjustment deserves medication review.

A diabetic hypertensive patient requires aggressive metabolic-health attention.

A man attempting conception requires a fertility-conscious plan.

A man with unstable cardiac symptoms may first need cardiology care before sexual treatment is attempted.

Unani medicine can then be used according to the patient's constitution, general health and actual clinical needs.

That is what I consider responsible integration.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, one of our important roles is helping men discuss problems they may otherwise hide.

Men sometimes stop blood-pressure medicine because they are embarrassed to tell their cardiologist about ED.

Some purchase erection products secretly.

Some believe erectile difficulty means permanent loss of masculinity.

Others assume everything is psychological despite having major vascular risk factors.

Our approach is to create a confidential setting where the patient can discuss **erections, ejaculation, fertility, medicines and cardiovascular health without judgment**.

We aim to provide sexual-health assessment, fertility-related counselling where necessary, interpretation of relevant investigations, lifestyle guidance and appropriately selected integrative Unani support.

Where cardiology, endocrinology, urology or other specialist assessment is required, timely referral or collaboration is part of good treatment.

Important Scientific Corrections to Common Claims About Hypertension and ED

A few points deserve especially clear clarification.

ED is not always a systemic vascular disease. Vasculogenic ED is common and important, but psychogenic, hormonal, neurological and medication-related ED also occur.

Not every antihypertensive medicine causes ED. Effects vary by medication and patient. ARBs generally have a favourable profile, calcium-channel blockers are largely neutral and nebivolol may be more favourable than older beta-blockers. Evidence regarding thiazides is mixed.

Patients should not stop antihypertensives because of sexual symptoms. The medication should be reviewed clinically.

PDE5 inhibitors can often be used with antihypertensives. The additional fall in blood pressure is usually small, but nitrates remain an absolute contraindication.

Controlled hypertension does not automatically prohibit sexual activity. Uncontrolled or unstable cardiovascular disease requires stabilization first.

Hijama has not been proven to cure hypertension or ED. Research is limited and it should remain complementary rather than replace standard cardiovascular treatment.

Herbs are not automatically cardiovascularly safe. Product quality, dosing and interactions matter.

These distinctions are important because they make an integrative approach **safer and more scientifically credible**.

Frequently Asked Questions

Can high blood pressure cause erectile dysfunction?

Yes. Chronic hypertension can damage vascular and endothelial function, reducing the ability of penile arteries and erectile smooth muscle to respond normally to sexual stimulation.

Can ED be an early warning sign of heart disease?

Sometimes. Predominantly vascular ED may precede clinically obvious cardiovascular disease by approximately two to five years in some men. Persistent ED therefore provides an opportunity to assess cardiovascular risk.

Does every hypertensive man develop ED?

No. Many men with hypertension maintain normal sexual function. Risk depends on age, duration and control of hypertension, vascular health, diabetes, smoking, medicines, psychological factors and other conditions.

Can my blood-pressure tablet cause ED?

Some antihypertensive classes are more commonly associated with sexual dysfunction than others, but the relationship is not simple. Older beta-blockers are more frequently implicated, while ARBs tend to have a favourable profile. Never stop medication without discussing it with the prescribing clinician.

Is nebivolol better for erectile function?

Nebivolol appears to have a more favourable sexual-function profile than several older beta-blockers, but medication selection must still be based on the patient's complete cardiovascular condition.

Can I use sildenafil or tadalafil if I have hypertension?

Many men with stable, controlled hypertension can use a PDE5 inhibitor under appropriate medical supervision. These medicines are generally compatible with many antihypertensives.

Who must not take PDE5 inhibitors?

Men taking nitrate medicines or nitric-oxide-donor drugs must not combine them with PDE5 inhibitors because severe hypotension can result. Certain unstable cardiovascular conditions also require medical stabilization before ED treatment.

Can I have sex if I have high blood pressure?

Sexual activity is usually acceptable in stable, adequately controlled hypertension. Uncontrolled hypertension or unstable cardiovascular disease requires medical assessment and stabilization first.

Can ED medicine lower blood pressure?

PDE5 inhibitors have vasodilatory effects and can modestly lower blood pressure. This is usually manageable with ordinary antihypertensive therapy, but the effect becomes dangerous when combined with nitrates.

Does hypertension lower testosterone?

Not necessarily. Obesity, diabetes, chronic disease, age and other factors associated with hypertension may also be associated with lower testosterone, but testosterone should be measured rather than assumed.

Should I take testosterone for ED?

Only if an appropriate clinical evaluation demonstrates testosterone deficiency and treatment is suitable. Men seeking fertility require particular caution because external testosterone can suppress sperm production.

Can ED from hypertension be improved?

Often it can be improved or effectively managed. The outcome depends on the degree of vascular disease, cardiovascular-risk-factor control, medication effects, diabetes, psychological factors and treatment chosen.

Can losing weight and exercising help ED?

They may. Lifestyle and cardiovascular-risk-factor modification are strongly recommended alongside ED treatment, particularly when obesity, inactivity or metabolic disease are present.

Can Unani medicine help?

It may provide **useful supportive care**, particularly through individualized nutrition, lifestyle management, general metabolic-health support, emotional wellbeing and selected professionally supervised Unani pharmacotherapy. It should not replace antihypertensive treatment, cardiovascular-risk assessment or evidence-based ED therapy.

Does Tribulus treat ED?

Recent studies are encouraging, but the evidence remains inconsistent in quality. It should not be considered a proven substitute for first-line ED therapy or cardiovascular care.

Can Hijama lower my blood pressure and cure ED?

Evidence for a sustained antihypertensive benefit is inadequate, and there is no high-quality evidence that Hijama cures hypertension-related ED. It should be regarded, if used at all, as complementary care.

Can massage cure vascular ED?

No good evidence shows that massage reverses established penile arterial disease. Relaxation or massage may support wellbeing but should not replace established treatment.

Is ED always permanent in hypertension?

No. Erectile dysfunction may improve when cardiovascular risk factors are controlled, medication effects are addressed and appropriate ED therapy is provided. Psychological components can also respond to counselling.

My Final Message to Men With Hypertension and Erectile Dysfunction

Whenever a man with high blood pressure tells me that his erection has become weak, my first message is:

Do not panic—and do not stop your blood-pressure treatment.

Your sexual health matters.

But so does your heart.

In fact, the two may be telling us something about the same vascular system.

Sometimes the problem is directly related to hypertension.

Sometimes diabetes, obesity, smoking or cholesterol are contributing.

Sometimes a medicine is involved.

Sometimes performance anxiety magnifies a mild vascular problem.

And sometimes the erection difficulty becomes the first reason we discover a cardiovascular risk that the patient did not know he had.

That is why I do not treat hypertension-related ED simply by giving a sexual stimulant.

I look at the **whole patient**.

My training in Unani medicine teaches me to consider *Mizaj*, *Quwwat-e-Bah*, diet, physical activity, mental wellbeing and the broader functional condition of the body. The traditional source material also emphasizes the relationship between cardiovascular and sexual health and the need for caution when combining Unani treatment with cardiovascular medicines.

Modern medicine gives us another powerful set of tools: standardized blood-pressure management, cardiovascular-risk assessment, metabolic investigation, PDE5 inhibitors, vacuum devices, injectable therapies and other evidence-based treatments.

I believe the strongest approach is not to make the patient choose between them.

It is to use each responsibly.

Control the blood pressure.
Protect the heart.
Investigate persistent ED rather than hiding it.
Review medicines rather than stopping them.
Treat diabetes, smoking, obesity and other vascular risks.
Use evidence-based ED treatment when appropriate.
Never combine PDE5 medicines with nitrates.
Use Unani supportive care only after considering interactions and cardiovascular safety.
And address psychological or fertility-related sexual pressure when it is part of the problem.

At **Saira Health Care**, our objective is not merely to create a temporary erection.

Our aim is to help the patient achieve **safer cardiovascular health, better sexual function, greater confidence and—when fertility is also a concern—a realistic reproductive plan**.

A man's sexual health should never be separated from his overall health.

And persistent erectile dysfunction in a hypertensive patient should never be ignored as merely an embarrassing bedroom problem.

Sometimes it is the body's opportunity to tell us that the vascular system deserves attention.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** has a focused emphasis on sexual disorders and infertility, including erectile and ejaculatory problems, male reproductive concerns, fertility-related sexual dysfunction, pre-conception counselling and individualized integration of Unani supportive care with appropriate modern assessment.

Website: www.sairahealthcare.com

Medical Disclaimer

This article is intended for **general medical education and public awareness**. It is not an individual diagnosis, prescription or guarantee of treatment outcome.

Persistent erectile dysfunction in a patient with hypertension may reflect vascular, endocrine, neurological, psychological, medication-related or mixed causes and deserves appropriate professional evaluation.

Patients should **not discontinue or alter antihypertensive treatment without medical advice**. PDE5 inhibitors such as sildenafil or tadalafil must not be combined with nitrate

medicines or other contraindicated nitric-oxide-related treatments because severe hypotension can occur.

Unani medicines, herbs, Hijama, sexual tonics and topical products should not be used to replace appropriate hypertension management or cardiovascular assessment. All herbal and traditional products should be reviewed for quality, dosing and possible interactions with antihypertensive, antiplatelet, anticoagulant and ED medicines.