BPH treatment: The sexual side effects clinicians must discuss

Written by The Life Science Feed Editorial Team · Edited by Mara Voss

Benign prostatic hyperplasia (BPH) treatments offer symptomatic relief for millions of men, but they often come with a hidden cost: sexual dysfunction. Clinicians face a persistent challenge in balancing effective symptom management with preserving quality of life, especially when therapies like 5±reductase inhibitors (5-ARIs) carry known risks for ejaculatory and erectile issues. Ignoring these potential adverse events during initial consultations risks patient dissatisfaction and non-adherence, undermining the very goal of treatment.

KEY TAKEAWAYS

- The Pivot: 5±reductase inhibitors, while effective for BPH and androgenetic alopecia, are consistently linked to sexual adverse events.
- The Data: A systematic review confirmed 5-ARIs are associated with decreased libido, erectile dysfunction, and ejaculatory disorders in a subset of patients.
- The Action: Clinicians must proactively counsel all patients on the specific sexual side effects of 5-ARIs before initiating therapy, ensuring comprehensive informed consent.

Benign prostatic hyperplasia (BPH) affects a substantial proportion of aging men, manifesting as bothersome lower urinary tract symptoms (LUTS) that significantly impair daily life. Treatment strategies range from watchful waiting and lifestyle modifications to pharmacotherapy and surgical interventions. Among the most commonly prescribed medications are 5±reductase inhibitors (5-ARIs), a class of drugs that reduce prostate volume by inhibiting the conversion of testosterone to dihydrotestosterone (DHT). These agents, including finasteride and dutasteride, are highly effective in improving LUTS and reducing the risk of acute urinary retention and the need for BPH-related surgery. But their mechanism of action, which involves altering androgen metabolism, also introduces a predictable array of sexual side effects that demand careful consideration and thorough patient counselling.1

A systematic review published in Frontiers in Medicine in 2026, conducted by Z[illegible]towska, Jastrzb-Mi[illegible]kiewicz, and Krajewski, explored the development of sexual dysfunction in patients receiving 5-ARIs.1 While the review specifically focused on patients with androgenetic alopecia (AGA) treated with 5-ARIs, its findings hold direct relevance for BPH management, given the identical drug class and mechanism of action. The authors aimed to synthesize existing preclinical and clinical evidence regarding sexual adverse events associated with 5-ARI use, emphasizing their importance in the clinical diagnosis of health disorders coexisting with hair loss. This analysis provides a clear lens through which to view patient counselling for BPH, highlighting the need for explicit discussions about sexual health.

The Mechanism of Sexual Dysfunction

The core mechanism behind 5-ARI-induced sexual dysfunction lies in their inhibition of 5±reductase enzymes. These enzymes convert testosterone to DHT, a potent androgen essential for prostate growth and hair follicle miniaturization in AGA. But DHT also plays a role in sexual function, influencing libido, erectile quality, and ejaculatory processes. By reducing DHT levels, 5-ARIs effectively shrink the prostate and slow hair loss, but they also disrupt these androgen-dependent pathways in sexual tissues. This disruption can lead to a constellation of symptoms, which the review meticulously catalogued.1

Preclinical studies, often conducted in animal models, have consistently demonstrated the impact of 5-ARIs on sexual behavior and physiology. These studies show alterations in penile tissue, neurotransmitter levels in the brain regions associated with sexual drive, and changes in the expression of androgen receptors. Such findings provide a biological basis for the observed clinical side effects, moving beyond mere anecdotal reports to establish a clear pharmacological link. The reduction in DHT can affect nitric oxide synthase activity, which is essential for erectile function, and alter smooth muscle relaxation in the penis, directly impairing the physiological processes of erection.1

The impact on ejaculatory function is particularly noteworthy. Patients often report reduced ejaculate volume, altered sensation during ejaculation, or even anejaculation. This is thought to be related to the androgenic control over the seminal vesicles and prostate, which contribute to seminal fluid production. Changes in the autonomic nervous system, also influenced by androgen levels, may further contribute to these ejaculatory disturbances. These effects are distinct from erectile dysfunction but frequently co-occur, presenting a complex picture of sexual impairment for patients.1

Clinical Manifestations and Patient Experience

The systematic review identified three primary categories of sexual adverse events associated with 5-ARI use: decreased libido, erectile dysfunction, and ejaculatory disorders.1 Decreased libido, or reduced sexual desire, is a common complaint. Patients describe a general lack of interest in sexual activity, which can significantly impact relationships and overall quality of life. This is often one of the first symptoms to emerge and can be particularly distressing, as it affects the psychological component of sexual health.

Erectile dysfunction (ED) manifests as difficulty achieving or maintaining an erection firm enough for satisfactory sexual intercourse. While ED is multifactorial and its prevalence increases with age, the introduction of 5-ARIs can either precipitate new-onset ED or exacerbate pre-existing issues. The review highlighted that a subset of patients on 5-ARIs for AGA reported ED, emphasizing the drug class's direct contribution. This is a significant point for BPH patients, many of whom are already at an age where ED is more common, making it difficult to disentangle drug-induced effects from age-related changes without careful history taking. Clinicians should also be aware of the broader context of sexual health, as discussed in our previous coverage on PTSD and sexual misconduct, which highlights the importance of comprehensive patient assessment.

Ejaculatory disorders encompass a range of issues, including reduced ejaculate volume, retrograde ejaculation, and anejaculation. These can be particularly bothersome for patients, affecting fertility concerns for younger individuals and overall sexual satisfaction for all. The review's focus on AGA patients, who are often younger than typical BPH patients, makes these findings even more salient, as younger men may be more acutely aware of and distressed by changes in ejaculatory function. The impact on fertility, while not the primary focus of the review, is an important consideration for any patient of reproductive age considering 5-ARI therapy.1

The term 'Post-Finasteride Syndrome' (PFS) has emerged in patient communities to describe persistent sexual,

neurological, and physical side effects that continue after discontinuing 5-ARI therapy. While the systematic review did not explicitly use this term, it acknowledged the persistence of sexual adverse events in a subset of patients. This phenomenon, though not fully understood or universally accepted in its definition by the medical community, shows the potential for long-lasting and debilitating effects that extend beyond the duration of drug exposure. This possibility makes pre-treatment counselling even more imperative, as patients need to understand the full spectrum of potential risks, including those that may not resolve quickly upon cessation of the drug.1

Counselling Strategies for BPH Patients

Given the clear evidence of sexual side effects, comprehensive counselling before initiating 5-ARI therapy for BPH is not merely good practice; it is a clinical imperative. Clinicians must move beyond a cursory mention of 'sexual side effects' and engage in a detailed discussion of specific symptoms. This includes explicitly addressing decreased libido, erectile dysfunction, and ejaculatory disorders, explaining their potential onset, severity, and reversibility. Patients need to understand that these are not minor inconveniences but potentially significant impacts on their quality of life.1

The discussion should be tailored to the individual patient, considering their age, baseline sexual function, relationship status, and personal priorities regarding sexual health. For a younger patient with BPH, fertility concerns and ejaculatory changes might be paramount. For an older patient, maintaining erectile function might be the primary concern. A thorough sexual history, including validated questionnaires if appropriate, can help establish a baseline and guide the counselling process. This proactive approach allows patients to make truly informed decisions about their treatment options, weighing the benefits of BPH symptom relief against the potential sexual risks. It also helps manage expectations, reducing the likelihood of distress and non-adherence if side effects do occur.

But the conversation should not stop at simply listing side effects. Clinicians should also discuss potential management strategies for these adverse events. For instance, if ED develops, options like PDE5 inhibitors could be considered. For ejaculatory issues, while fewer direct pharmacological interventions exist, open communication and psychological support can be valuable. The possibility of dose reduction or switching to an alternative BPH therapy, such as alpha-blockers, should also be part of the ongoing dialogue if sexual side effects become intolerable. This holistic approach ensures that patients feel supported and have avenues for recourse if their sexual health is compromised. The long road to recovery after prostatectomy also highlights the importance of managing patient expectations for sexual and urinary function.

The Broader Context of BPH Treatment

The findings from the systematic review, while focused on AGA, serve as a stark reminder for BPH management. The same drugs, finasteride and dutasteride, are used in both conditions, and their pharmacological effects on androgen metabolism are identical. Therefore, the sexual adverse events observed in AGA patients are directly translatable to the BPH population. This means that every clinician prescribing a 5-ARI for BPH must internalize these risks and integrate them into their patient communication.1

The review also implicitly highlights the need for a comprehensive approach to BPH treatment selection. While 5-ARIs are highly effective, they are not the only option. Alpha-blockers, for example, primarily relax smooth muscle in the prostate and bladder neck, improving urine flow without directly impacting androgen levels. While alpha-blockers can have their own set of sexual side effects, such as retrograde ejaculation, they typically do not cause the same spectrum

of libido and erectile issues as 5-ARIs. For patients who prioritize sexual function, an alpha-blocker might be a more appropriate first-line therapy, or a combination therapy might need careful consideration of the individual drug profiles. This decision-making process is complex and requires a deep understanding of both the efficacy and side effect profiles of all available agents, a skill that can be honed with resources like the Oxford Handbook of General Practice.

Still, the review's limitation to AGA patients means that specific prevalence rates of sexual dysfunction in BPH populations on 5-ARIs are not directly provided here. But the underlying biological mechanisms and the drug class are identical, making the extrapolation clinically sound. Future systematic reviews explicitly focusing on BPH patients would provide more precise epidemiological data for this specific population. But the absence of such a review does not negate the need for proactive counselling based on the established pharmacology and the evidence from analogous patient groups. The consistency of findings across different patient populations using the same drug class reinforces the robustness of the observed association between 5-ARIs and sexual dysfunction.1

The importance of this counselling extends beyond mere patient satisfaction. Unanticipated sexual side effects can lead to poor adherence, as patients may discontinue medication without consulting their physician, potentially leading to a resurgence of BPH symptoms or even acute urinary retention. This creates a cycle of ineffective treatment and patient frustration. By setting realistic expectations upfront, clinicians empower patients to report side effects early, allowing for timely intervention, dose adjustment, or a change in therapy, thereby optimizing long-term outcomes for BPH management. This proactive approach to managing adverse effects is a cornerstone of good clinical practice, as seen in discussions around T-DXd side effects in breast cancer.

Where it Falls Short

The systematic review, while valuable, focused exclusively on patients with androgenetic alopecia. This means the precise incidence and prevalence rates of these sexual side effects in the BPH population are not directly quantifiable from this paper. While the pharmacological mechanism is identical, patient demographics, comorbidities, and baseline sexual function often differ between men seeking treatment for hair loss and those with BPH. AGA patients are typically younger, potentially with fewer pre-existing sexual dysfunctions, which might make drug-induced effects more noticeable or impactful for them. BPH patients, being older, may have a higher baseline prevalence of ED or other sexual issues, making it harder to attribute causality solely to the 5-ARI.1

Another limitation is the inherent challenge in systematically reviewing subjective symptoms like decreased libido or ejaculatory changes, especially when studies may use varying assessment tools or reporting methods. This variability can make direct comparisons and meta-analysis of specific incidence rates difficult. The review also did not examine the long-term persistence of these side effects after drug cessation, a significant concern for patients and a topic of ongoing debate in the medical community regarding 'Post-Finasteride Syndrome'. Future research needs to specifically address the long-term trajectory and reversibility of these side effects in BPH patients.1

The review also did not explore the psychological impact of these side effects in depth, beyond their clinical manifestation. Sexual dysfunction can lead to significant psychological distress, anxiety, depression, and relationship problems. A more comprehensive understanding of these psychosocial dimensions would further emphasize the importance of thorough counselling and support mechanisms. The trial was not powered to detect differences in specific patient subgroups, such as those with pre-existing depression or anxiety, and that gap matters for a holistic understanding of patient experience.1

CLINICAL IMPLICATIONS

Clinicians prescribing 5-ARIs for BPH must elevate the discussion around sexual side effects from a footnote to a central component of informed consent. It is no longer acceptable to simply list 'sexual dysfunction' as a generic adverse event. Patients need to understand the specific risks of decreased libido, erectile dysfunction, and ejaculatory disorders, and how these might impact their individual lives.

This means moving beyond a checklist approach and engaging in a genuine dialogue. The potential for these side effects to persist even after drug discontinuation, as suggested by patient reports and acknowledged in the broader literature, adds another layer of complexity that demands transparency. Failing to provide this detailed information not only risks patient dissatisfaction but also undermines trust and adherence, compromising treatment outcomes for BPH.

The pharmaceutical industry also bears a responsibility here. While prescribing information lists these side effects, the emphasis in promotional materials often focuses solely on efficacy for BPH symptom relief.

A more balanced presentation that foregrounds the potential for sexual adverse events, perhaps even with patient-friendly risk communication tools, would empower both clinicians and patients to make better decisions. This is not about discouraging effective treatment but about ensuring truly informed choice.

The onus falls on the individual practitioner to integrate this evidence into their daily practice. A brief, candid conversation about sexual health before starting a 5-ARI can prevent significant distress down the line, fostering better patient-provider relationships and ensuring that the benefits of BPH treatment are not overshadowed by avoidable sexual complications.

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