

PREVALENCE AND SEVERITY OF ERECTILE DYSFUNCTION AMONG MEN WITH TYPE 2 DIABETES MELLITUS

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ABSTRACT

Background: Erectile dysfunction (ED) is one of the most common yet underrecognized chronic complications of type 2 diabetes mellitus (T2DM). Persistent hyperglycemia contributes to endothelial dysfunction, autonomic neuropathy, oxidative stress, and vascular insufficiency, all of which adversely affect erectile function. In addition to impairing quality of life, ED is increasingly recognized as an early marker of cardiovascular disease. Despite its clinical significance, routine screening for ED is often overlooked in diabetic care, particularly in developing countries. The objective is to determine the prevalence and severity of erectile dysfunction among men with type 2 diabetes mellitus and to evaluate its association with selected demographic and clinical risk factors. **Materials and Methods:** A hospital-based cross-sectional observational study was conducted in the Department of General Medicine, Navodaya Medical College Hospital and Research Centre, Raichur, Karnataka, India, from January to December 2025. A total of 240 adult men with confirmed type 2 diabetes mellitus were enrolled using consecutive sampling. Demographic characteristics, duration of diabetes, body mass index (BMI), smoking status, hypertension, diabetic complications, and laboratory parameters including glycated hemoglobin (HbA1c) were recorded using a structured proforma. Erectile dysfunction was assessed using the validated International Index of Erectile Function-5 (IIEF-5) questionnaire and categorized as mild, mild-to-moderate, moderate, or severe based on standard scoring criteria. Data were analyzed using descriptive statistics, Chi-square test, and multivariate logistic regression. A p-value <0.05 was considered statistically significant. **Result:** The mean age of the study participants was 52.8 ± 9.4 years, and the majority (34.2%) belonged to the 50–59-year age group. Erectile dysfunction was identified in 178 (74.2%) participants. Based on IIEF-5 scores, 56 (23.3%) had mild ED, 54 (22.5%) had mild-to-moderate ED, 38 (15.8%) had moderate ED, and 30 (12.5%) had severe ED. The prevalence of ED increased significantly with advancing age, longer duration of diabetes, and poor glycaemic control (p<0.001). Hypertension, obesity, smoking, dyslipidaemia, peripheral neuropathy, nephropathy, and retinopathy were also significantly associated with ED (p<0.05). On multivariate logistic regression, age ≥50 years (AOR=2.68), diabetes duration >10 years (AOR=2.91), HbA1c ≥9% (AOR=3.47), hypertension (AOR=2.13), and peripheral neuropathy (AOR=3.82) emerged as independent predictors of erectile dysfunction. **Conclusion:** Erectile dysfunction is highly prevalent among men with type 2 diabetes mellitus and is strongly associated with advancing age, prolonged duration of diabetes, poor glycaemic control, hypertension, and diabetic microvascular complications. Routine screening using the IIEF-5 questionnaire should be incorporated into comprehensive diabetes care to facilitate early diagnosis, timely intervention, and improved quality of life.

INTRODUCTION

Diabetes mellitus (DM) is one of the most prevalent chronic non-communicable diseases worldwide and represents a major public health challenge. According to the International Diabetes Federation (IDF), approximately 537 million adults aged 20–79 years were living with diabetes in 2021, and this number is projected to rise to 643 million by 2030 and 783 million by 2045. India has one of the largest populations of individuals with diabetes globally, earning the distinction of being the "diabetes capital of the world" due to its rapidly increasing disease burden.^[1]

Type 2 diabetes mellitus (T2DM) accounts for nearly 90–95% of all diabetes cases and is associated with several chronic microvascular and macrovascular complications. In addition to well-recognized complications such as retinopathy, nephropathy, neuropathy, and cardiovascular disease, sexual dysfunction has emerged as an important yet frequently overlooked consequence of diabetes.^[2]

Erectile dysfunction (ED) is defined as the persistent inability to attain and/or maintain a penile erection sufficient for satisfactory sexual performance. The condition has significant physical, psychological, and social implications, adversely affecting self-esteem, interpersonal relationships, and overall quality of life.^[3] Men with diabetes are approximately two to three times more likely to develop erectile dysfunction than non-diabetic individuals, and diabetic men typically experience ED 10–15 years earlier than the general population.^[4]

The pathophysiology of erectile dysfunction in diabetes is multifactorial and involves vascular, neurological, hormonal, and psychological mechanisms. Chronic hyperglycemia results in endothelial dysfunction through decreased nitric oxide bioavailability, increased oxidative stress, advanced glycation end-product formation, autonomic neuropathy, and structural alterations in cavernosal smooth muscle, all of which impair normal erectile function.^[5,6] Additionally, comorbid conditions such as hypertension, obesity, dyslipidaemia, metabolic syndrome, chronic kidney disease, and cardiovascular disease further contribute to the development and progression of erectile dysfunction.^[7]

Erectile dysfunction is now recognized not only as a complication of diabetes but also as an early clinical marker of systemic endothelial dysfunction and future cardiovascular events. Several longitudinal studies have demonstrated that men presenting with ED have a significantly increased risk of coronary artery disease, myocardial infarction, stroke, and cardiovascular mortality. Therefore, assessment of erectile function provides an opportunity for early cardiovascular risk stratification and preventive intervention.^[8,9]

The reported prevalence of erectile dysfunction among men with type 2 diabetes varies widely across different populations, ranging from approximately

35% to over 90%, depending on study design, age distribution, duration of diabetes, glycaemic control, associated comorbidities, and diagnostic criteria used.^[10] Indian studies have consistently demonstrated a high prevalence of erectile dysfunction among diabetic men, highlighting the need for routine screening in clinical practice.^[11]

The International Index of Erectile Function-5 (IIEF-5) questionnaire is a validated, reliable, and widely accepted instrument for evaluating erectile function. It provides an objective assessment and classifies erectile dysfunction into mild, mild-to-moderate, moderate, and severe categories, thereby facilitating both clinical management and research comparisons.^[12]

Despite the high prevalence and considerable impact of erectile dysfunction, it remains substantially underreported because many patients hesitate to discuss sexual problems due to embarrassment, social stigma, and cultural beliefs. Likewise, healthcare providers often fail to inquire routinely about sexual health during diabetes follow-up visits. Consequently, many affected individuals remain undiagnosed and untreated, resulting in diminished quality of life and missed opportunities for early identification of cardiovascular disease.^[13]

Considering the growing burden of type 2 diabetes mellitus in India and the limited data available from North Karnataka, the present study was undertaken to determine the prevalence and severity of erectile dysfunction among men with type 2 diabetes mellitus attending the Department of General Medicine, Navodaya Medical College Hospital and Research Centre, Raichur. The findings of this study are expected to provide valuable evidence for incorporating routine sexual health assessment into comprehensive diabetes care.

Objectives

Primary Objective: To determine the prevalence of erectile dysfunction among men with type 2 diabetes mellitus.

Secondary Objectives

- To assess the severity of erectile dysfunction using the International Index of Erectile Function-5 (IIEF-5).
- To study the association between erectile dysfunction and selected demographic and clinical characteristics.

MATERIALS AND METHODS

Study Design: Hospital-based cross-sectional observational study.

Study Setting: Department of General Medicine, Navodaya Medical College Hospital and Research Centre, Raichur, Karnataka, India.

Study Duration: January 2025 to December 2025.

Study Population: Adult male patients diagnosed with type 2 diabetes mellitus attending the outpatient and inpatient departments.

Sample Size: A total of 240 patients with type 2 diabetes mellitus were included.

Sampling Technique: Consecutive sampling.

Inclusion Criteria

- Male patients aged ≥ 18 years.
- Diagnosed with type 2 diabetes mellitus.
- Sexually active during the previous six months.
- Willing to provide written informed consent.

Exclusion Criteria

- Type 1 diabetes mellitus.
- Known psychiatric illness.
- History of pelvic trauma or pelvic surgery.
- Patients receiving medications known to cause erectile dysfunction (unless stable and clinically indicated).
- Severe chronic kidney disease requiring dialysis.
- Malignancy.
- Patients unwilling to participate.

Study Tool

A structured proforma consisting of:

- Demographic details
- Medical history
- Lifestyle factors
- Clinical examination
- Laboratory investigations
- International Index of Erectile Function-5 (IIEF-5)

Data Collection: After obtaining approval from the Institutional Ethics Committee, the study was conducted in the Department of General Medicine, Navodaya Medical College Hospital and Research Centre, Raichur, Karnataka, from January 2025 to December 2025. Eligible male patients with a confirmed diagnosis of type 2 diabetes mellitus attending the outpatient and inpatient departments were screened for inclusion in the study. The purpose and objectives of the study were explained in detail, and written informed consent was obtained from all participants before enrolment.

A total of 240 consecutive patients fulfilling the inclusion criteria were recruited. Information was collected using a predesigned, pretested, and structured case record proforma. Demographic details including age, marital status, educational status, occupation, socioeconomic status, and place of residence were recorded. A detailed medical history was obtained regarding the duration of diabetes mellitus, treatment modality (oral hypoglycaemic agents, insulin, or combination therapy), history of hypertension, dyslipidaemia, cardiovascular disease, smoking, alcohol consumption, physical activity, and the presence of

diabetic complications such as neuropathy, nephropathy, and retinopathy.

All participants underwent a thorough general and systemic clinical examination. Anthropometric measurements including height and weight were recorded using standardized techniques, and body mass index (BMI) was calculated as weight in kilograms divided by the square of height in meters (kg/m^2). Blood pressure was measured using a calibrated sphygmomanometer after the participant had rested for at least five minutes, following standard recommendations.

Relevant laboratory investigations available in the patient's medical records or performed during the study period were documented. These included fasting blood sugar (FBS), postprandial blood sugar (PPBS), glycated hemoglobin (HbA1c), serum creatinine, lipid profile, and other routine investigations wherever indicated. Glycaemic control was assessed primarily using HbA1c values.

Erectile dysfunction was assessed using the validated International Index of Erectile Function-5 (IIEF-5) questionnaire. The questionnaire was administered in a private and confidential setting to ensure participant comfort and encourage honest responses. Participants were requested to answer all five questions based on their sexual experiences during the preceding six months. The total IIEF-5 score ranged from 5 to 25, with higher scores indicating better erectile function. Based on the total score, participants were classified as having no erectile dysfunction (22–25), mild erectile dysfunction (17–21), mild-to-moderate erectile dysfunction (12–16), moderate erectile dysfunction (8–11), or severe erectile dysfunction (5–7).

To maintain confidentiality, each participant was assigned a unique identification number, and all collected information was anonymized before analysis. The completed proformas were checked daily for completeness and accuracy, and the data were entered into a Microsoft Excel spreadsheet before being exported to the Statistical Package for the Social Sciences (SPSS) version 26.0 for statistical analysis.

IIEF-5 Scoring

Score	Interpretation
22–25	No ED
17–21	Mild ED
12–16	Mild to Moderate ED
8–11	Moderate ED
5–7	Severe ED

RESULTS

Table 1: Baseline Characteristics of the Study Participants (n = 240)

Variable	Frequency (n)	Percentage (%)
Age (years)		
<40	36	15
40–49	74	30.8
50–59	82	34.2
≥ 60	48	20

Duration of Diabetes (years)		
<5	68	28.3
5–10	94	39.2
>10	78	32.5
BMI (kg/m ²)		
Normal	64	26.7
Overweight	98	40.8
Obese	78	32.5
HbA1c		
<7%	54	22.5
7–8.9%	96	40
≥9%	90	37.5
Hypertension	118	49.2
Current Smokers	66	27.5

A total of 240 men with type 2 diabetes mellitus were included in the study. The majority of participants belonged to the 50–59 years age group (82, 34.2%), followed by 40–49 years (74, 30.8%), while 48 (20.0%) participants were aged 60 years or above. Regarding the duration of diabetes, 94 (39.2%) participants had diabetes for 5–10 years, 78 (32.5%) had diabetes for more than 10 years, and 68 (28.3%) had diabetes for less than 5 years.

With respect to body mass index, 98 (40.8%) participants were overweight and 78 (32.5%) were obese, whereas only 64 (26.7%) had a normal BMI. Glycemic assessment showed that 90 (37.5%) participants had poor glycemic control (HbA1c ≥9%), while 96 (40.0%) had HbA1c between 7.0% and 8.9%, and only 54 (22.5%) had good glycemic control (HbA1c <7%). Hypertension was present in 118 (49.2%) participants, and 66 (27.5%) were current smokers.

Table 2: Prevalence and Severity of Erectile Dysfunction According to IIEF-5 (n = 240)

IIEF-5 Category	Frequency (n)	Percentage (%)
No Erectile Dysfunction	62	25.8
Mild	56	23.3
Mild-to-Moderate	54	22.5
Moderate	38	15.8
Severe	30	12.5
Total with Erectile Dysfunction	178	74.2

Among the 240 study participants, 178 (74.2%) were found to have erectile dysfunction based on the IIEF-5 questionnaire, whereas 62 (25.8%) had normal erectile function.

Among patients with erectile dysfunction, mild erectile dysfunction was the most common category,

affecting 56 (23.3%) participants, followed by mild-to-moderate erectile dysfunction in 54 (22.5%) participants. Moderate erectile dysfunction was observed in 38 (15.8%) participants, while 30 (12.5%) had severe erectile dysfunction.

Table 3: Association Between Age and Erectile Dysfunction

Age Group (Years)	ED Present n (%)	ED Absent n (%)	Total	p-value
<40	16 (44.4)	20 (55.6)	36	
40–49	48 (64.9)	26 (35.1)	74	
50–59	70 (85.4)	12 (14.6)	82	
≥60	44 (91.7)	4 (8.3)	48	<0.001

A statistically significant association was observed between age and erectile dysfunction ($p < 0.001$). The prevalence of erectile dysfunction increased progressively with advancing age. Among participants aged less than 40 years, 16 (44.4%) had erectile dysfunction. This proportion increased to 48 (64.9%) in the 40–49 years age group and 70 (85.4%)

among participants aged 50–59 years. The highest prevalence was observed in participants aged 60 years and above, where 44 (91.7%) had erectile dysfunction. These findings indicate that advancing age is an important determinant of erectile dysfunction among men with type 2 diabetes mellitus.

Table 4: Association of Duration of Diabetes and Glycaemic Control with Erectile Dysfunction

Variable	ED Present n (%)	ED Absent n (%)	p-value
Duration of Diabetes			
<5 years	38 (55.9)	30 (44.1)	
5–10 years	72 (76.6)	22 (23.4)	
>10 years	68 (87.2)	10 (12.8)	<0.001
HbA1c			
<7%	26 (48.1)	28 (51.9)	
7–8.9%	72 (75.0)	24 (25.0)	
≥9%	80 (88.9)	10 (11.1)	<0.001

A significant association was observed between both duration of diabetes and glycaemic control with erectile dysfunction ($p<0.001$). The prevalence of erectile dysfunction increased with increasing duration of diabetes. Among participants with diabetes duration of less than 5 years, 38 (55.9%) had erectile dysfunction. This increased to 72 (76.6%) among those with 5–10 years of diabetes and further

to 68 (87.2%) among participants with diabetes duration of more than 10 years. Similarly, erectile dysfunction was more common among participants with poor glycaemic control. Nearly 88.9% of participants with $\text{HbA1c} \geq 9\%$ had erectile dysfunction compared to 75.0% among those with HbA1c 7–8.9% and only 48.1% among participants with $\text{HbA1c} < 7\%$.

Table 5: Association of Clinical Risk Factors with Erectile Dysfunction

Variable	ED Present n (%)	ED Absent n (%)	p-value
Hypertension (n=118)	102 (86.4)	16 (13.6)	<0.001
Obesity (n=78)	68 (87.2)	10 (12.8)	0.002
Smoking (n=66)	58 (87.9)	8 (12.1)	0.003
Dyslipidaemia (n=104)	86 (82.7)	18 (17.3)	0.011

Clinical risk factors including hypertension, obesity, smoking, and dyslipidaemia showed significant associations with erectile dysfunction. Among participants with hypertension, 102 (86.4%) had erectile dysfunction compared to 16 (13.6%) without erectile dysfunction ($p<0.001$). Similarly, erectile dysfunction was present in 68 (87.2%) obese

participants ($p=0.002$) and 58 (87.9%) current smokers ($p=0.003$). Participants with dyslipidaemia also had a significantly higher prevalence of erectile dysfunction (86, 82.7%; $p=0.011$). These findings suggest that traditional cardiovascular risk factors substantially increase the likelihood of erectile dysfunction in patients with type 2 diabetes mellitus.

Table 6: Association of Diabetic Complications with Erectile Dysfunction

Diabetic Complication	ED Present n (%)	ED Absent n (%)	p-value
Peripheral Neuropathy (n=76)	70 (92.1)	6 (7.9)	<0.001
Diabetic Retinopathy (n=48)	42 (87.5)	6 (12.5)	0.008
Diabetic Nephropathy (n=36)	34 (94.4)	2 (5.6)	0.002

Diabetic microvascular complications were significantly associated with erectile dysfunction. Among participants with peripheral neuropathy, 70 (92.1%) had erectile dysfunction, representing the strongest association among diabetic complications ($p<0.001$). Erectile dysfunction was also highly prevalent among participants with diabetic

nephropathy, affecting 34 (94.4%) individuals ($p=0.002$), while 42 (87.5%) participants with diabetic retinopathy also had erectile dysfunction ($p=0.008$). These findings indicate that erectile dysfunction frequently coexists with diabetic microvascular complications.

Table 7: Multivariate Logistic Regression Analysis for Predictors of Erectile Dysfunction

Variable	Adjusted Odds Ratio (AOR)	95% CI	p-value
Age ≥ 50 years	2.68	1.41–5.10	0.002
Duration of Diabetes > 10 years	2.91	1.48–5.72	0.001
$\text{HbA1c} \geq 9\%$	3.47	1.74–6.90	<0.001
Hypertension	2.13	1.10–4.11	0.024
Peripheral Neuropathy	3.82	1.68–8.70	0.001

Multivariate logistic regression analysis identified several independent predictors of erectile dysfunction after adjusting for potential confounding factors. Participants aged 50 years or older had approximately 2.7 times higher odds of developing erectile dysfunction than younger participants (AOR=2.68; 95% CI: 1.41–5.10; $p=0.002$). Participants with diabetes duration of more than 10 years had nearly threefold higher odds of erectile dysfunction (AOR=2.91; 95% CI: 1.48–5.72; $p=0.001$). Poor glycaemic control ($\text{HbA1c} \geq 9\%$) emerged as one of the strongest independent predictors, increasing the odds of erectile dysfunction by approximately 3.5 times (AOR=3.47; 95% CI: 1.74–6.90; $p<0.001$). Likewise, hypertension independently increased the risk of erectile

dysfunction by approximately twofold (AOR=2.13; 95% CI: 1.10–4.11; $p=0.024$). Peripheral neuropathy was identified as the strongest independent predictor, with affected participants having nearly four times higher odds of erectile dysfunction (AOR=3.82; 95% CI: 1.68–8.70; $p=0.001$).

Overall, the analysis demonstrated that advancing age, longer duration of diabetes, poor glycaemic control, hypertension, and peripheral neuropathy were independent determinants of erectile dysfunction among men with type 2 diabetes mellitus.

DISCUSSION

The present hospital-based cross-sectional study evaluated the prevalence and severity of erectile dysfunction (ED) among men with type 2 diabetes mellitus (T2DM). The findings demonstrated that erectile dysfunction is a common complication of diabetes and is significantly associated with advancing age, longer duration of diabetes, poor glycaemic control, cardiovascular risk factors, and diabetic microvascular complications.

Baseline Characteristics: In the present study, the majority of participants belonged to the 50–59 years age group, and nearly three-fourths of the study population were either overweight or obese. Almost half of the participants had hypertension, and more than one-third had poor glycaemic control (HbA1c $\geq 9\%$). Similar demographic characteristics have been reported in diabetic cohorts by Maiorino et al.^[4] and Defeudis et al.^[5] who observed that advancing age, obesity, hypertension, and poor metabolic control are common among patients with type 2 diabetes and substantially contribute to sexual dysfunction. These findings reflect the increasing burden of metabolic syndrome among diabetic patients.

Prevalence and Severity of Erectile Dysfunction: The present study observed an overall erectile dysfunction prevalence of 74.2%, indicating that nearly three out of four men with T2DM were affected. Mild erectile dysfunction was the most frequent category, followed by mild-to-moderate erectile dysfunction. These findings are consistent with the systematic review and meta-analysis conducted by Kouidrat et al.^[10] which reported a pooled prevalence of erectile dysfunction exceeding 50% among diabetic men, with prevalence varying according to age, duration of diabetes, and study population. Likewise, Kalra et al.^[11] reported a high burden of erectile dysfunction among Indian men with diabetes and emphasized the importance of routine screening using validated questionnaires such as the IIEF-5.

Association of Age with Erectile Dysfunction: The prevalence of erectile dysfunction increased significantly with advancing age, reaching more than 90% among participants aged 60 years and above. Similar observations have been reported by Yafi et al.^[7] who described ageing as an independent determinant of erectile dysfunction due to progressive endothelial dysfunction, declining testosterone levels, vascular stiffness, and increased prevalence of comorbid conditions. Burnett et al.^[3] also emphasized that advancing age is one of the strongest non-modifiable risk factors for erectile dysfunction and should prompt routine assessment in older diabetic men.

Duration of Diabetes and Glycaemic Control: The present study demonstrated a significant increase in erectile dysfunction with longer duration of diabetes and worsening glycaemic control. Participants with diabetes duration greater than 10 years and HbA1c

$\geq 9\%$ showed the highest prevalence of erectile dysfunction. Similar findings have been reported by Defeudis et al.^[5] and Maiorino et al.^[4] who explained that prolonged exposure to chronic hyperglycemia accelerates endothelial dysfunction, autonomic neuropathy, oxidative stress, and vascular damage, thereby impairing erectile function. These observations support the importance of maintaining optimal glycaemic control to reduce diabetic complications, including erectile dysfunction.

Clinical Risk Factors: Hypertension, obesity, smoking, and dyslipidaemia were significantly associated with erectile dysfunction in the present study. These findings are in agreement with Yafi et al.^[7] who highlighted the synergistic role of cardiovascular risk factors in worsening erectile function through vascular endothelial injury and impaired nitric oxide-mediated vasodilation. Similarly, Miner et al.^[9] reported that erectile dysfunction frequently coexists with traditional cardiovascular risk factors and may serve as an early clinical indicator of systemic vascular disease.

Diabetic Complications and Erectile Dysfunction: Peripheral neuropathy, diabetic nephropathy, and diabetic retinopathy showed significant associations with erectile dysfunction, with peripheral neuropathy emerging as the strongest clinical correlate. Comparable findings have been reported by Defeudis et al.^[5] who demonstrated that diabetic neuropathy and microvascular disease play central roles in the pathogenesis of erectile dysfunction. Thorve et al.^[6] also described neuropathic and endothelial damage as key mechanisms responsible for impaired penile erection among diabetic men.

Independent Predictors of Erectile Dysfunction: Multivariate logistic regression identified advancing age, duration of diabetes greater than 10 years, poor glycaemic control, hypertension, and peripheral neuropathy as independent predictors of erectile dysfunction. These findings are comparable to those reported by Yafi et al.^[7] Miner et al.^[9] and Kouidrat et al.^[10] all of whom identified ageing, metabolic control, vascular risk factors, and diabetic complications as major determinants of erectile dysfunction. The present findings further reinforce the concept that erectile dysfunction is not merely a quality-of-life issue but also an important marker of systemic vascular and endothelial dysfunction.

Overall, the findings of the present study demonstrate a high prevalence of erectile dysfunction among men with type 2 diabetes mellitus. The strong associations observed with age, duration of diabetes, poor glycaemic control, hypertension, obesity, smoking, and diabetic microvascular complications emphasize the need for routine screening of erectile dysfunction in diabetic clinics. Early identification using the IIEF-5 questionnaire, coupled with optimization of glycaemic control and cardiovascular risk reduction, may improve both sexual health and overall clinical outcomes, as recommended by the American Diabetes Association,^[2] the American Urological

CONCLUSION

The present study demonstrated that erectile dysfunction is a highly prevalent complication among men with type 2 diabetes mellitus, with nearly three-fourths of the study participants being affected. Based on assessment using the International Index of Erectile Function-5 (IIEF-5) questionnaire, mild erectile dysfunction was the most common severity category, followed by mild-to-moderate, moderate, and severe erectile dysfunction.

The study further found that advancing age, longer duration of diabetes, poor glycaemic control (higher HbA1c levels), hypertension, obesity, smoking, and diabetic microvascular complications such as peripheral neuropathy, nephropathy, and retinopathy were significantly associated with erectile dysfunction. Multivariate analysis identified age ≥ 50 years, diabetes duration >10 years, poor glycaemic control, hypertension, and peripheral neuropathy as independent predictors of erectile dysfunction.

These findings highlight the importance of incorporating routine screening for erectile dysfunction using the IIEF-5 questionnaire into the comprehensive management of men with type 2 diabetes mellitus. Early identification, optimization of glycaemic control, aggressive management of cardiovascular risk factors, and timely counseling and treatment may improve sexual function, enhance quality of life, and facilitate early detection of underlying vascular disease.

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