

THE EXTENDED PROTOCOL

The 12-Week System for Men on Beta-Blockers,
Thiazides, or Combination Prescriptions



by Tunde A.



A Note Before You Begin

This guide is educational and does not replace medical care. It's designed to work alongside your prescribed blood pressure and diabetes treatment - never as a substitute for it. Do not stop, reduce, or change any medication based on anything in this book without speaking to your doctor first. Individual results vary, and the timelines and outcomes described reflect general research findings, not a guarantee for any individual reader. If you experience chest pain, severe symptoms, or anything that feels seriously wrong, contact a doctor immediately regardless of where you are in this program.

About the research in this guide: the exercise, nutrition, and medication information in this book is drawn from published clinical research on hypertension medications and pelvic floor training. Where the evidence is mixed or incomplete, this guide says so directly rather than presenting it as settled fact.

Table of Contents

Introduction Why the Base Protocol Wasn't Enough (And That's Not Your Fault)

Chapter 1 The Quick Win: Finding Your Baseline in the Next 20 Minutes

Chapter 2 Your Medication, Honestly Explained

Chapter 3 Metformin: What the Evidence Actually Says

Chapter 4 The 12-Week Pelvic Floor Progression

Chapter 5 Feeding Your Vascular System (Especially If You're on a Diuretic)

Chapter 6 Tracking Your Twelve Weeks

Chapter 7 The Plateau: What to Do (And When It's a Doctor Conversation)

Chapter 8 Maintaining It Long-Term



INTRODUCTION

Why the Base Protocol Wasn't Enough (And That's Not Your Fault)

If you're reading this, you already did the hard part. You bought the guide, you followed the six weeks, and you're a man who takes his health seriously enough to actually do the reading - most men never get that far.

So let's start with something you deserve to hear plainly: if you're on atenolol, hydrochlorothiazide, or a combination that includes metformin alongside a blood pressure medication, and six weeks gave you some improvement but not the full picture you were hoping for - that's not you failing the protocol. That's the protocol running out of time for what your specific medication is doing.

The Part Module 1 Told You, and What It Didn't Have Room For

Module 1 was honest with you. It told you that not every blood pressure medication carries the same risk to erectile function. That was true, and it wasn't fear-mongering - it's one of the more consistently documented findings in hypertension research.

Here's the fuller picture. Medications like amlodipine (a calcium-channel blocker) and lisinopril (an ACE inhibitor) tend to have a neutral, sometimes even mildly positive, relationship with erectile function. Beta-blockers - especially older ones like atenolol and metoprolol - and thiazide diuretics like hydrochlorothiazide sit in a different category. Large hypertension trials going back decades have shown meaningfully higher rates of erectile difficulty in men on these two drug classes compared to men on placebo or on gentler alternatives. This isn't a fringe finding. It's shown up consistently enough that it shapes how doctors think about prescribing for men who report sexual side effects.

That's the honest reason six weeks wasn't enough. The base protocol was built as a general starting point. This one is built specifically for your medication category.

Why Twelve Weeks, Not Six

The exercise research this book is built on - the strongest trials on pelvic floor training for erectile function - ran for twelve weeks, not six. Men doing three structured sessions a week for a full twelve weeks saw significantly better results than men who got general lifestyle advice alone. Six weeks is roughly the halfway point of that timeline. If you stopped at six and felt like you were "almost there but not quite," that's often exactly what the research would predict - you were mid-program, not at the finish line.

I want to be straightforward with you about something else, too: most of that research was done on general populations of men with erectile difficulty, not specifically men on beta-blockers or thiazides. That's an honest gap in the evidence, and I won't pretend otherwise. What this means practically is that pelvic floor training is your best non-drug tool for supporting erectile function - not a guaranteed fix for what your specific medication is doing on its own. Used alongside your doctor's care, it gives your body every reasonable advantage while the two of you manage the medication side of things together.

A Word on Metformin

If you're also on metformin - often prescribed alongside blood pressure medication when blood sugar is a factor - you may have seen or heard claims that the combination "compounds" the problem. I want to be honest with you here rather than tell you what sounds tidy: the actual research on metformin and erectile function is mixed. Some studies have found a higher rate of sexual difficulty in men on metformin. Other studies - including small clinical trials - have found metformin can actually support the blood vessel function involved in erections, particularly when paired with standard ED treatments. There is no settled answer yet. What that means for you is simple: this is a specific, worthwhile question to bring to your doctor, not something to assume is working against you. Chapter 3 covers this in more depth.

SAFETY NOTE

This book will not tell you to stop your medication. It will not sell you on a fix that skips your doctor. Everything here is designed to work alongside your prescribed treatment, never instead of it. If anything in this guide ever conflicts with something your doctor has told you specifically about your case, your doctor's guidance wins. Every time.

What the Next Twelve Weeks Look Like

- **Chapter 1** gives you a real starting point - a short assessment you'll use to measure where you are right now, and again at weeks six and twelve.
- **Chapter 2** explains, in plain language, what your specific medication is likely doing and why.
- **Chapter 3** takes an honest look at metformin, if that applies to you.
- **Chapter 4** is the core of the book: the full twelve-week pelvic floor progression.
- **Chapter 5** covers food-based support for men on diuretics specifically.
- **Chapter 6** shows you how to track your progress properly.
- **Chapter 7** is, in some ways, the most important chapter in this book - how to tell a normal plateau from a sign that it's time to go back to your doctor.
- **Chapter 8** is about what you do after week twelve, whatever your results look like.

Let's start with where you actually stand today.



CHAPTER 1

The Quick Win: Finding Your Baseline in the Next 20 Minutes

Before you change a single thing about your routine, you need a number. Not a feeling, not a guess - an actual baseline you can compare yourself against at week six and week twelve. Without it, you won't know if this is working; you'll only have a vague sense of "better" or "not better," and vague senses are exactly what let people quit in week 8 right before things turn.

This chapter gives you that number in the next twenty minutes.

Why This Matters More Than It Sounds Like It Should

Men chronically underestimate small improvement because they're comparing today to their imagined "normal" self, not to where they actually started. A written baseline fixes that. It's the difference between "I don't feel like anything's changed" and "actually, three of these five numbers went up." The second one is what keeps a man doing his exercises in week 9 when motivation runs low.

This is also, frankly, good practice for a conversation with your doctor. If you ever need to discuss your symptoms with a physician - which Chapter 7 will walk you through - walking in with three data points across twelve weeks makes that a five-minute, productive conversation instead of a vague one.

The Assessment

Below is a simplified version of a well-established type of self-assessment used in men's sexual health research (a plain-language adaptation, not a diagnostic tool - it won't tell you why anything is happening, only how things are trending over time for you specifically).

Answer honestly. There's no one grading this but you.

Rate each of the following from 0 (not at all) to 5 (almost always / very high), based on the last 4 weeks:

- Confidence that you could get an erection
- When you had erections, how often they were firm enough for penetration
- How often you were able to maintain an erection after penetration
- How difficult it was to maintain the erection to completion of intercourse
- Overall satisfaction with your sexual function

Add your five scores together. Total possible score: 0-25.

Write today's date and your total in the tracker below. You'll fill in the same five questions again at the end of week 6 and week 12.

Your Baseline Tracker

	Date	Q1	Q2	Q3	Q4	Q5	Total
Week 0 (today)	_____	—	—	—	—	—	___ / 25
Week 6	_____	—	—	—	—	—	___ / 25
Week 12	_____	—	—	—	—	—	___ / 25

Keep this page. You'll need it again in Chapter 6.

What a "Good" Score Change Looks Like

Don't expect a jump from 8 to 22. In the strongest pelvic floor trials, meaningful change was often a shift of several points - enough to move a man from a lower functional range into a noticeably better one - not a total transformation overnight. If your week 6 number is only 2-3 points higher than today, that is normal progress at the halfway mark of a twelve-week program, not a sign that anything has failed.

If your week 12 number hasn't moved at all from your baseline, that's meaningful information too - and Chapter 7 tells you exactly what to do with it.

SAFETY NOTE

This assessment is a tracking tool, not a diagnosis. If your score is very low, or if you have any symptoms beyond erectile difficulty - chest pain, unusual fatigue, numbness - that is a reason to speak with your doctor now, not in twelve weeks. This book supports the medical care you're already receiving; it doesn't replace it.

With your baseline written down, you're ready for Chapter 2: understanding exactly what your medication is doing, and why.



CHAPTER 2

Your Medication, Honestly Explained

Let's talk plainly about what's actually happening in your body, because understanding the "why" makes everything in the rest of this book make more sense - and because you deserve real information, not vague talk about "side effects."

The Two Categories, Revisited

Blood pressure medications work in different ways, and those different mechanisms have different relationships with erectile function. Broadly:

- **Calcium-channel blockers** (amlodipine, nifedipine) and **ACE inhibitors / ARBs** (lisinopril, losartan, valsartan) tend to be neutral or even mildly favorable for erectile function.
- **Beta-blockers**, especially older ones like **atenolol** and **metoprolol**, and **thiazide diuretics** like **hydrochlorothiazide (HCTZ)**, are more consistently associated with erectile difficulty.

This isn't a minor footnote in the research - it's shown up across large hypertension trials for decades, and it's one of the reasons doctors sometimes switch a patient's prescription when sexual side effects come up. If you're on one of these two classes, or both together, you're not imagining that this feels harder than it should. There's a documented reason for it.

What Beta-Blockers Are Actually Doing

Beta-blockers work by blocking the effect of adrenaline-related hormones on your heart and blood vessels - that's how they slow your heart rate and ease pressure on your arteries. The trouble is that the same signaling pathway plays a role in the blood flow response involved in

getting an erection.

Not all beta-blockers behave the same way. Newer-generation ones, particularly nebivolol, appear to carry a meaningfully lower risk of erectile difficulty than older ones like atenolol, metoprolol, or carvedilol. If you're on one of the older-generation beta-blockers and struggling, that's genuinely useful information to bring to your doctor - sometimes a switch within the same drug class solves more than any exercise or food change ever could. This book isn't a substitute for that conversation; it's what you do in addition to it.

What Thiazide Diuretics Are Actually Doing

Hydrochlorothiazide and similar thiazide diuretics lower blood pressure by helping your kidneys release excess sodium and water. That's genuinely effective blood-pressure management - but the same process appears to affect erectile function through a few overlapping mechanisms researchers have studied:

- **Direct effects on vascular smooth muscle.** Laboratory studies have shown hydrochlorothiazide can affect the contraction behavior of the smooth muscle tissue involved in erections.
- **Mineral depletion.** Thiazides are well known to lower levels of zinc, magnesium, and potassium in the body over time. Zinc in particular plays a role in male hormonal health, and some small studies have found that men who developed sexual difficulty on thiazides saw improvement after their zinc levels were corrected - under medical supervision. Chapter 5 covers this in more depth, with a food-first approach.
- **Blood pressure changes themselves.** Lowering blood pressure - which is, again, the entire point of the medication - can itself reduce the blood flow surge that used to happen during arousal, independent of any other mechanism.

None of this means the medication is "wrong" for you. It means your body is doing exactly what a well-functioning diuretic does, and one of the side effects of that is erectile difficulty in a meaningful percentage of men. Older research going back to major hypertension trials found this to be one of the most common reasons men asked to come off thiazide therapy altogether - which tells you it's common enough to take seriously, and specific enough to have a plan for. That's what the rest of this book is.

Why This Isn't About Blame

I want to be direct about something: nothing above is a reason to feel like your body is failing you, or like this is something you caused. You're managing a real medical condition with a real, effective medication. Erectile difficulty is a known, documented trade-off of some of the best tools we have for controlling blood pressure - and blood pressure, left uncontrolled,

carries its own serious risks to the same blood vessels involved in erectile function. This is a genuinely difficult trade-off, and it's one you and your doctor are best positioned to manage together - including whether a different medication in the same class might work better for you specifically.

SAFETY NOTE

This chapter is not telling you to stop your medication, adjust your dose, or switch prescriptions on your own. Blood pressure medication changes need to happen with your doctor, based on your full medical picture - not based on a chapter in this guide.

Next, if metformin is also part of your prescription list, Chapter 3 takes an honest look at what the evidence says - because the answer is more complicated than most guides let on.



CHAPTER 3

Metformin: What the Evidence Actually Says

If you're managing blood sugar alongside blood pressure, there's a good chance metformin is part of your daily routine. And if you've gone looking for information on metformin and erectile function, you've probably run into confident-sounding claims in both directions - that it makes things worse, or that it helps. I'm not going to give you a confident-sounding claim. I'm going to give you the honest state of the research, because you deserve that more than you deserve a tidy answer.

The Case That Metformin Might Contribute to the Problem

Some research has found men on metformin report higher rates of erectile difficulty and other sexual health concerns than men not on the medication. The proposed reasons vary - possible effects on testosterone levels, and changes in the way certain muscle tissue involved in erections responds. This research exists, and I won't pretend it doesn't.

The Case That Metformin Might Actually Help

At the same time, a separate body of research - including small clinical trials - has found that metformin can improve the function of the blood vessel lining (the endothelium) involved in achieving an erection, particularly in men with insulin resistance. In at least one trial, men who added metformin alongside a standard ED medication saw better results than the ED medication alone. The proposed mechanism is that metformin improves blood vessel signaling in a way that actually supports erectile function, especially in men whose blood sugar regulation is part of the underlying picture.

So Which Is It?

Honestly - we don't know yet, not with the kind of certainty I'd want to give you. The studies point in different directions, use different populations, and haven't been combined into a large, definitive trial that settles the question. Anyone who tells you with total confidence that metformin "compounds" your blood-pressure-medication side effects is oversimplifying research that genuinely doesn't support that level of certainty.

What I can tell you with confidence is this: this is a specific, worthwhile question for your next doctor's visit - not something to quietly assume is working against you, and not something to try to "fix" yourself by skipping doses. Metformin plays an important role in managing blood sugar, and blood sugar control itself matters enormously for long-term vascular and erectile health. Stopping or reducing it without medical guidance could do far more harm than any uncertainty about its effect on erectile function.

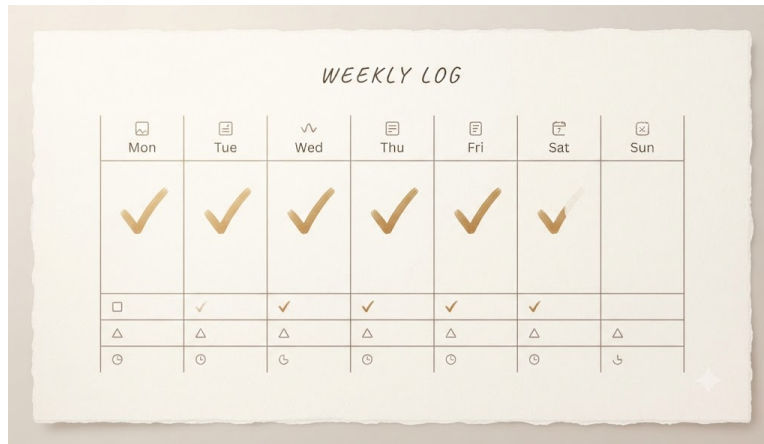
A short list of questions worth bringing to that appointment:

- Has my metformin dose or combination changed recently, around the same time I noticed changes in erectile function?
- Is there a reason to think my blood sugar control itself might be a factor here, separate from the medication?
- Would it be worth discussing this alongside my blood pressure medication as a combined picture, rather than looking at each one separately?

What This Means for the Rest of This Book

Because the metformin evidence doesn't point clearly in one direction, nothing in the following chapters treats metformin as a problem to work around. The pelvic floor training in Chapter 4 and the food-based guidance in Chapter 5 are both about supporting the blood vessel function and pelvic muscle strength involved in erections generally - useful whether metformin is helping, hurting, or doing nothing at all in your specific case. You don't need to have this question resolved to move forward with the rest of the program.

Let's get into the part of this book you can act on immediately: the twelve-week pelvic floor progression.



CHAPTER 4

The 12-Week Pelvic Floor Progression

This is the core of the program, and it's built directly on the strongest research available on pelvic floor training and erectile function - trials where men doing structured sessions three times a week for twelve weeks saw significantly better outcomes than men who only received general lifestyle advice.

Before we start, one honest note I raised in the introduction and want to repeat here: most of that research was done on general populations of men with erectile difficulty - not specifically men on beta-blockers or thiazides. That's a real gap in what's been studied. What this means practically is that this program is your best non-drug tool for supporting erectile function, used alongside your doctor's management of your medication - not a promise that it will undo what your specific prescription is doing. Men who've done this work report real benefit. Whether it fully resolves your situation depends on factors this book can't see, which is exactly why Chapter 7 exists.

Finding the Right Muscles

Your pelvic floor is the group of muscles running between your pubic bone and tailbone. When they're weak, blood can leave the penis too quickly during an erection - a phenomenon researchers call venous leakage. Strengthening these muscles helps trap blood more effectively, supporting both rigidity and duration.

To find them: Next time you urinate, try to stop the stream partway through. The muscles you just used are your pelvic floor. That's the only time you should use this test - don't make a habit of stopping urine flow regularly, as it can affect bladder function over time. Once you know the sensation, you can practice the contraction without needing to urinate.

Getting the technique right:

- Tighten those muscles for 3-5 seconds, then relax fully for the same count.
- Breathe normally throughout - don't hold your breath.
- Keep your abdomen, buttocks, and inner thighs relaxed. If those are tightening, you're using the wrong muscles.
- Practice lying down or sitting first, before attempting the exercises standing.

The 12-Week Program

Weeks 1-4 - Foundation

- 10 contractions, holding 3-5 seconds each, with equal rest between
- 3 sets per day
- Do this seated or lying down

Weeks 5-8 - Building

- 12-15 contractions, holding 5-8 seconds each
- 3 sets per day
- Begin practicing some sets standing

Weeks 9-12 - Advanced

- 15-20 contractions combining quick 1-second pulses with longer holds up to 10 seconds
- 3 sets per day
- All sets standing

Add roughly 2 seconds to your hold time each week as it starts to feel manageable - don't rush the progression. Consistency across all twelve weeks matters more than intensity in any single week.

Your Full Weekly Exercise Script

Week	Reps	Hold Time	Sets/Day	Position
1	10	3 sec	3	Seated/lying
2	10	4 sec	3	Seated/lying
3	10	4 sec	3	Seated/lying
4	10	5 sec	3	Seated/lying

Week	Reps	Hold Time	Sets/Day	Position
5	12	5 sec	3	Mixed
6	12	6 sec	3	Mixed
7	14	7 sec	3	Mixed
8	15	8 sec	3	Standing
9	15	8-10 sec	3	Standing
10	18	8-10 sec	3	Standing
11	18	8-10 sec	3	Standing
12	20	10 sec + pulses	3	Standing

Print this page and check off each day you complete your sets - the Progression Tracker in Chapter 6 builds directly on this.

SAFETY NOTE

Stop and speak with your doctor before continuing if you experience pelvic pain, urinary difficulty, or any new symptom that wasn't there before you started. This program is meant to strengthen, not strain.

Next, if you're on a thiazide diuretic specifically, Chapter 5 covers the food side of this - because what a diuretic does to your minerals is just as relevant as what it does to blood flow.

SAFETY NOTE

This is the one place in this book where I want to be extra careful: I'm not going to hand you supplement dosages. You're already on a medication that affects your body's mineral and fluid balance, and adding concentrated mineral supplements on top of that - especially magnesium and potassium - without medical supervision can genuinely be risky, particularly for kidney function. What I can give you is a food-first approach, and a clear recommendation to ask your doctor for a simple blood panel checking zinc, magnesium, and potassium levels the next time you're in for a routine visit. That's a five-minute ask that gives you (and your doctor) real numbers to work from.

The Food-First Approach

Below are everyday foods naturally rich in the three minerals thiazides most commonly deplete. None of these require a prescription, none carry the risk profile of concentrated supplements, and all of them fit easily into normal meals.

- **Zinc-rich foods:** pumpkin seeds, beans and lentils, eggs, groundnuts, oats, chicken
- **Magnesium-rich foods:** leafy greens (ugu, spinach), beans, bananas, almonds, whole grains
- **Potassium-rich foods:** bananas, sweet potatoes, avocado, beans, tomatoes, coconut water

Your Weekly Vascular-Support Checklist

Aim to check off each item at least 4 times this week:

- ☐ A handful of pumpkin seeds or groundnuts as a snack
- ☐ A serving of beans or lentils with a main meal
- ☐ Leafy greens (ugu, spinach, or similar) with at least one meal
- ☐ A banana or sweet potato
- ☐ An egg-based breakfast
- ☐ Water throughout the day - diuretics increase fluid loss, so staying hydrated matters more, not less, while on this medication

Repeat this checklist each week of the twelve-week program. There's no need to track exact grams or milligrams - the goal is steady, varied intake of whole foods, not precision supplementation.

Food changes support your body's baseline mineral status, but they are not a substitute for medical monitoring if you're already experiencing symptoms like unusual muscle cramping, heart palpitations, or significant fatigue - those warrant a conversation with your doctor regardless of where you are in this program, since they can indicate more significant electrolyte shifts than diet alone addresses.

With your exercise progression and food support both underway, Chapter 6 shows you how to actually track whether all of this is working.



CHAPTER 6

Tracking Your Twelve Weeks

You already have two tools working for you: the baseline assessment from Chapter 1, and the exercise log from Chapter 4. This chapter brings them together so you actually know, in concrete terms, whether the last twelve weeks are working - instead of relying on a vague feeling.

Why Tracking Matters More Than It Feels Like It Should

Progress with pelvic floor training tends to be gradual, and gradual change is notoriously easy to miss day-to-day. Men often report feeling like "nothing's really different" around week 6 or 7, only to look back at their own numbers and realize they've genuinely improved - they just couldn't feel the change happening in real time. Writing it down protects you from quitting right before the part of the program where results tend to show up most.

It also protects you from the opposite problem: convincing yourself something is working when it isn't, which delays a doctor conversation that might actually be the more useful next step. Numbers don't let you fool yourself either way.

The 12-Week Progression Tracker

Use this alongside your Chapter 1 baseline and Chapter 4 exercise log. Fill it in once a week, ideally on the same day each week.

Week	Exercise sessions completed (out of 21)	Notes on any change
1	___ / 21	

Week	Exercise sessions completed (out of 21)	Notes on any change
2	___ / 21	
3	___ / 21	
4	___ / 21	
5	___ / 21	
6	___ / 21	Week 6 assessment score (from Ch. 1): ___ / 25
7	___ / 21	
8	___ / 21	
9	___ / 21	
10	___ / 21	
11	___ / 21	
12	___ / 21	Week 12 assessment score (from Ch. 1): ___ / 25

Reading Your Own Results Honestly

At week 6, compare your score to your Week 0 baseline:

- Any upward movement at all (even 2-3 points) is a normal, meaningful sign at the halfway mark. Keep going.
- No movement, or a drop, isn't a reason to panic at week 6 - this is still early for medication-related cases - but it's worth noting so you can watch closely over the next six weeks.

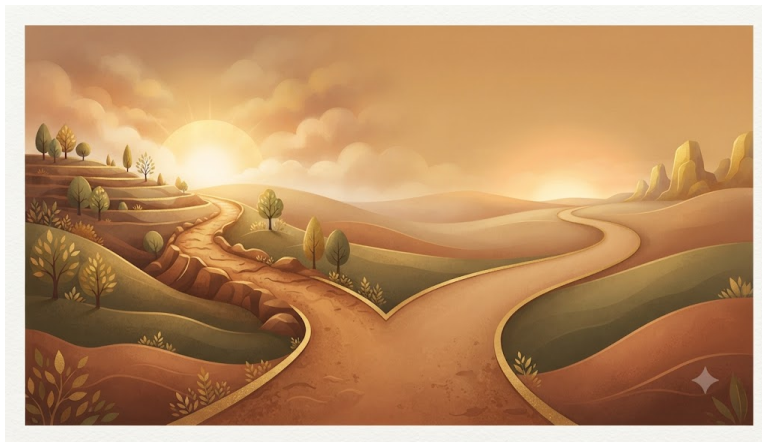
At week 12, compare again:

- A clear upward trend across both check-ins suggests the program is doing real work. Chapter 8 covers how to maintain that.
- Some improvement, but not full resolution, is a common and realistic outcome for men on higher-risk medications - and still worth continuing, potentially alongside a conversation with your doctor about your prescription.
- No change at all between Week 0 and Week 12, despite consistent completion of sessions, is genuinely useful information - not a personal failure, and not a sign to try harder on your own. That's exactly the situation Chapter 7 is written for.

An Honest Word on Adherence

If your session count is consistently low (say, under 12 of 21 most weeks), that matters for how you interpret your results. A low score change alongside low adherence tells you less about whether the program works and more about whether you've been able to do it consistently. There's no judgment here - life gets in the way - but be honest with yourself about which situation you're actually in before drawing conclusions.

Whatever your numbers show at week 12, the next chapter is where you decide what happens next.



CHAPTER 7

The Plateau: What to Do (And When It's a Doctor Conversation)

This is, in some ways, the most important chapter in this book. Not because it's the most exciting, but because knowing when to stop managing something yourself and bring in your doctor is one of the most valuable skills in health management - and it's the one most guides like this skip entirely, because it doesn't sell anything.

What a Normal Plateau Looks Like

Progress with pelvic floor training and lifestyle support rarely moves in a straight line. It's normal to see:

- Improvement in weeks 1-6, followed by a slower stretch in weeks 7-9 before movement picks back up
- Some weeks where your assessment score barely changes, even while you're doing everything right
- Physical improvement that outpaces confidence, or the reverse - confidence returning before physical changes feel consistent

None of this is cause for alarm. It's simply how gradual physiological change tends to behave, especially when a medication is part of the underlying picture.

Signs That Point Toward a Doctor Conversation, Not Another Six Weeks

Keep going with the program if:

- Your Week 12 score shows any upward movement from baseline, even modest
- You've had inconsistent adherence (missed sessions, gaps in food tracking) - the honest move is to complete a full, consistent twelve weeks before drawing conclusions
- You feel physically capable but mentally discouraged - this is common and doesn't reflect your actual physical progress

Talk to your doctor if:

- Your Week 12 score shows no meaningful change from your Week 0 baseline, despite consistent adherence
- Your score has gotten worse over the twelve weeks
- You've noticed new symptoms unrelated to erectile function - fatigue, muscle cramping, chest discomfort, mood changes
- You suspect your specific medication (rather than general health factors) is the dominant cause, and you haven't yet discussed alternatives within the same drug class with your prescriber

SAFETY NOTE

Talk to your doctor now, regardless of where you are in the twelve weeks, if you experience chest pain (particularly during or after sexual activity), sudden or severe symptoms of any kind, or anything about your health that feels seriously wrong. Trust that instinct over any program timeline.

What That Conversation Can Actually Look Like

If you land in the "talk to your doctor" category, that conversation is not a failure or a dead end - it's often the single most effective next step available, more so than any exercise or food change. Useful things to bring with you:

- Your Week 0, Week 6, and Week 12 assessment scores
- Your adherence record from the Progression Tracker
- A specific question: "Given my results, is it worth reviewing whether a different medication in the same class might work better for me?"

Many men find that a straightforward medication adjustment - sometimes as simple as switching from an older beta-blocker to nebivolol, or adjusting a thiazide dose - resolves more than months of independent effort could. That's not this book failing you. That's this book doing exactly its job: helping you figure out, with real data, when the next step belongs to a doctor rather than a workbook.

If You're Not Sure Which Category You're In

That's normal too. Bring your tracker to your next scheduled appointment - even a routine blood pressure check-in - and ask your doctor to look at it with you. You don't need a special appointment or a "sexual health" visit to raise this. It's a legitimate medical topic connected directly to medications they're already managing for you.

Whatever you decide after this chapter - continuing the program, adjusting it, or bringing in your doctor - Chapter 8 covers what maintaining your results looks like from here.



CHAPTER 8

Maintaining It Long-Term

You've made it through twelve weeks. Whatever your numbers show, this chapter is about what comes next - because a twelve-week program only matters if what it built actually lasts.

If Your Results Held or Improved

If your Week 12 score shows real improvement over your baseline, the temptation is often to stop here - you got the result, so the work feels done. Resist that. The muscle strength and vascular support you've built over twelve weeks doesn't stay in place on its own any more than any other physical gain does.

Maintenance exercise schedule: Once you've completed the full 12-week progression, drop from 3 sessions a week to 2 sessions a week, keeping the Week 12 rep, hold, and position parameters (20 reps, 10-second holds with pulses, standing). This maintenance frequency is enough to hold onto what you've built without requiring the same daily commitment as the build phase.

Maintenance food habits: Keep the Chapter 5 weekly checklist as a loose ongoing habit rather than a strict weekly tracker - the goal shifts from active correction to simple consistency. If you had a mineral panel done and corrected any deficiencies, ask your doctor whether a follow-up check in 3-6 months makes sense, particularly if you remain on a thiazide diuretic long-term.

A quarterly check-in with yourself: Every three months, redo the Chapter 1 assessment once. This isn't about creating a new twelve-week cycle - it's a simple way to catch any gradual drift early, whether that's from reduced exercise consistency, a medication change, or something else worth mentioning at your next doctor's visit.

If Your Results Were Partial

If you saw some improvement but not full resolution, you have a genuine choice, not a failure to fix. Options worth considering:

- Continue the Week 9-12 exercise level for another 4-6 weeks before reassessing - some men see continued gains beyond the initial twelve weeks, particularly if adherence was inconsistent early on.
- Revisit the doctor conversation from Chapter 7, even if you didn't feel you needed it before - partial results are exactly the kind of data worth discussing at a routine visit.
- Do both. Continuing the program and having a medication conversation aren't mutually exclusive; many men find the best long-term outcome comes from combining consistent non-drug support with an optimized prescription.

If You Had the Doctor Conversation

If Chapter 7 led you to a conversation with your doctor - whether that resulted in a medication change, additional testing, or simply reassurance - this program still has a role. Pelvic floor strength and vascular-supportive nutrition remain useful regardless of what your prescription looks like going forward. Nothing about adjusting your medication makes the last twelve weeks wasted effort; if anything, it means you now have both a stronger physical foundation and a medication plan better suited to you.

The Long View

Managing blood pressure - and doing it in a way that also protects sexual health - isn't a twelve-week project with a finish line. It's an ongoing relationship between you, your body, and your doctor, one that will likely need small adjustments over years, not weeks. The tools in this book - knowing your baseline, tracking honestly, recognizing when something needs medical attention rather than more effort - are meant to serve you well beyond this specific program.

You did real work here. Whatever the numbers say, showing up consistently for your own health, and being willing to look honestly at what is and isn't working, matters more than any single outcome in this book.

Take care of yourself out there.

- Tunde