Female Infertility: PCOS, Blocked Fallopian Tubes, Egg Quality and Hormonal Imbalance

A Complete Modern and Unani Approach to Understanding and Treating Female Fertility Problems

By 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

Introduction

When a woman comes to me because pregnancy is not occurring, I usually explain that **female fertility does not depend on one organ, one hormone or one laboratory report**. Successful conception requires several reproductive processes to work together.

An egg must develop and be released from the ovary. At least one fallopian tube must usually be sufficiently functional for natural conception. Sperm must reach the egg. Fertilization must occur. The resulting embryo must travel toward the uterus, and the endometrium must be capable of supporting implantation.

A disturbance at any one of these stages may reduce the probability of pregnancy.

This is why the term **female infertility** actually covers many different conditions. Common problems include ovulatory dysfunction, particularly **polycystic ovary syndrome (PCOS)**; fallopian-tube obstruction or damage; endometriosis; uterine abnormalities; age-related decline in reproductive potential; thyroid or prolactin disorders; and other endocrine or metabolic problems.

The World Health Organization defines infertility as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse** and estimates that approximately **one in six people of reproductive age experience infertility during their lifetime**. In November 2025, WHO released its first global guideline dedicated to the prevention, diagnosis and treatment of infertility.

The detailed material prepared for this article focuses particularly on four interconnected areas: **PCOS and ovulation, fallopian-tube patency, oocyte or egg health, and hormonal balance**.

These are indeed very important subjects, but they must be interpreted carefully. Some concepts in the supplied material belong to classical Unani theory; some represent emerging biomedical hypotheses; and some claims about specific herbs, supplements or procedures are not yet supported strongly enough to be presented as established fertility treatments.

My approach at **Saira Health Care** is therefore to combine the useful individualized philosophy of Unani medicine with appropriate modern reproductive investigation while remaining clear about what current scientific evidence does and does not establish.

What Is Female Infertility?

Female infertility means that a factor affecting the female reproductive system is contributing to difficulty achieving pregnancy.

The condition can result from abnormalities involving the ovaries, fallopian tubes, uterus, cervix or endocrine system. WHO's current infertility guidance explicitly recognizes this broad range of causes.

Female infertility may be **primary**, where a pregnancy has never previously occurred, or **secondary**, where the woman has conceived in the past but is currently unable to achieve another pregnancy.

It is important to understand that infertility is not automatically a woman's problem. Male factors are common, and both partners should usually be evaluated together when infertility is being investigated.

ASRM recommends assessment of ovulation, the structure and patency of the female reproductive tract and semen evaluation of the male partner, with parallel male evaluation where applicable.

When Should a Woman Seek Fertility Evaluation?

Women younger than 35 are generally advised to seek infertility evaluation after approximately **12 months** of regular unprotected intercourse without conception.

For women aged 35 years or older, assessment is generally recommended after approximately **6 months**, while women over 40 or those with known conditions associated with infertility may warrant more immediate evaluation.

I do not advise waiting the full 12 months when a woman already has a significant fertility risk—for example very irregular or absent periods, known tubal disease, previous pelvic inflammatory disease, severe endometriosis, previous major pelvic surgery or another recognized reproductive disorder.

Time should be used intelligently.

The Four Major Questions in Female Fertility

When I evaluate female infertility, I usually want to answer four practical questions.

Is the woman ovulating?

Can the egg and sperm meet through a functional reproductive pathway?

Is the uterus suitable for implantation?

Are age, hormones or metabolic conditions interfering with reproductive function?

The answers guide treatment far better than simply prescribing a general fertility medicine.

PCOS: One of the Most Important Causes of Ovulatory Infertility

Polycystic ovary syndrome, or PCOS, is a common endocrine-metabolic disorder.

The international evidence-based PCOS guideline estimates that PCOS affects approximately **10–13% of women of reproductive age when contemporary diagnostic criteria are applied**.

PCOS may affect menstrual cycles, ovulation, androgen levels, metabolism and psychological wellbeing.

Typical manifestations can include irregular or infrequent periods, difficulty predicting ovulation, excess facial or body hair, acne, weight gain or difficulty managing weight, and infertility due to irregular ovulation.

However, women vary considerably. A woman does not need to have every symptom.

How PCOS Develops: The Modern Understanding

PCOS does not have one single cause.

Genetic susceptibility, altered ovarian hormone production, insulin resistance, metabolic factors and hypothalamic-pituitary-ovarian signalling all appear to contribute.

Many women with PCOS have increased androgen activity. Insulin resistance can increase circulating insulin, which may stimulate ovarian androgen production and contribute to disrupted follicular development.

As a result, follicles may begin developing but fail to progress normally to dominant follicle selection and regular ovulation.

This is why a woman with PCOS may have many small follicles visible on ultrasound but still fail to release an egg regularly.

PCOS Does Not Simply Mean "Cysts in the Ovary"

This is an important misconception.

Despite the name, PCOS is not fundamentally a disease of dangerous ovarian cysts.

The "polycystic" appearance usually represents an increased number of small follicles rather than large pathological cysts requiring removal.

The 2023 international guideline recommends diagnosing PCOS in adults after excluding relevant alternative conditions when at least two of three features are present: **clinical or biochemical hyperandrogenism, ovulatory dysfunction, and polycystic ovarian morphology**. In adults, AMH may under defined circumstances be used as an alternative marker of polycystic ovarian morphology, but it should not be used as a single standalone PCOS test.

If irregular cycles and clear hyperandrogenism are already present, ultrasound is not necessarily required simply to establish the diagnosis.

PCOS According to the Unani Perspective

The supplied clinical background refers to PCOS using the Unani terminology **Marz Akyas Khusyatur Raham** and describes the condition through disturbance of *Mizaj* and the humoral system.

Within the traditional Unani framework, PCOS-like presentations are frequently interpreted as being associated with excessive **Balgham**, or phlegmatic predominance, and a *Barid Ratab*—cold and moist—temperamental pattern.

Classical Unani theory may describe excessive or abnormal *Balgham* as interfering with normal reproductive processes and menstrual regularity.

These concepts were developed before modern endocrinology and therefore should not be interpreted literally as explanations for insulin resistance or androgen excess.

I explain this to patients carefully: **the Unani model describes a constitutional pattern; modern endocrinology describes measurable biological mechanisms.**

The two frameworks can be discussed together, but they are not scientifically identical.

How Unani Medicine Can Be Useful in PCOS

PCOS is one area where the broader lifestyle-oriented nature of Unani medicine can be particularly relevant.

Traditional Unani management may focus on *Tadeel-e-Mizaj*—correction of temperament—together with *Ilaj-bil-Ghiza*, physical activity, sleep regulation, digestive health and individualized pharmacotherapy.

The source supplied for this article also describes **Munzij-Mushil** therapy as a traditional approach intended to prepare and eliminate abnormal humoral material.

This remains a traditional Unani therapeutic concept. However, claims that purgative regimens reliably normalize PCOS hormones or produce pregnancy at rates equivalent or superior to established modern treatment require stronger clinical evidence than is presently available.

In contemporary practice, I consider Unani therapy most useful when it addresses **weight, metabolic health, diet, lifestyle, menstrual symptoms and general constitution as part of an individualized plan**, rather than being presented as a guaranteed substitute for evidence-based ovulation treatment.

Modern Treatment of PCOS-Related Infertility

Treatment depends on whether pregnancy is currently desired.

For women with PCOS who have anovulatory infertility and no other major infertility factor, the 2023 international evidence-based guideline recommends **letrozole as first-line pharmacological ovulation-induction therapy**, where its use is permitted.

Clomiphene citrate, metformin and gonadotrophins also have roles in selected patients.

Metformin is particularly useful for metabolic features and may contribute to reproductive management in specific women, but it is not automatically the best fertility medicine for every patient with PCOS.

This is why I do not treat PCOS from an ultrasound report alone.

I first want to know whether the woman is actually ovulating, her age, body weight and metabolic profile, how long pregnancy has been delayed, whether the fallopian tubes are functional and whether her partner's semen parameters are adequate.

Lifestyle Treatment Is a Real Part of PCOS Management

Lifestyle intervention is not merely general advice given because there is “nothing else to do.”

It is an important component of PCOS management.

Nutrition, physical activity, sleep and weight management can improve metabolic health. In women who are above their healthiest weight, modest weight reduction may improve ovulatory function in some cases.

At the same time, PCOS can occur in women who are not overweight, so telling every patient simply to “lose weight” is neither sufficient nor appropriate.

PCOS treatment must remain individualized.

Fallopian Tube Blockage: A Different Type of Infertility

A woman may ovulate perfectly every month and still struggle to conceive if the fallopian tubes are significantly damaged or blocked.

The fallopian tube is where sperm and egg normally meet.

After fertilization, the early embryo travels through the tube toward the uterus.

Tubal disease therefore interferes with the physical pathway required for natural conception.

ASRM estimates that **tubal disease accounts for approximately 25–35% of female-factor infertility**, with many cases related to previous salpingitis or pelvic infection.

What Causes Blocked Fallopian Tubes?

Common causes include previous pelvic inflammatory disease, chlamydia or gonorrhoea, previous ectopic pregnancy, endometriosis, pelvic or abdominal surgery and other inflammatory conditions.

Genital tuberculosis is another important cause in regions where tuberculosis remains prevalent.

Depending on the problem, obstruction may be proximal—near the uterus—or distal—closer to the ovary.

Some tubes are completely blocked; others are technically open but have damaged internal lining or adhesions that reduce function.

This distinction is extremely important because **a tube being "open" on a test does not necessarily prove that it functions normally**.

How Is Tubal Patency Tested?

ASRM identifies **hysterosalpingography (HSG)** as a standard first-line method for evaluating fallopian-tube patency. Appropriate ultrasound-based contrast studies can also be used.

HSG involves introducing contrast through the cervix and observing whether it passes through the fallopian tubes.

Sometimes an apparent proximal blockage results from temporary tubal spasm rather than permanent obstruction, so results must be interpreted carefully.

Laparoscopy can directly visualize pelvic anatomy and adhesions but is invasive and is not required simply as a routine tubal test in every patient.

Hydrosalpinx

A particularly important form of tubal disease is **hydrosalpinx**, where a blocked fallopian tube becomes enlarged and filled with fluid.

Hydrosalpinx can interfere with natural conception and also reduce IVF success.

ASRM reports that pregnancy, implantation and delivery rates with IVF may be substantially lower when a communicating hydrosalpinx remains untreated. For women with severe, surgically irreparable hydrosalpinges, salpingectomy or proximal tubal occlusion before IVF can improve reproductive outcomes.

This is a structural disease.

No responsible clinician should promise that every severe hydrosalpinx can be permanently opened by oral medicine alone.

Fallopian Tube Blockage in Unani Medicine

The supplied material describes tubal obstruction through a traditional concept of **Su-e-Mizaj**, abnormal humoral material and *Sudad*, meaning obstruction.

Within Unani therapeutics, medicines categorized as **Mufatteh-e-Sudad** are traditionally intended to address obstruction, while **Muhallil-e-Waram** medicines are used within the classical framework for inflammatory swelling.

These concepts may help guide supportive treatment of inflammation, constitution and associated reproductive symptoms.

However, a mature fibrotic scar inside a fallopian tube is a structural anatomical problem. Traditional terms such as “opening obstruction” should therefore not automatically be interpreted to mean that an herbal medicine has been clinically proven to reopen a severely scarred tube.

An Important Clarification About Uttar Basti

The source material supplied for this article discusses **Uttar Basti** for tubal blockage.

For textbook accuracy, an important clarification is necessary: **Uttar Basti is principally an Ayurvedic/Panchakarma procedure rather than a standard classical Unani treatment modality.**

It should therefore not be presented to patients as though it is a routine Unani procedure.

More importantly, introducing oils or herbal preparations into the uterus carries potential risks, including infection and trauma, and should not be promoted as a proven method for reopening fallopian tubes without high-quality evidence and appropriate clinical governance.

In Unani-focused care, I prefer to discuss established Unani pharmacotherapy, dietotherapy and regimenal principles rather than merge unrelated traditional systems without explanation.

Can Unani Treatment Help a Woman With Tubal Disease?

Unani medicine may be useful for **supporting pelvic health, managing selected inflammatory complaints, regulating lifestyle, improving general health and preparing a woman for conception** when used appropriately.

But the role depends on the actual pathology.

If the problem is mild inflammation without irreversible structural damage, supportive management may be relevant after the primary cause is appropriately treated.

If a woman has severe bilateral fibrotic obstruction or hydrosalpinx, prolonged empirical treatment should not delay reproductive referral.

This distinction is crucial.

Active inflammation may improve. Mature scar tissue may not.

Tubal Surgery Versus IVF

Treatment of tubal infertility is individualized.

In younger women with limited tubal disease and otherwise favourable fertility factors, selected reparative procedures may be considered.

In severe disease, particularly poor-prognosis hydrosalpinx, IVF is often a more appropriate strategy.

ASRM recommends considering the woman's age, ovarian reserve, semen quality, location and extent of tubal disease, ectopic-pregnancy risk, desired family size, surgeon experience, IVF success rates, costs and patient preference when deciding between surgery and IVF.

This is the kind of counselling I consider essential.

The objective should not be to “avoid IVF at all costs” or to “do IVF immediately” without evaluating the individual patient.

Understanding Egg Quantity and Egg Quality

Women often use the terms “egg count” and “egg quality” interchangeably.

They are not the same.

Ovarian reserve broadly refers to the remaining quantity of recruitable follicles.

Egg quality is a much more complex concept involving the egg's chromosomal competence, cellular machinery and ability to contribute to a viable embryo.

Age is one of the most important predictors of reproductive potential.

ASRM states that **female age is the single most important predictor of fecundity**.

As reproductive age advances, both the number of remaining follicles and the proportion of chromosomally competent eggs decline.

What Does AMH Really Tell Us?

Anti-Müllerian hormone, or **AMH**, is often misunderstood.

Patients sometimes arrive extremely frightened because their AMH is low.

AMH provides useful information about ovarian reserve and expected response to ovarian stimulation, particularly in fertility treatment.

However, AMH alone does not tell us whether a woman can or cannot conceive naturally.

Likewise, a high AMH does not guarantee pregnancy.

The international PCOS guideline also warns that AMH should not be used as a standalone test for diagnosing PCOS.

I therefore never like to counsel a woman from one AMH number alone.

Her age, cycle pattern, ovulation, ovarian reserve, fallopian tubes, uterus and partner's semen all matter.

Can Egg Quality Be Improved?

This is one of the most commercially exploited areas of fertility medicine.

Women are frequently offered large combinations of antioxidants and supplements with promises to “reverse ovarian ageing.”

Current evidence does **not** support claims that a supplement can reverse a woman's biological reproductive age or reliably convert older eggs into younger eggs.

Lifestyle measures—particularly avoiding tobacco, maintaining adequate nutrition and controlling medical conditions—support general reproductive health.

Some supplements, including CoQ10, have been investigated in fertility treatment, but evidence varies by population and outcome and does not justify promising dramatic improvement in egg quality.

DHEA, melatonin and multiple other products should not be taken routinely simply because they appear in an online “egg-quality protocol.”

Treatment should be individualized.

Smoking and Female Fertility: Important 2026 Evidence

A particularly important modifiable factor is tobacco.

On **8 September 2026**, WHO released a new knowledge summary examining smoking and infertility. It reported that women who currently smoke had about a **40% higher risk of infertility compared with nonsmokers** in the evidence reviewed. WHO also highlighted adverse reproductive effects in men and possible reductions in assisted-reproduction success.

This is exceptionally relevant to fertility counselling.

Stopping tobacco is not an alternative therapy—it is an evidence-based reproductive-health intervention.

Second-hand smoke should also be minimized.

Oxidative Stress and Reproduction

The supplied background discusses oxidative stress and mitochondrial function in relation to ageing oocytes.

Oxidative biology is genuinely relevant to reproductive ageing, but patients should be cautious about the way this science is converted into marketing.

The fact that oxidative stress participates in cellular ageing does not mean that very high doses of antioxidants can reverse age-related reproductive decline.

Normal cellular signalling also uses reactive oxygen species, and more antioxidant is not always better.

For practical fertility care, age-appropriate investigation, avoidance of smoking, balanced nutrition and timely treatment remain more important than relying on an extensive unproven supplement regimen.

Thyroid Function and Fertility

The thyroid gland influences metabolism and reproductive function.

Significant hypothyroidism can disrupt menstrual cycles and ovulation. Hyperthyroidism can also interfere with reproductive physiology.

When menstrual irregularity, infertility or suggestive symptoms are present, thyroid evaluation may be appropriate.

ASRM recommends targeted hormonal testing according to clinical findings rather than indiscriminately ordering every endocrine test in every patient.

If thyroid disease is confirmed, treating the thyroid condition is preferable to repeatedly prescribing fertility medicine without correcting the underlying endocrine problem.

Prolactin and Ovulation

Prolactin is another important hormone.

Markedly elevated prolactin can suppress hypothalamic GnRH signalling and interfere with ovulation and menstruation.

Women may present with infrequent periods, absent periods and sometimes milk-like breast discharge unrelated to breastfeeding.

However, prolactin testing is not necessarily required as a routine screening test in every regularly menstruating infertile woman.

It is most useful when history or symptoms suggest a relevant abnormality.

This principle—testing because there is a clinical reason—is central to high-quality fertility care.

Progesterone and the Luteal Phase

Progesterone is essential after ovulation because it prepares and maintains the endometrium for implantation and early pregnancy.

However, “low progesterone” is often diagnosed too casually.

ASRM explains that a serum progesterone level above approximately 3 ng/mL can provide evidence that ovulation occurred when measured at an appropriate time, but progesterone varies considerably during the day and a single measurement cannot reliably define the quality of the luteal phase.

The concept of isolated **luteal phase deficiency** remains controversial. ASRM states that no reliable diagnostic test has been demonstrated to distinguish fertile from infertile women based solely on luteal-phase deficiency and that treatment has not been shown to improve pregnancy rates in natural, unstimulated cycles.

This is an important correction to the supplied material, which presents progesterone deficiency more definitively than current evidence supports.

The LH/FSH Ratio Should Not Be Used Alone to Diagnose PCOS

Another common misconception is that an **LH/FSH ratio above 2 automatically means PCOS**.

It does not.

Some women with PCOS have a relatively high LH level; others do not.

The contemporary international PCOS diagnostic criteria are based on ovulatory dysfunction, hyperandrogenism and polycystic ovarian morphology or appropriately used AMH—not on a mandatory LH/FSH ratio.

Therefore, I would not diagnose or exclude PCOS from an LH/FSH ratio alone.

The Uterus and Endometrium

Even when ovulation occurs and the tubes are open, the uterus must be capable of supporting pregnancy.

Fibroids, endometrial polyps, congenital uterine abnormalities, intrauterine adhesions and other conditions can interfere with fertility in selected women.

Transvaginal ultrasound is an important initial imaging tool.

Further investigations—such as saline infusion sonography or hysteroscopy—may be advised when a uterine cavity abnormality is suspected.

WHO's 2025 infertility guideline specifically includes evidence-based recommendations for **ovulatory dysfunction, tubal disease and uterine cavity disorders**.

Female Infertility Is Rarely Diagnosed From One Test

This is one of the most important principles I explain to patients.

An ultrasound showing polycystic ovaries does not prove that PCOS is the only problem.

A low AMH does not prove pregnancy is impossible.

An HSG showing tubal blockage may occasionally require confirmation or further interpretation.

A progesterone result should not be judged without knowing when it was measured.

A normal female report also does not prove the couple has no fertility problem because male factors must be considered.

Fertility diagnosis is the process of putting **all the evidence together**.

A Practical Diagnostic Approach at Saira Health Care

When I evaluate female infertility, my first step is a detailed conversation rather than immediately ordering many investigations.

I review the woman's age, duration of infertility, menstrual history, evidence of ovulation, previous pregnancies, miscarriage or ectopic pregnancy, pelvic infection, surgery, weight and metabolic health, symptoms of PCOS, thyroid or prolactin problems, sexual history and previous fertility treatment.

Physical examination and ultrasound are selected when appropriate.

If cycles are irregular, endocrine investigation may be indicated.

If the history suggests tubal disease—or infertility has reached a stage where tubal assessment will affect treatment—HSG or another appropriate patency test may be advised.

And when there is a male partner, **semen analysis should not be postponed until the woman has completed months of investigations**.

Female Infertility According to Unani Medicine

Unani medicine approaches reproductive disease through an individualized constitutional framework.

Health is traditionally associated with an appropriate **Mizaj** and balance among the four *Akhlat*: *Dam*, *Balgham*, *Safra* and *Sauda*.

Female reproductive disorders may be considered in relation to disturbance of temperament, nutrition, organ function and abnormal humoral states.

The supplied material applies this framework to PCOS, tubal obstruction and endocrine disturbances, including concepts such as *Su-e-Mizaj*, *Balgham-e-Lazuj*, *Mudir-e-Haiz*, *Mufatteh-e-Sudad* and *Muhallil-e-Awaram*.

These terms form part of the traditional theoretical vocabulary and should be understood as such.

The Strength of Unani Medicine in Female Fertility

In my opinion, one of the greatest strengths of Unani medicine is **individualization**.

Two women may both have irregular menstruation but for very different reasons.

One may have PCOS with obesity and insulin resistance.

Another may be underweight and experiencing hypothalamic suppression.

Another may have thyroid disease.

Another may be approaching diminished ovarian reserve.

Giving all four women the same “fertility medicine” would not be rational.

Unani concepts such as *Mizaj*, together with *Ilaj-bil-Ghiza* and lifestyle assessment, encourage the physician to consider the whole patient.

When combined with objective modern diagnosis, this can create a thoughtful integrative approach.

Ilaj-bil-Ghiza: Dietotherapy

Diet occupies an important position in Unani medicine.

For women with PCOS or metabolic dysfunction, dietary counselling may help improve body weight, glycaemic health and general wellbeing.

I do not prescribe one universal “fertility diet.”

The diet should be realistic, nutritionally adequate and adapted to the woman's metabolic profile and preferences.

Very restrictive dieting, repeated fasting or extreme detoxification should not be encouraged simply because pregnancy has not occurred.

No single fruit, herb, seed, dry fruit or traditional food guarantees ovulation or pregnancy.

Unani Pharmacotherapy

Unani pharmacotherapy includes herbs and compound formulations traditionally used for menstrual and reproductive disorders.

The supplied background lists agents including *Withania somnifera*, fennel, cinnamon, *Tribulus terrestris* and several other botanicals.

Some of these plants have biologically active constituents and preliminary research relating to metabolism, inflammation or endocrine function.

However, the evidence is not sufficiently uniform to state that individual herbs are equivalent or superior to established ovulation-induction treatment.

Therefore, at Saira Health Care, any Unani medicine should ideally be chosen **according to diagnosis, constitution, other medications and reproductive plans**, rather than simply prescribed because it is traditionally associated with fertility.

Once pregnancy occurs, the treatment plan should be reviewed because a medicine appropriate before conception may not necessarily be appropriate during pregnancy.

Regimenal Therapy in Unani Medicine

Unani medicine also includes **Ilaj-bil-Tadbeer**, or regimenal therapy.

In fertility care, its safest potential contribution is generally through lifestyle regulation, appropriate movement, relaxation, sleep and general metabolic health.

Some Unani traditions use massage, Hammam and Hijama for selected indications.

At present, however, there is insufficient high-quality evidence to claim that cupping or massage can unblock a fallopian tube, increase ovarian reserve or reverse age-related oocyte decline.

Such therapies should therefore remain adjunctive when used—not replacements for reproductive investigation.

Munzij-Mushil Therapy: How Should It Be Viewed Today?

The supplied source presents a structured **Munzij-Mushil** regimen for PCOS.

In Unani theory, *Munzij* agents are traditionally used to prepare abnormal humours for elimination and *Mushil* agents promote evacuation.

This is an established traditional concept.

However, the claim that such treatment consistently improves LH/FSH ratios or menstrual regularity at rates comparable with metformin requires independent, adequately powered clinical trials before being stated as a general medical fact.

Purgative medicines can also cause dehydration, electrolyte disturbance or gastrointestinal complications inappropriately selected patients.

For that reason, they should not be self-administered and are not required for every woman with PCOS.

Modern and Unani Care Should Not Be Presented as Competitors

I do not believe a woman should be told:

“Either choose Unani medicine or choose modern fertility medicine.”

That is often a false choice.

Modern reproductive medicine can tell us whether she is ovulating, whether her fallopian tubes appear patent, whether her ovarian reserve is reduced, whether her thyroid or prolactin is abnormal and whether the male partner has a semen problem.

Unani medicine can contribute to a **whole-person approach involving diet, lifestyle, constitution, metabolic wellbeing and carefully selected supportive pharmacotherapy**.

When used responsibly, the two approaches have different strengths.

Female Infertility and Emotional Health

The emotional burden of infertility can be substantial.

WHO's recent infertility work highlights feelings of stigma, guilt, anxiety and social isolation experienced by couples undergoing prolonged infertility treatment.

Women may feel responsible even when the main fertility factor is male.

Family questions, social comparison and repeated menstrual cycles without pregnancy can become emotionally exhausting.

This is why counselling should be part of infertility care.

A patient should leave a consultation understanding what we know, what remains uncertain and what the next logical step is.

She should not leave with more fear than when she arrived.

PCOS and Mental Health

Women with PCOS can also experience increased psychological burden.

Acne, hirsutism, weight concerns and fertility problems can affect confidence and quality of life.

The international PCOS guideline specifically highlights the psychological impact of the condition and encourages attention to mental health as part of comprehensive management.

Treatment should therefore not focus only on making periods regular.

The woman should be treated as a whole person.

Fertility Treatment: A Stepwise Approach

WHO's 2025 infertility guideline emphasizes evidence-based treatment pathways according to the diagnosed cause rather than a one-treatment-for-all model. It includes recommendations addressing ovulatory dysfunction, tubal disease, uterine disorders, male factors and unexplained infertility.

For some women, appropriately timed intercourse and lifestyle optimization are enough.

A woman with anovulatory PCOS may require ovulation induction.

A woman with mild selected tubal disease may be considered for tubal intervention.

A woman with severe bilateral tubal disease may be better served by IVF.

A couple with unexplained infertility may need an entirely different pathway.

This is why treatment should follow diagnosis.

IVF Is Not a Failure of Natural Treatment

Some patients are frightened when IVF is mentioned.

They feel that being advised IVF means their body has "failed."

I explain that IVF is simply a medical technique that bypasses certain reproductive barriers.

If both fallopian tubes are severely damaged, IVF allows eggs and sperm to meet outside the tubes.

In such a situation, continuing medicine for years in the hope that severe fibrosis will suddenly disappear may waste valuable reproductive time.

The ethical obligation of a fertility physician is to explain this clearly.

My Specialized Approach as Dr. Nizamuddin Qasmi

As **Founder & Chief Physician of Saira Health Care**, with a focused practice in sexual disorders and infertility, I follow an individualized approach rather than prescribing one fertility formula to every woman.

My assessment begins with the most basic but most important question:

Why is pregnancy not occurring?

If the problem appears to be PCOS, I evaluate menstrual pattern, metabolic factors, androgen symptoms, ultrasound findings where appropriate and the woman's reproductive goals.

If tubal disease is suspected, I consider the history of pelvic infection, previous surgery, ectopic pregnancy or endometriosis and advise appropriate tubal evaluation.

If ovarian reserve is a concern, I interpret AMH and other findings in the context of age rather than frightening a patient from one laboratory value.

If thyroid or prolactin abnormalities are suspected, they are investigated and treated appropriately.

At the same time, the male partner is evaluated rather than allowing the woman to carry the entire diagnostic burden.

After identifying the principal problem, I may integrate **Unani dietotherapy, lifestyle regulation and individualized supportive pharmacotherapy** where clinically suitable.

The purpose is not simply to make a menstrual cycle appear regular. The objective is to improve the couple's realistic pathway toward conception while protecting long-term reproductive health.

Why Dr. Qasmi's Treatment Is Individualized

Infertility is not one disease.

Therefore, there cannot be one medicine that is appropriate for every patient.

A woman with PCOS and insulin resistance requires different management from a woman with bilateral hydrosalpinx.

A 25-year-old woman with irregular ovulation requires different counselling from a 40-year-old woman with diminished ovarian reserve.

A woman with normal fertility findings but a husband with severe oligospermia requires a couple-based treatment plan rather than repeated female treatment.

This is why my approach at Saira Health Care is based on **clinical history, appropriate investigation, reproductive age, cause of infertility and individualized Unani assessment**.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, our work in infertility overlaps closely with sexual and reproductive health.

Some couples are unable to conceive because intercourse itself is difficult due to erectile dysfunction, premature ejaculation, vaginismus, painful intercourse or other sexual concerns.

Others have hormonal or structural fertility problems.

Some couples have both male and female factors.

Our objective is therefore not limited to prescribing fertility medicine.

We aim to educate couples, interpret investigations in understandable language, identify the likely cause, determine when modern reproductive intervention is necessary and integrate Unani supportive care where it can add genuine value.

A fertility clinic should help patients avoid two opposite mistakes: **undertreatment of a significant medical problem and overtreatment of normal reproductive variation.**

Important Scientific Corrections to Common Female Fertility Claims

Several claims frequently seen online require caution.

A high LH/FSH ratio is **not by itself diagnostic of PCOS**.

A single progesterone value cannot reliably measure "luteal quality," and isolated luteal-phase deficiency remains controversial.

Low AMH does not mean pregnancy is impossible.

High AMH does not guarantee pregnancy.

No herbal medicine has been demonstrated conclusively to reverse reproductive ageing.

No oral medicine should be guaranteed to reopen severely scarred fallopian tubes.

Uttar Basti should not be described as standard Unani therapy.

Supplements such as DHEA, melatonin or high-dose antioxidants should not automatically be recommended to every woman trying to conceive.

Correcting these points does not weaken integrative medicine. It protects patients from unnecessary treatment.

Frequently Asked Questions

What are the most common causes of female infertility?

Important causes include ovulatory disorders such as PCOS, fallopian-tube disease, endometriosis, uterine conditions, age-related reproductive decline and endocrine disorders. In some couples more than one factor is present. WHO's latest infertility guideline recognizes abnormalities of the ovaries, uterus, fallopian tubes and endocrine system among major female causes.

Is PCOS curable permanently?

PCOS is generally considered a chronic endocrine-metabolic condition rather than a short-term infection that can simply be eradicated. Symptoms and reproductive effects can often be managed very effectively through lifestyle and appropriate medical treatment.

Can women with PCOS become pregnant naturally?

Yes. Many women with PCOS conceive naturally, while others require ovulation treatment. The international guideline specifically advises reassuring women that pregnancy can often be achieved naturally or with assistance.

What is the first-line fertility medicine for PCOS?

For anovulatory infertility caused by PCOS without another infertility factor, the international evidence-based guideline recommends letrozole as first-line pharmacological ovulation induction where appropriate and permitted.

Can Unani medicine help PCOS?

Unani medicine may provide useful **individualized supportive management**, particularly through diet, physical activity, metabolic-health support, sleep, constitution and selected traditional medicines. It should be integrated responsibly and should not delay evidence-based fertility treatment when it is needed.

Can blocked fallopian tubes be treated?

Treatment depends on where the blockage is located and how severely the tube is damaged. Selected proximal or mild distal disease may sometimes be managed surgically, while severe bilateral damage may be better managed with IVF.

Can Unani medicine definitely reopen fallopian tubes?

There is not sufficient high-quality evidence to guarantee that Unani medicine can reopen severely scarred or fibrotic tubes. Appropriate tubal imaging should determine the anatomy before prolonged treatment.

What is the best test for fallopian-tube blockage?

HSG is commonly used as a first-line test for tubal patency. Sonographic contrast methods are also used in appropriate settings.

Does low AMH mean there are no eggs?

No. AMH provides information about ovarian reserve but should not be interpreted as a direct fertility verdict.

Can a woman improve egg quality after 35?

General reproductive health can be supported through healthy lifestyle, avoidance of tobacco and appropriate medical management, but there is no proven treatment that completely reverses age-related oocyte ageing.

Is smoking harmful for female fertility?

Yes. WHO's September 2026 evidence summary reported a significantly increased infertility risk among women who currently smoke and recommends fertility counselling and cessation support.

Does high prolactin affect pregnancy?

Significant hyperprolactinaemia can interfere with GnRH signalling and ovulation. It should be investigated when clinically indicated rather than assumed in every case.

Does every woman need progesterone treatment?

No. Progesterone has clear roles in particular reproductive and obstetric settings, but there is no evidence that routine progesterone improves fertility in every natural cycle.

Should the husband also be evaluated?

Yes. Parallel male evaluation is recommended when infertility is being investigated.

My Final Message to Women With Fertility Problems

Whenever a woman comes to me because pregnancy is not happening, I want her to understand one thing before anything else:

Infertility is not one disease, and you should not be treated from one report alone.

If you have PCOS, we need to know whether you are ovulating and whether metabolic or hormonal factors are contributing.

If your tubes are reported as blocked, we need to know where the blockage is, how severe it is and whether the finding is reliable.

If your AMH is low, we need to interpret it according to your age and overall reproductive picture rather than telling you that pregnancy is impossible.

If thyroid, prolactin or another endocrine problem is present, we should treat the actual abnormality.

And we must never forget the male partner.

My training in the **Unani system of medicine** teaches me to consider *Mizaj*, diet, lifestyle, digestive health, sleep, emotional wellbeing and the whole constitution of the patient. The supplied background appropriately emphasizes this broader integrative view of female reproductive health.

Modern reproductive medicine gives us equally valuable tools: hormonal evaluation, ultrasound, HSG, ovarian-reserve assessment, evidence-based ovulation induction, tubal surgery and IVF.

I believe these approaches should be used intelligently rather than placed in opposition.

At **Saira Health Care**, my aim is therefore:

to diagnose before treating, to individualize rather than generalize, to use Unani medicine where it can genuinely support the patient, and to recommend modern fertility treatment when structural or endocrine disease requires it.

Our goal is not to promise every woman a "100% natural pregnancy." Such promises are neither scientific nor ethical.

Our goal is to provide a **clear, medically responsible and personalized pathway toward conception**, while respecting the woman's health, time, reproductive potential and preferences.

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** focuses on sexual disorders and infertility, with emphasis on confidential consultation, couple-based fertility evaluation, appropriate modern diagnostic investigation and individualized integration of Unani supportive care.

Website: www.sairahealthcare.com

Medical Disclaimer

This article is provided for **general education and public awareness** and does not constitute an individual diagnosis, prescription or guarantee of pregnancy.

Female infertility can result from multiple conditions, and treatment should be based on appropriate assessment of both partners. Unani medicines, herbs, supplements, purgative regimens or regimenal therapies should not be used to delay indicated hormonal treatment, infection treatment, surgery, IVF or other evidence-based reproductive care.

Claims regarding herbal treatment of PCOS, restoration of egg quality or non-surgical reopening of fallopian tubes remain areas in which the quality of evidence varies

substantially. Patients should seek individualized advice from appropriately qualified professionals before beginning fertility treatment.