

Hypospermia (Low Semen Volume) and Qillat-e-Mani in Unani Medicine: Causes, Diagnosis, Fertility Impact and Integrative Treatment

Introduction

Hypospermia is a male reproductive-health finding in which the **volume of semen released during ejaculation is lower than expected**. It is commonly discovered during semen analysis performed as part of a fertility assessment, although some men seek medical advice because they themselves notice that the amount of ejaculate has decreased.

An important terminology correction is necessary at the outset: **hypospermia refers to low semen volume, not necessarily a low number of sperm**. Semen is the fluid ejaculated from the male reproductive tract, whereas spermatozoa are the reproductive cells carried within that fluid. A man can therefore have a low semen volume with a reasonable sperm concentration, or a normal semen volume with a low sperm concentration.

According to the current World Health Organization sixth-edition semen-analysis framework, reflected in the 2026 European Association of Urology guidance, the lower fifth-percentile reference value for semen volume is **1.4 mL per ejaculate**. Older literature frequently used 1.5 mL, which explains why that figure still appears on many websites and older reports. Importantly, 1.4 mL is a **reference value, not an absolute line separating fertile men from infertile men**.

Hypospermia deserves proper evaluation when it is persistent, particularly when accompanied by infertility, azoospermia, severe oligozoospermia, painful ejaculation, a “dry” orgasm, hormonal symptoms, previous pelvic surgery, diabetes, or other reproductive-health concerns.

From the Unani perspective, disorders involving reduced seminal quantity have traditionally been discussed under concepts such as **Qillat-i-Mani**. However, the terminology requires careful interpretation because authoritative Unani literature also uses Qillat-i-Mani for **oligospermia or reduced spermatozoal quantity**. The Central Council for Research in Unani Medicine describes Qillat-i-Mani as a form of sexual debility characterized by scanty semen production and classifies it under oligospermia. Therefore, Qillat-i-Mani and modern hypospermia overlap conceptually but are not exact one-to-one diagnostic equivalents.

A modern integrative approach should therefore combine the holistic strengths of Unani medicine with accurate semen analysis, reproductive examination, hormonal evaluation, imaging when required, and evidence-based management of structural or medical causes.

What Exactly Is Semen?



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Semen is not composed only of sperm.

During ejaculation, sperm originating from the testes and epididymides are mixed with secretions from several male reproductive glands. The seminal vesicles and prostate contribute most of the seminal fluid, while spermatozoa themselves represent only a relatively small portion of total ejaculate volume.

This distinction explains why semen volume and sperm concentration are different measurements.

A patient can have:

Finding	Meaning
Low semen volume	Hypospermia
Low sperm concentration	Oligozoospermia
No sperm detected	Azoospermia
Poor sperm movement	Asthenozoospermia
High proportion of abnormal sperm forms	Teratozoospermia
No ejaculate released	Anejaculation or another ejaculatory disorder, depending on cause

The WHO/EAU 2021 reference distribution currently lists a semen volume of **1.4 mL**, sperm concentration of **16 million/mL**, total sperm number of **39 million per ejaculate**, progressive motility of **30%**, total motility of **42%**, and normal morphology of **4%** as lower fifth-percentile reference values. These numbers should always be interpreted together rather than individually.

Why the 1.4 mL Value Should Not Be Treated as a Fertility “Pass or Fail” Test

Patients frequently become alarmed when their semen report shows a volume such as 1.2 or 1.3 mL.

This result deserves attention, but it does not automatically diagnose infertility.

The current reference limits were calculated from approximately 3,500 men whose partners achieved natural conception within 12 months. The EAU specifically emphasizes that these fifth-percentile values **do not represent boundaries between fertile and infertile men**.

Fertility depends on the combined reproductive potential of both partners and on several semen characteristics simultaneously.

A man with a semen volume below 1.4 mL may still achieve natural conception.

Conversely, a man with 3 mL of semen may experience infertility because sperm concentration, motility, morphology, DNA integrity, reproductive anatomy, or another factor is abnormal.

The entire clinical picture matters.

Why Semen Volume Can Vary Naturally

Semen volume can vary between ejaculations even in the same man.

Factors such as the interval since the previous ejaculation and whether the entire specimen was collected can significantly affect laboratory results.

The current WHO manual recommends semen collection after approximately **2–7 days of ejaculatory abstinence**, and the complete sample should be collected. Missing any portion—especially the early fraction—can distort interpretation.

Therefore, before diagnosing persistent hypospermia, the clinician should first ask:

Was the entire sample collected?

Was some semen spilled?

Was the collection container appropriate?

Was the abstinence period unusually short?

Were the instructions followed correctly?

Was the test repeated?

A technically poor semen collection can create an apparent abnormality where no persistent disease exists.

Common Causes of Hypospermia

Low semen volume is not a single disease with one cause.

A classic review of low-volume ejaculation divides causes into collection-related factors, psychogenic factors, and pathological conditions such as retrograde ejaculation, failure of emission, ejaculatory-duct obstruction, congenital abnormalities of the seminal vesicles or vas deferens, hypogonadism, and other reproductive disorders.

Understanding the underlying cause is therefore the most important step in treatment.



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1. Incomplete Semen Collection

This is one of the simplest and most frequently overlooked explanations.

The patient may lose part of the sample during collection, particularly the first portion.

Because the entire ejaculate needs to be measured, even a small amount lost outside the specimen container can produce an artificially low recorded volume.

WHO guidance specifically instructs that the whole sample should be collected and any lost fraction reported to the laboratory.

Before ordering expensive investigations, this possibility should always be reviewed.

2. Short Interval Between Ejaculations

Frequent ejaculation can temporarily reduce the volume of individual ejaculates.

This is physiological rather than a disease.

The WHO continues to use a standardized 2–7 day abstinence interval for diagnostic semen analysis partly because ejaculation frequency influences semen measurements. Longer abstinence generally increases sperm output, although it can influence other sperm characteristics as well.

Therefore, a man who ejaculated shortly before the test may obtain a different semen-volume result from a properly standardized repeat test.

3. Retrograde Ejaculation

Retrograde ejaculation occurs when semen travels backward into the urinary bladder instead of being expelled normally through the penis.

A patient may experience:

a very small amount of semen, almost no visible semen, or a “dry orgasm.”

The urine after orgasm may appear cloudy because semen has entered the bladder.

Current EAU guidance describes retrograde ejaculation as complete or partial failure of forward ejaculation caused by semen passing backward through the bladder neck.

Recognized causes include neurological disease, diabetes-related autonomic neuropathy, previous pelvic or prostate surgery, bladder-neck dysfunction, some medications—particularly alpha-adrenergic blockers—and other neurological or anatomical problems.

Retrograde ejaculation can therefore be especially relevant in men with:



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diabetes, previous prostate surgery, spinal-cord or nerve disease, certain pelvic operations, or medication exposure.

When semen volume is very low or absent, EAU guidance advises looking for sperm in urine after ejaculation as part of evaluation in appropriate patients.

4. Ejaculatory Duct Obstruction

The ejaculatory ducts carry reproductive secretions into the urethra.

Partial or complete blockage can reduce semen volume and interfere with sperm transport.

Ejaculatory-duct obstruction may be congenital or acquired and may involve:

ductal narrowing, cysts, inflammation, calcification, previous infection, or structural abnormalities.

It is uncommon but clinically important because it can sometimes be surgically correctable.

Current EAU guidance recommends considering **transrectal ultrasound (TRUS)** when semen volume is low and the semen is acidic in a man with severe oligozoospermia or azoospermia where obstruction is suspected. TRUS can evaluate the seminal vesicles, ejaculatory ducts, cysts, dilatation, hypoplasia, or other structural abnormalities.

AUA/ASRM guidance similarly highlights low-volume, acidic semen with azoospermia as a pattern that should raise suspicion for distal reproductive-tract obstruction.

5. Congenital Absence of the Vas Deferens or Seminal Vesicle Abnormalities

Some men are born with abnormalities affecting the vas deferens, seminal vesicles, or associated reproductive ducts.

Congenital bilateral absence of the vas deferens, often associated with **CFTR gene abnormalities**, can present with very low semen volume, acidic semen, and azoospermia.

The EAU notes that men with azoospermia, very low semen volume and acidic pH should be carefully examined for congenital absence of the vas deferens. Genetic testing becomes important when such abnormalities are found.

In these situations, drinking more water or taking a “semen booster” cannot correct the anatomical problem.

A precise diagnosis is essential.

6. Hormonal Deficiency and Hypogonadism



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Adequate androgen activity contributes to normal function of the male accessory reproductive glands.

Men with significant hypogonadism may have reduced secretory activity and lower semen volume alongside symptoms such as:

reduced libido, decreased spontaneous erections, fatigue, reduced muscle mass, infertility, or small testes depending on the cause.

Current male-infertility guidelines recommend hormonal assessment—including testosterone and gonadotropins—when clinical or semen findings suggest testicular or endocrine dysfunction.

One very important fertility point is that **testosterone replacement should not be used as a treatment for male infertility in men actively trying to conceive**, because external testosterone can suppress normal sperm production. Current EAU guidance explicitly advises against testosterone therapy for infertile men seeking fatherhood.

7. Diabetes and Neurological Disease

Long-standing diabetes can damage autonomic nerves.

These nerves contribute to normal bladder-neck closure and coordinated ejaculation.

Diabetic autonomic neuropathy can therefore contribute to retrograde ejaculation or other ejaculatory disorders, resulting in reduced forward semen volume.

Neurological disorders, spinal-cord injury, multiple sclerosis, and certain pelvic neurological injuries can similarly disturb ejaculation.

The treatment in these cases must address the neurological or metabolic problem—not merely the visible semen quantity.

8. Medicines and Previous Surgery

Certain medications can interfere with ejaculation.

Alpha-1 adrenergic blockers used for urinary symptoms or prostate disease are particularly well recognized for their effects on ejaculation.

Some antidepressants, antipsychotics, blood-pressure medicines, and other drugs may also influence ejaculatory function in selected patients.

Surgery affecting the prostate, bladder neck, retroperitoneum, or pelvic nerves may alter ejaculation as well.



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A complete medication and surgical history is therefore an essential part of evaluating low ejaculate volume.

Patients should not stop prescribed medicines without professional advice.

9. Prostate or Seminal Vesicle Disease

Because accessory reproductive glands contribute significantly to semen, disease affecting them may influence ejaculatory volume.

Inflammation, infection, congenital abnormalities, cysts, or obstruction involving the seminal vesicles or prostate may contribute in selected patients.

Symptoms such as painful ejaculation, blood in semen, pelvic discomfort, urinary burning, fever, or recurrent infection should prompt proper urological assessment rather than treatment based solely on semen quantity.

10. Psychological or Ejaculatory Dysfunction

Some men have difficulty producing a complete ejaculate during laboratory collection because of anxiety, unfamiliar surroundings, difficulty reaching orgasm, or psychogenic ejaculatory dysfunction.

The result may be an incomplete sample or reduced emission.

A detailed sexual history can help distinguish true low-volume ejaculation from collection-related difficulties.

Does Smoking Cause Hypospermia?

Smoking is associated with poorer overall semen quality and male reproductive health, although it should not be described as the universal direct cause of low semen volume.

Current EAU evidence identifies smoking as negatively associated with sperm parameters and recommends smoking cessation as part of fertility care.

Stopping smoking is therefore advisable for men planning pregnancy, even though it cannot be promised that quitting alone will normalize semen volume.

Alcohol and Semen Health

High alcohol consumption can negatively affect male reproductive and hormonal health.



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Current EAU evidence distinguishes moderate intake from chronic high intake and notes that heavy alcohol consumption is associated with poorer fertility and reduced testosterone.

Reducing excessive alcohol use is therefore appropriate in men experiencing infertility or abnormal semen parameters.

Again, this is part of overall reproductive care, not a stand-alone treatment for every cause of hypospermia.

Obesity and Physical Activity

Obesity, metabolic syndrome, and low physical activity are relevant to male reproductive health.

Current EAU guidance recommends lifestyle improvement—including weight management and appropriate physical activity—because these factors can influence hormonal function and sperm quality.

Moderate regular exercise is preferable to extremes.

Men using anabolic steroids for bodybuilding should inform their clinician because anabolic-androgenic drugs can significantly suppress sperm production.

Symptoms of Hypospermia

Hypospermia itself may cause no physical symptoms other than reduced ejaculate volume.

Some men notice that less fluid appears during orgasm, while others only discover the finding during infertility testing.

Associated symptoms depend on the underlying cause.

A patient with retrograde ejaculation may describe a dry or nearly dry orgasm and cloudy urine afterward.

A patient with hormonal deficiency may report low libido or fatigue.

A patient with obstruction may have infertility, low semen volume, azoospermia, or painful ejaculation.

A patient with infection or inflammation may experience pelvic pain, burning urination, painful ejaculation, fever, or blood in the semen.

Therefore, symptoms around the hypospermia can often provide more diagnostic information than the semen volume alone.



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Does Low Semen Volume Mean Low Fertility?

Not automatically.

Semen volume influences the **total sperm number per ejaculate**, because:

Total sperm number = semen volume × sperm concentration.

For example, a man with 1 mL of semen containing 60 million sperm/mL has a different reproductive profile from a man with 1 mL containing only 2 million sperm/mL.

Similarly, low-volume semen associated with obstruction or absent seminal-vesicle secretions may be more clinically significant than a mildly low volume caused by incomplete collection.

The EAU emphasizes that semen analysis as a whole—not one individual parameter—should be interpreted when assessing fertility.

Hypospermia Is Not the Same as Oligospermia

This is one of the most important educational points.

Hypospermia

Low **volume of semen**.

Oligozoospermia

Low **concentration of sperm** within semen.

Azoospermia

No sperm detected in the ejaculate after appropriate laboratory assessment.

A patient can have hypospermia without oligozoospermia.

He can also have oligozoospermia with a normal semen volume.

The distinction determines the diagnostic pathway.

Hypospermia Is Not the Same as “Watery Semen”

Patients commonly judge semen by appearance.

Thin-looking or watery semen does not necessarily mean semen volume is low, sperm count is low, or fertility is impaired.

Semen appearance changes naturally during liquefaction after ejaculation.



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Reliable assessment requires laboratory semen analysis rather than visual interpretation.

How Hypospermia Is Diagnosed

Proper Semen Analysis

Diagnosis starts with correctly performed semen analysis.

WHO-standard collection requires approximately 2–7 days of abstinence and complete collection of the ejaculate. The laboratory should know if any portion was lost.

If the baseline result is abnormal, current EAU guidance recommends performing **at least two consecutive semen analyses** before proceeding with further andrological investigation.

This avoids over-diagnosing a temporary or collection-related abnormality.

What the Semen Report Should Be Reviewed For

The clinician should not examine volume alone.

Important accompanying information includes:

Parameter	Why It Matters
Semen volume	Confirms whether the ejaculate is low volume
Sperm concentration	Helps determine whether sperm production/output is reduced
Total sperm number	Combines concentration with ejaculate volume
Motility	Shows how effectively sperm move
Morphology	Assesses sperm shape
pH	Very acidic low-volume semen may suggest absent seminal-vesicle contribution or obstruction
Azoospermia/severe oligozoospermia	Can substantially change the differential diagnosis
Clinical history	Helps identify collection, endocrine, neurological, medication or surgical causes

The current EAU consensus threshold for semen pH is above 7.2, although interpretation depends on the full clinical picture.



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Medical and Reproductive History

A detailed history may explore fertility duration, previous pregnancies, ejaculation pattern, whether orgasm occurs normally, whether urine becomes cloudy afterward, diabetes, medication use, pelvic surgery, urinary symptoms, infections, congenital abnormalities, sexual function, testosterone-related symptoms, and whether the sample was fully collected.

History can often reveal the probable diagnosis before advanced testing.

Physical Examination

Male fertility evaluation may include assessment of:

testicular size and consistency, epididymides, presence of the vas deferens, varicocele, secondary sexual characteristics, genital anatomy, and other abnormalities.

EAU guidance emphasizes examination of the vas deferens and epididymis because absence or obstruction may explain abnormalities in semen volume and sperm transport.

Post-Ejaculatory Urine Examination

When retrograde ejaculation is suspected, the patient's urine after orgasm may be examined for sperm.

The presence of substantial sperm in post-ejaculatory urine in the correct clinical setting can support retrograde ejaculation.

The EAU specifically states that when ejaculate volume is low or absent in an obstructive infertility work-up, sperm should be sought in urine after ejaculation.

Interpretation should be performed by an experienced clinician because small numbers of sperm may sometimes appear in urine even without clinically significant retrograde ejaculation.

Hormonal Testing

Hormonal investigation is selected according to the patient's findings.

Possible tests may include testosterone, FSH, LH, and prolactin when indicated.

This is particularly relevant in patients with low libido, erectile dysfunction, very low sperm concentration, azoospermia, small testes, or signs of hormonal abnormality.



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Hormonal treatment should be directed toward a documented disorder rather than prescribed empirically to “increase semen.”

Transrectal Ultrasound

TRUS is not required for every man with low semen volume.

Current EAU guidance recommends it particularly when there is:

low semen volume + acidic semen + severe oligozoospermia or azoospermia + suspicion of obstruction.

It can help detect:

ejaculatory-duct cysts, seminal-vesicle dilatation, hypoplasia, agenesis, or other abnormalities.

Routine imaging without a clinical indication can generate incidental findings and unnecessary anxiety.

Genetic Testing

When congenital absence of the vas deferens is identified, CFTR-related genetic evaluation may be appropriate.

The EAU specifically recommends CFTR testing when unilateral or bilateral absence of the vas deferens or seminal-vesicle agenesis is found.

Genetic counselling is particularly important when a couple is considering assisted reproductive technology.

Modern Treatment of Hypospermia

There is no single medicine that treats every patient with low semen volume.

Treatment depends entirely on the cause.

If Collection Technique Is the Problem

The semen analysis should simply be repeated using proper collection instructions.

This may be the only intervention necessary.

Patients should avoid unnecessary medication until a true abnormality has been confirmed.



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If Frequent Ejaculation Is the Cause

A standardized abstinence period before repeat semen testing can clarify whether the low volume was temporary.

Frequent sexual activity is not itself a disease and does not require medication merely because one ejaculate has a smaller volume.

If Retrograde Ejaculation Is Present

Management depends on the cause.

The clinician may review medications that impair bladder-neck function, manage diabetes or neurological disease, and consider selected pharmacological approaches where appropriate.

For fertility, sperm may sometimes be recovered from post-ejaculatory urine or obtained using assisted reproductive techniques.

Current EAU neuro-urology guidance describes clinician-directed pharmacological and sperm-retrieval approaches for retrograde ejaculation in selected neurological patients.

No patient should self-medicate with sympathomimetic drugs because these can affect blood pressure and cardiovascular health.

If Ejaculatory Duct Obstruction Is Confirmed

Treatment can include a surgical procedure such as transurethral resection or incision of the ejaculatory ducts in appropriately selected patients, or sperm retrieval combined with assisted reproduction.

AUA/ASRM guidance recognizes both surgical correction and sperm-retrieval approaches for infertility caused by confirmed ejaculatory-duct obstruction.

The decision depends on anatomy, semen parameters, patient preference, and the fertility status of the female partner.

If Infection Is Present

Appropriate antimicrobial treatment should target the diagnosed infection.

Antibiotics should not be prescribed simply because semen volume is low.



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Evidence of prostatitis, urethritis, epididymitis, or other reproductive-tract infection should guide treatment.

If a Hormonal Disorder Is Present

Hormonal treatment should address the actual endocrine abnormality.

For example, men with hypogonadotropic hypogonadism who desire fertility may receive specialist gonadotropin therapy to stimulate spermatogenesis.

External testosterone is generally inappropriate for men actively trying to conceive because it can suppress sperm production.

Assisted Reproductive Technology

When low semen volume occurs together with severe sperm abnormalities or irreversible reproductive-tract abnormalities, assisted reproductive techniques may be considered.

Depending on the couple, these can involve sperm retrieval, intrauterine insemination, IVF, or ICSI.

The reproductive health and age of the female partner should be considered at the same time. EAU guidance strongly recommends evaluating both partners rather than managing the male factor in isolation.

Lifestyle Treatment: What Can and Cannot Be Promised

Improving lifestyle is worthwhile because overall metabolic health and reproductive health are connected.

Current EAU evidence associates obesity, low physical activity, smoking, and heavy alcohol intake with poorer sperm quality and recommends lifestyle improvement for infertile men.

However, lifestyle modification should not be presented as a guaranteed way to increase semen volume.

A congenital absence of the vas deferens, ejaculatory-duct obstruction, or retrograde ejaculation cannot be corrected simply by eating better foods.

Lifestyle therapy works best when directed at modifiable risk factors.

Zinc, Selenium, Vitamin E and “Fertility Supplements”



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Zinc, selenium, vitamin E and other micronutrients play biological roles in human health, but this does not mean that routinely taking supplements will correct hypospermia.

Current AUA/ASRM guidance states that the clinical benefit of antioxidant and vitamin supplements in male infertility is of **questionable utility**, with insufficient evidence to recommend particular agents universally.

The 2026 EAU guideline similarly concludes that antioxidant evidence remains conflicting and advises against routinely treating idiopathic male infertility with antioxidants.

A nutritious diet is sensible.

Blind supplementation is not a substitute for diagnosis.

Hypospermia in the Unani System of Medicine

Unani medicine approaches reproductive disorders through the condition of the entire individual rather than focusing exclusively on one laboratory value.

The classical concept of **Qillat-i-Mani** describes reduced seminal production and reproductive weakness within the framework of Unani physiology.

The authoritative CCRUM *Standard Unani Treatment Guidelines for Common Diseases* describes Qillat-i-Mani as a condition characterized by scanty semen production and traditionally associates it with factors such as general debility, inadequate nutrition, altered temperament of the semen-producing organs—including excess heat, coldness, dryness, or moisture—and excessive evacuation.

Traditional Unani understanding therefore evaluates both the quantity of the reproductive material and the patient's broader constitutional state.

A Terminology Point for Textbook Accuracy

Modern medicine separates:

semen volume,
sperm concentration, and
total sperm number

into different laboratory variables.

Classical Unani terminology developed before modern microscopic semen analysis and therefore does not always map perfectly to contemporary categories.

CCRUM formally translates Qillat-i-Mani as **oligospermia**, while also describing it as scanty semen production.



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For this reason, it is scientifically safer to write:

“Hypospermia may overlap with the traditional Unani concept of Qillat-i-Mani, although Qillat-i-Mani is broader and is also used in Unani literature for reduced sperm quantity/oligozoospermia.”

This preserves both traditions accurately.

Classical Unani Causes of Qillat-i-Mani

Within traditional Unani theory, reproductive health is influenced by **Mizaj**, the functional strength of organs, nourishment, digestion, and the qualitative balance of the body.

CCRUM's standard guideline describes possible traditional contributors such as:

general debility, undernutrition, altered heat or coldness of reproductive organs, excessive dryness or moisture, and excessive bodily depletion.

These are traditional concepts and should not be represented as biomedical equivalents of testosterone deficiency, duct obstruction, or infection.

Instead, they provide a traditional framework for individualized treatment.

Usul-e-Ilaj: Principles of Unani Treatment

The CCRUM guideline describes treatment principles tailored to the patient's apparent cause and temperament.

These include improving nutrition when poor nourishment is considered important, supporting digestion, encouraging psychological well-being, and using warming, cooling, or moistening interventions according to the traditional Mizaj assessment.

This individualized approach can be clinically valuable when combined with contemporary investigations.

For example, a patient may simultaneously benefit from:

nutritional correction within an Unani framework and modern treatment of diabetes or hormonal deficiency.

The systems need not be treated as mutually exclusive.

Ilaj-bil-Ghiza: Dietotherapy

Diet occupies an important place in Unani management.



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The objective is not simply to recommend one “sperm-increasing food” but to improve the patient's overall nutritional and metabolic state.

A contemporary diet plan may emphasize adequate protein, vegetables, fruits, whole grains, nuts, seeds, and appropriate healthy fats while being individualized for obesity, diabetes, digestive disease, and other medical conditions.

Traditional Unani dietary recommendations can then be tailored according to Mizaj and associated symptoms.

This approach is more defensible than claiming that any one food will automatically increase semen volume.

Ilaj-bil-Tadbeer: Regimental and Lifestyle Treatment

Lifestyle management may include regulation of sleep, appropriate exercise, stress management, moderation of unhealthy habits, improved nutrition, and correction of factors traditionally considered to weaken reproductive health.

Modern medicine supports several of these principles at the general fertility level.

Regular physical activity, weight management, tobacco cessation, and avoidance of heavy alcohol use are also recommended in contemporary male-fertility guidance.

This creates a useful practical overlap between Unani and modern reproductive care.

Ilaj-bil-Dawa: Unani Pharmacotherapy

Unani medicines may be chosen according to:

the patient's Mizaj, degree of weakness, digestive state, sexual and reproductive symptoms, semen-analysis pattern, associated medical problems, and the traditional nature of the imbalance identified by the physician.

The same medicine should not automatically be prescribed to every man with a semen volume below 1.4 mL.

A patient with retrograde ejaculation is clinically different from a patient with poor nutrition.

A patient with ejaculatory-duct obstruction is different from a patient with idiopathic mildly reduced semen volume.

A patient with severe oligozoospermia requires a different fertility evaluation altogether.

Individualization is therefore essential.



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What Does Research Say About Unani Treatment?

There is growing research interest in Unani therapy for male reproductive disorders, but an important limitation must be understood.

Most published clinical studies concern **oligozoospermia or sperm parameters**, not isolated modern hypospermia.

For example, a 2022 randomized controlled study investigated *Mucuna pruriens* in oligozoospermia within an Unani framework. Other research has evaluated traditional formulations in men with low sperm counts.

These studies are relevant to male infertility and the broader Unani concept of Qillat-i-Mani, but they should **not be used as direct proof that the same treatment increases semen volume in men with true hypospermia**.

Larger, high-quality trials specifically focused on low semen volume are still needed.

Dr. Qasmi's Nuskha No. 129 – Vitasem Max

Saira Health Care Pharmacy describes **Dr. Qasmi's Nuskha No. 129 – Vitasem Max** as a Unani formulation used for men's general weakness, low energy, and reproductive-health support, with the product page also making claims related to sperm count and semen quality. Its published formulation contains botanical as well as traditional mineral ingredients, and the page explicitly advises against self-medication and overdose.

[View Dr. Qasmi's Nuskha No. 129 – Vitasem Max](#)

Within Saira Health Care's clinical practice, Nuskha No. 129 may therefore be considered in selected patients whose broader presentation includes reproductive weakness or abnormal semen parameters.

However, its use should be described correctly:

the current product page's claims are clinic/manufacturer claims and do not constitute independent randomized evidence proving that Vitasem Max corrects every cause of hypospermia.

Patients with structural obstruction, retrograde ejaculation, congenital reproductive abnormalities, or significant endocrine disease need cause-specific management.

Dr. Qasmi's Nuskha No. 158

Saira Health Care Pharmacy describes **Nuskha No. 158** as a powder formulation intended for sexual strength and stamina, with published claims relating to libido, early ejaculation,



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sperm motility, and sperm count. Its listed ingredients include Kaunch, Safed Musli, Makhana, Talmakhana, and other components. The page states that it should be used as prescribed by a physician or nutrition professional.

[View Dr. Qasmi's Nuskha No. 158](#)

For textbook-level accuracy, it is important to note that the current product page primarily discusses sexual vitality, sperm count and motility rather than providing clinical evidence specifically for isolated low ejaculate volume.

Therefore, it should form part of **individualized Unani treatment when clinically selected**, rather than being presented as a universal hypospermia medicine.

Spermogenic Powder

Spermogenic Powder is particularly relevant to this article because the current Saira Health Care Pharmacy page specifically lists **low semen volume and watery semen** among its intended clinical uses.

The formulation contains a combination of traditional ingredients including Darchini, Asgand Nagori, Kaunch, Khulanjan, Salab preparations, Satawar and Musli Safed. The pharmacy recommends physician-guided use and currently lists 2 grams twice daily with cow's milk or water, or as directed by a physician.

[View Spermogenic Powder](#)

Again, the distinction between **product indication and independently established clinical efficacy** should be maintained.

The product may be incorporated into Dr. Qasmi's individualized Unani treatment strategy, but no powder can reverse an ejaculatory-duct obstruction or congenital absence of reproductive ducts.

Diagnostic accuracy must come first.

Why Combining Nuskha No. 129, Nuskha No. 158 and Spermogenic Cannot Be Standardized for Everyone

One patient may have a semen volume of 1.2 mL because he lost part of the sample during collection.

Another may have 0.5 mL of acidic semen with azoospermia because of ejaculatory-duct obstruction.

A third may have a normal sperm concentration but mild idiopathic low semen volume.



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A fourth may have hypogonadotropic hypogonadism.

A fifth may have retrograde ejaculation caused by diabetes.

It would be medically inappropriate to assume that all five require the same medicines.

At Saira Health Care, these formulations are best positioned as components of an **individualized Unani treatment programme** after the probable cause has been identified.

This approach strengthens rather than weakens the role of Unani medicine because it allows traditional treatment to be applied intelligently rather than generically.

The Specialized Approach of Dr. Nizamuddin Qasmi

Saira Health Care identifies **Dr. Nizamuddin Qasmi** as its founder and chief physician with a focused practice in sexual disorders and infertility.

His currently published Saira Health Care professional profile lists:

BUMS, MD, CGO, Certificate in Infertility, and Certificate in Urology – London, UK. The clinic describes his work as particularly focused on male and female sexual disorders and infertility, including azoospermia, oligozoospermia, abnormal sperm motility and morphology, varicocele, epididymal cyst, hormonal disorders, erectile dysfunction, premature ejaculation, and other reproductive-health problems.

According to credential information supplied by **Saira Health Care for this publication**, Dr. Qasmi has additionally completed **Masters in Male Infertility – Master Health Pro (MHPro)**.

Master Health Pro's published programme materials describe a six-month **Masters Course in Male Infertility** focused on andrology, semen analysis, reproductive physiology, diagnostic algorithms, sexual dysfunction and evidence-based male-infertility management.

For formal credential accuracy on the final website page, the title should ideally be written exactly as it appears on Dr. Qasmi's issued MHPro certificate.

Why Specialist Experience Matters in Hypospermia

Hypospermia is a good example of why male reproductive disorders cannot be managed solely by prescribing “sperm medicines.”

A specialist must distinguish among:

low semen volume, low sperm count, poor motility, azoospermia, retrograde ejaculation, ejaculatory-duct obstruction, hormonal disorders, congenital reproductive abnormalities, infection, sexual dysfunction, and collection error.



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The correct treatment is completely different for each.

A clinician experienced in both sexual medicine and infertility is therefore better positioned to interpret semen reports in the context of the patient's:

sexual function, fertility history, physical examination, hormonal status, lifestyle, and reproductive anatomy.

Saira Health Care's Contribution to Sexual Disorders and Infertility Care

Saira Health Care describes itself as a **registered Unani clinic specializing in sexual disorders and infertility**, with an approach combining traditional Unani medicine, modern diagnostic information, nutritional guidance and lifestyle modification.

The clinic's male-infertility services include educational and clinical work involving azoospermia, oligospermia, sperm motility abnormalities, abnormal morphology, varicocele, epididymal conditions and other reproductive problems.

One of the important contributions of a specialized centre is patient education.

Many men see a low semen volume and immediately believe:

“My sperm has finished.”

“I cannot become a father.”

“My masculinity is decreasing.”

“I need a semen-increasing medicine immediately.”

These conclusions are often incorrect.

Proper counselling can prevent anxiety, unnecessary self-medication and delayed diagnosis of genuine reproductive disease.

Psychological Impact of Hypospermia

Male fertility problems can affect self-confidence, relationships and emotional well-being.

Current EAU guidance recognizes that male infertility may create significant emotional distress and challenges to personal identity, and psychological support can form part of comprehensive infertility care.

A man should understand that semen volume does not define masculinity.

A laboratory finding is a medical parameter—not a measure of personal worth.



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This message is particularly important in South Asian societies where semen has traditionally been associated with strength and masculinity.

Common Myths About Hypospermia

Myth: Less semen always means fewer sperm.

Fact: Semen volume and sperm concentration are separate parameters.

Myth: Semen must always be at least 2–5 mL to achieve pregnancy.

Fact: The current WHO lower reference value is 1.4 mL, and even this is not an absolute fertility threshold.

Myth: Low semen volume means permanent infertility.

Fact: Many reversible or harmless factors can cause low volume.

Myth: Drinking more water will cure all cases.

Fact: Hydration supports general health but cannot correct obstruction, retrograde ejaculation, congenital abnormalities or hormonal disorders.

Myth: Testosterone injections increase male fertility.

Fact: External testosterone may suppress sperm production and is contraindicated as fertility treatment in men actively seeking fatherhood.

Myth: Any herbal powder can correct hypospermia.

Fact: Treatment must address the underlying cause.

Myth: A single semen analysis is enough.

Fact: Current EAU guidance recommends at least two consecutive analyses when the initial result is abnormal.

When Should a Man Seek Medical Advice?

Professional fertility or urological evaluation is particularly important if low semen volume persists on repeat properly collected tests, especially when accompanied by any of the following:

- infertility or difficulty achieving pregnancy;
- azoospermia or severe oligozoospermia;
- semen volume that is extremely low or nearly absent;



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- dry orgasm or cloudy urine after ejaculation;
 - painful ejaculation, blood in semen or pelvic pain;
 - diabetes or neurological disease;
 - previous prostate, bladder, pelvic or retroperitoneal surgery;
 - hormonal symptoms such as markedly reduced libido;
 - absent vas deferens or another genital abnormality;
 - urinary or reproductive-tract infection symptoms;
 - significant anxiety or relationship distress.
-

Frequently Asked Questions

Is hypospermia dangerous?

Hypospermia itself is usually not dangerous. Its significance depends on the cause.

Mild isolated low semen volume may represent normal variation or collection error, whereas very low volume with azoospermia may point toward an important reproductive-tract disorder.

What semen volume is considered low?

The current WHO sixth-edition reference distribution uses **1.4 mL** as the lower fifth-percentile reference value.

This does not mean every result below 1.4 mL represents infertility.

Can a man with 1 mL of semen become a father?

Yes, pregnancy may still be possible.

Fertility depends on sperm concentration, total sperm number, motility, morphology, female reproductive health and many other factors.

Does hypospermia mean low sperm count?

No.

Low semen volume is hypospermia.



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Low sperm concentration is oligozoospermia.

They can occur together or separately.

Can frequent sex reduce semen volume?

Frequent ejaculation can temporarily decrease the amount released in an individual ejaculate.

That is why standardized semen testing uses an abstinence interval before collection.

Can diabetes cause low semen volume?

Yes, particularly when diabetes causes autonomic nerve dysfunction leading to retrograde ejaculation or impaired ejaculation.

What does acidic, low-volume semen mean?

In the appropriate clinical setting, particularly with severe oligozoospermia or azoospermia, low-volume acidic semen can suggest reduced seminal-vesicle contribution or distal reproductive-tract obstruction.

Current guidelines recommend considering TRUS in such patients.

Can Unani medicine help?

Unani medicine offers a useful individualized framework involving Mizaj assessment, nutrition, digestion, lifestyle, stress, general strength and appropriately selected traditional pharmacotherapy.

Its greatest value in modern practice is achieved when it is combined with proper diagnostic assessment.

Structural obstruction, retrograde ejaculation, infections and endocrine disorders should not be overlooked.

Can Spermogenic increase semen volume?

Saira Health Care Pharmacy currently lists low semen volume and watery semen among the intended uses of Spermogenic Powder.



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However, this represents clinic/product information. High-quality independent clinical trials specifically proving normalization of semen volume in modern hypospermia have not been established.

It should therefore be considered under professional supervision rather than as a guaranteed cure.

Are Nuskha No. 129 and Nuskha No. 158 proven treatments for hypospermia?

Their current Saira Health Care product pages describe reproductive and sexual-health uses, including sperm-related support.

However, independent evidence specifically demonstrating that these formulations correct all causes of modern low-volume ejaculation is not established.

The appropriate role is individualized physician-guided use.

A Practical Integrative Treatment Model

A scientifically responsible contemporary approach can be summarized as:

Confirm true low semen volume → repeat properly collected semen analysis → review sperm concentration, total count, motility, morphology and pH → take detailed reproductive and sexual history → assess medications, diabetes and previous surgery → perform examination → investigate hormones, retrograde ejaculation or obstruction where indicated → correct the underlying cause → optimize lifestyle → integrate individualized Unani diet, regimen and pharmacotherapy when appropriate → monitor response.

This approach respects both contemporary reproductive science and the individualized philosophy of Unani medicine.

Prognosis

The outlook for hypospermia depends strongly on its cause.

Collection-related low volume may disappear entirely when the test is repeated properly.

Lifestyle-related reproductive impairment may improve with healthier habits.

Medication-related ejaculatory dysfunction may improve after appropriate clinician-supervised adjustment.



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Some cases of retrograde ejaculation can be managed medically or through fertility techniques.

Selected ejaculatory-duct obstructions can be treated surgically.

Congenital abnormalities may require assisted reproductive strategies rather than attempts to increase semen volume pharmacologically.

Therefore, the patient's prognosis is best understood after proper diagnosis.

Conclusion

Hypospermia is best defined as **reduced semen volume during ejaculation**, not as low sperm count.

This distinction is fundamental.

Under the current WHO sixth-edition reference framework, incorporated into 2026 EAU guidance, the lower fifth-percentile semen-volume reference is approximately **1.4 mL**. Older references using 1.5 mL are therefore outdated, although the difference is small. More importantly, the threshold is not an absolute boundary between fertility and infertility.

Hypospermia may result from something as simple as incomplete collection or frequent ejaculation, or from more significant conditions such as retrograde ejaculation, ejaculatory-duct obstruction, congenital absence of reproductive ducts, hormonal deficiency, diabetes-related neuropathy, medication effects or previous surgery.

Proper investigation therefore comes before treatment.

The Unani concept of **Qillat-i-Mani** provides an important traditional framework for understanding reduced reproductive quantity and general reproductive weakness. CCRUM's formal Unani guidelines describe Qillat-i-Mani in terms of scanty seminal production and individualized disturbances involving nutrition, physical strength and Mizaj, although the same term is also used for modern oligozoospermia.

This makes Unani medicine particularly valuable as a **whole-person treatment system**, provided the traditional diagnosis is integrated with modern semen analysis and appropriate medical investigation.

At **Saira Health Care**, Dr. Nizamuddin Qasmi's approach to sexual disorders and infertility can combine Unani principles such as individualized Mizaj assessment, Ilaj-bil-Ghiza, Ilaj-bil-Tadbeer and Ilaj-bil-Dawa with contemporary fertility investigations and lifestyle guidance. Saira Health Care's publicly listed qualifications for Dr. Qasmi include **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK**. According to additional credential information supplied by the clinic for publication, he has also completed **Masters in Male Infertility from Master Health Pro (MHPro)**.



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Dr. Qasmi's **Nuskha No. 129 – Vitasem Max, Nuskha No. 158 and Spermogenic Powder** may be considered within an individualized Unani programme for selected patients.

Spermogenic's current product information specifically includes low semen volume among its intended uses, while the other formulations are positioned for broader male reproductive and sexual-health support.

However, no traditional formulation should be represented as capable of correcting every cause of low semen volume.

A blocked ejaculatory duct requires evaluation for obstruction.

Retrograde ejaculation requires investigation of bladder-neck function and associated disease.

Hormonal deficiency requires endocrine evaluation.

Congenital reproductive abnormalities may require genetic and fertility management.

This is why the most effective modern philosophy is not simply:

“Increase the semen.”

It is:

“Find out why the semen volume is low, understand the patient's complete reproductive health, and then select the most appropriate individualized treatment.”

That diagnosis-led, patient-centred model allows contemporary male reproductive medicine and authentic Unani principles to complement one another responsibly.

About Saira Health Care

Saira Health Care describes itself as a registered Unani clinic in Barabanki, Uttar Pradesh, focused particularly on **sexual disorders and infertility**. Its stated treatment philosophy combines traditional Unani approaches with modern diagnostic insights, nutrition, lifestyle modification and individualized patient care.

[Visit Saira Health Care](#)

[Visit Saira Health Care Pharmacy](#)

Medical Disclaimer

This article is intended for **general medical education and reproductive-health awareness**. It does not provide an individual diagnosis and should not replace consultation, physical examination, semen analysis, laboratory testing, imaging or treatment by an appropriately qualified healthcare professional.

A low semen-volume result should be confirmed with properly collected semen analysis before treatment is started. Men with infertility, azoospermia, severe oligozoospermia, dry



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orgasm, painful ejaculation, blood in semen, significant hormonal symptoms, previous pelvic surgery or suspected retrograde ejaculation should obtain appropriate specialist evaluation.

Unani, herbal and nutritional formulations should be used under professional supervision. Natural products are not automatically free of adverse effects or interactions, and individual treatment outcomes vary.

No medicine, herbal formulation, supplement, diet, surgical procedure or lifestyle intervention can responsibly guarantee normalization of semen parameters or pregnancy for every patient.



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