Past Infections and Infertility: How Previous Infections Can Affect Male and Female Fertility Years Later

Understanding the Silent Reproductive Effects of Chlamydia, Gonorrhoea, Pelvic Inflammatory Disease, Genital Tuberculosis, Epididymitis, Mumps and Other Infections

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Introduction

In my clinical practice, I frequently meet couples who are surprised when I ask about infections that occurred several years earlier.

They may say, “Doctor, that infection was treated long ago. Why are you asking about it now?”

The reason is important. An infection may disappear, the pain may settle, the discharge may stop and laboratory tests may later become negative—but **damage caused by the inflammation can sometimes remain**. The organism and the injury it created are not always the same problem.

This is particularly relevant in reproductive medicine. Infection can sometimes leave behind scarring of the fallopian tubes in women, obstruction or inflammation of the male reproductive tract, or damage to testicular tissue. These changes may remain unnoticed until a couple begins trying to conceive.

The background material prepared for this article describes this phenomenon as the “silent legacy” of a previous infection—the possibility that reproductive difficulty seen today may represent a consequence of an infection experienced years earlier.

This is not merely a theoretical concern. In its first global guideline on infertility, published in November 2025, the World Health Organization specifically identifies **untreated sexually transmitted infections as a preventable cause of infertility**. WHO estimates that approximately **one in six people of reproductive age experience infertility during their lifetime**.

However, an equally important message is that **not every previous infection causes infertility**. Many infections are diagnosed and treated before permanent damage develops. When fertility difficulty occurs, we must investigate carefully rather than automatically blaming an old infection.

My aim in this article is to explain how infection-related infertility develops, how it differs between women and men, how we diagnose the possible damage, what modern treatment can achieve, and where responsible **Unani medicine can play a meaningful supportive and integrative role**.

What Is Post-Infectious Infertility?

Post-infectious infertility means difficulty achieving pregnancy because a previous infection contributed to damage or dysfunction in the reproductive system.

WHO continues to define infertility as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**. The cause may originate from the female partner, male partner, both partners, or sometimes remain unexplained even after appropriate investigation.

In women, WHO identifies blocked fallopian tubes as an important cause of infertility and notes that these blockages may result from untreated STIs as well as postpartum infection, unsafe abortion complications or previous abdominal and pelvic disease. In men, WHO recognizes reproductive-tract obstruction caused by injury or genital infection among possible causes of infertility.

Therefore, infection-related infertility is broader than simply “having an STI.” It is about the **consequences left behind after infection or inflammation**.

How Can an Infection Cause Infertility After It Has Gone?

The human body responds to infection with inflammation.

Inflammation is necessary. Immune cells travel to the infected area, inflammatory chemicals are released and damaged tissue begins to repair itself.

Usually this process ends successfully.

Sometimes, however, severe or repeated inflammation leads to **fibrosis**, commonly understood as scar formation.

A scar on the skin may be mainly cosmetic. A scar inside a fallopian tube or epididymal duct can be very different because these structures are extremely narrow and must remain functional for conception.

A woman may have cleared an infection but remain with narrowed or blocked fallopian tubes. A man may no longer have an active infection but retain scarring affecting sperm transport.

This distinction explains why antibiotics can eliminate a susceptible bacterium but **cannot automatically reverse mature scar tissue that has already formed**.

The uploaded source explores inflammatory and fibrotic mechanisms—including cytokine signalling, tissue remodelling and possible immune-mediated effects—as explanations for how a previous infection may leave lasting reproductive consequences. Some of these molecular pathways remain areas of ongoing research and should not all be treated as established clinical tests or treatment targets.

Why Chlamydia Is So Important in Fertility

Chlamydia trachomatis is particularly important because infection is frequently asymptomatic.

WHO's November 2025 update describes chlamydia as a preventable and curable bacterial STI and estimates approximately **128.5 million new infections among adults aged 15–49 worldwide in 2020**. Many infected people develop no symptoms or only very mild symptoms.

In women, untreated chlamydia may ascend from the cervix into the upper reproductive tract, producing **pelvic inflammatory disease**, or PID. This can subsequently increase the risk of fallopian-tube damage, infertility and ectopic pregnancy.

This is why I sometimes describe chlamydia to patients as a “silent reproductive infection.” The danger is not that every infection causes infertility—it does not—but that a person may not know treatment is needed because no obvious warning symptoms appear.

Gonorrhoea and Reproductive Damage

Gonorrhoea is caused by **Neisseria gonorrhoeae**.

WHO estimated approximately **82.4 million new gonorrhoea infections in adults worldwide in 2020**. Many women with gonorrhoea have no symptoms, while men more commonly develop urethral discharge and burning during urination.

When untreated, gonorrhoea may lead to pelvic inflammatory disease, ectopic pregnancy and infertility in women. WHO also recognizes reproductive complications in men, including scrotal inflammatory disease, urethral stricture and infertility in some cases.

Gonorrhoea has another important modern problem: **antimicrobial resistance**. The organism has developed resistance to multiple antibiotics, which is why patients should not repeatedly take random antibiotics for genital discharge without proper evaluation.

Pelvic Inflammatory Disease: The Main Link Between STIs and Female Infertility

PID is one of the clearest clinical links between infection and female infertility.

Pelvic inflammatory disease occurs when infection and inflammation spread into the upper female reproductive tract. It may affect the uterus, fallopian tubes and surrounding pelvic tissues.

Chlamydia and gonorrhoea are important causes, although PID can also occur through organisms that are not sexually transmitted.

Some women develop obvious lower abdominal pain, fever, painful intercourse or abnormal discharge. Others develop relatively mild disease.

This is medically important because **mild symptoms do not guarantee mild reproductive damage**.

CDC reports that approximately **one in eight women with a history of PID have difficulty becoming pregnant**.

How Fallopian-Tube Damage Prevents Pregnancy

For natural conception, sperm must travel through the reproductive tract and meet an egg, usually inside the fallopian tube.

The fertilized egg must then travel toward the uterus.

A healthy tube is therefore not simply an open pipe. Its internal lining and normal movement also matter.

When inflammation damages the tube, several different problems may occur.

The tube may become completely blocked. It may remain technically open but become functionally damaged. Adhesions may distort its relationship with the ovary. A damaged distal tube may accumulate fluid, producing **hydrosalpinx**.

These abnormalities can reduce the chances of natural conception.

Importantly, partial damage can increase the risk of **ectopic pregnancy**, where the pregnancy implants outside the normal uterine cavity, most commonly within a fallopian tube.

What Is Hydrosalpinx?

Hydrosalpinx develops when the end of a fallopian tube becomes obstructed and fills with fluid.

It is often associated with previous pelvic inflammation or infection.

Hydrosalpinx can prevent natural conception and may also adversely affect IVF outcomes in certain patients.

The American Society for Reproductive Medicine recommends addressing surgically irreparable hydrosalpinges before IVF in appropriate cases; laparoscopic salpingectomy is among established approaches for improving reproductive outcomes in selected patients.

No oral medicine—modern, herbal or Unani—should be promised as a guaranteed method of reopening a severely scarred hydrosalpinx.

Can Antibiotics Reverse Tubal Damage?

This question is extremely important.

Antibiotics treat the infection. They do not reliably remove established fibrosis.

When active chlamydia, gonorrhoea or PID is diagnosed, prompt antimicrobial treatment is important because it can control infection and help prevent additional damage.

But if both fallopian tubes have already become extensively scarred or obstructed, repeated courses of antibiotics will not necessarily restore normal anatomy.

The same principle applies to traditional medicine. An anti-inflammatory or supportive formulation should not be advertised as proven to dissolve severe tubal fibrosis unless robust clinical evidence demonstrates that effect.

This is why diagnosis must come before prolonged treatment.

Mycoplasma genitalium: An Emerging Reproductive Concern

Another organism receiving increasing attention is **Mycoplasma genitalium**.

CDC recognizes *M. genitalium* as a cause of urethritis in men and reports associations in women with cervicitis, PID, spontaneous abortion, preterm delivery and infertility. In women, studies have found approximately a twofold association with some of these reproductive outcomes, although important uncertainties remain, especially regarding asymptomatic infection.

For men, the evidence linking *M. genitalium* directly to epididymitis, prostatitis or infertility remains insufficient.

This is a good example of why modern fertility medicine must distinguish **established causes from emerging associations**.

Chronic Endometrial Inflammation and Implantation

Not all infection-related fertility problems involve the fallopian tubes.

Inflammation can also involve the **endometrium**, the tissue lining the inside of the uterus where an embryo implants.

Chronic endometritis has been investigated in patients with infertility, recurrent implantation failure and recurrent pregnancy loss. However, diagnostic definitions, testing strategies and estimates of prevalence vary considerably between studies.

The uploaded research discusses chronic endometritis and its possible relationship with altered endometrial immunity and implantation.

From a practical clinical perspective, chronic endometritis should **not** be diagnosed merely because a woman has infertility. Investigation should be selected for appropriate clinical circumstances rather than routinely treating every infertile patient with antibiotics.

Genital Tuberculosis and Infertility

For patients in regions where tuberculosis remains prevalent, **genital tuberculosis** deserves particular consideration.

Female genital tuberculosis can affect the fallopian tubes and endometrium, causing inflammation, fibrosis, adhesions or tubal obstruction. Infertility may sometimes be the presenting complaint.

Male genital tuberculosis can involve the epididymis, vas deferens or other parts of the genitourinary system and may cause obstruction.

The uploaded source describes genital tuberculosis as an important infection-related cause of severe reproductive scarring, particularly in endemic settings.

Diagnosis can be difficult and should be made using appropriate gynecological, urological and tuberculosis investigations rather than symptoms alone.

If genital TB is confirmed, **standard anti-tuberculosis treatment is essential**. WHO's current consolidated TB guideline provides contemporary evidence-based treatment recommendations for drug-susceptible and drug-resistant tuberculosis.

Unani medicine should not replace anti-tuberculosis therapy.

Male Infertility After Infection

In men, infection-related infertility is more complicated than it is often presented.

A previous infection can sometimes affect the epididymis, testis, prostate or sperm-carrying ducts. However, evidence does not support the idea that every past STI causes low sperm count or infertility.

The **2026 European Association of Urology Sexual and Reproductive Health guideline** states that infection of the male urogenital tract is a potentially treatable cause of male infertility, but evidence linking symptomatic or asymptomatic infections with impaired sperm quality and natural conception is inconsistent. It also notes that treating infection may sometimes improve sperm parameters without necessarily increasing the probability of conception.

This balanced position is very important.

I do not want a man to see an abnormal semen report and immediately believe that a hidden infection must be responsible.

Epididymitis and Sperm Transport

The epididymis is a long, highly coiled structure attached to the testicle. Sperm mature and travel through it before entering the vas deferens.

Chlamydia and gonorrhoea are recognized causes of acute epididymitis in sexually active men.

CDC's current guidance emphasizes treating sexually transmitted epididymitis promptly to eradicate infection, reduce transmission and decrease the potential for complications including chronic pain and infertility.

Most appropriately treated men do not become infertile.

However, severe bilateral inflammation can sometimes produce obstruction or reproductive impairment.

This is why persistent testicular or epididymal pain and swelling should not be ignored.

Can Infection Cause Obstructive Azoospermia?

Yes, in selected patients.

Azoospermia means that no sperm are detected in the ejaculate.

In obstructive azoospermia, sperm production inside the testes may remain adequate, but sperm cannot reach the ejaculate because the transport pathway is blocked.

Previous inflammation or infection is one possible cause of obstruction.

However, there are many other causes, including congenital abnormalities, previous surgery and genetic conditions.

A man with azoospermia therefore requires a structured evaluation. It is inappropriate to assume that it was caused by infection—or to simply prescribe repeated "sperm-producing" medicines without determining whether sperm can physically reach the ejaculate.

Infection, Inflammation and Sperm Quality

Inflammation can alter the biochemical environment in which sperm develop and travel.

Researchers have investigated whether inflammatory cells and oxidative stress can affect sperm motility, membrane integrity and DNA.

The uploaded background document discusses oxidative stress, sperm DNA fragmentation and inflammatory mechanisms as possible pathways of post-infectious male reproductive dysfunction.

These mechanisms are scientifically plausible and supported to varying degrees by research, but they should not lead to indiscriminate testing.

The current EAU guideline emphasizes that evidence in male genital-tract infection is heterogeneous and that improvements in laboratory semen measures after treating infection do not necessarily translate into higher natural-pregnancy rates.

Mumps Orchitis and Later Fertility

Not every infection affecting fertility is sexually transmitted.

Mumps is an important example.

Mumps can cause orchitis—painful inflammation of one or both testes—especially when infection occurs after puberty.

WHO notes that orchitis may occur in young adult men with mumps. In men who develop orchitis, testicular atrophy can occur and may subsequently be associated with oligospermia, azoospermia or reduced sperm motility. Importantly, available evidence does not establish that every case of mumps orchitis causes permanent sterility.

This illustrates a broader point: the reproductive effect depends on **which organ was affected, how severely it was damaged and whether one or both testes were involved**.

Other Infections and Fertility

Several less common infectious conditions may affect fertility in particular geographical or clinical settings.

Urogenital schistosomiasis may cause inflammatory and fibrotic genital disease in endemic regions. Other parasitic infections may indirectly affect the genital tract. Viral infections are also being investigated for potential effects on semen and reproductive function.

The uploaded source discusses schistosomiasis, filariasis, HPV, herpes and Zika among less common or emerging areas of interest.

These conditions should be evaluated according to exposure history and geography rather than included indiscriminately in every infertility investigation.

How Do We Investigate Possible Infection-Related Female Infertility?

When I evaluate a woman with infertility and a possible history of reproductive infection, my first objective is to establish whether there is evidence of present or previous reproductive-tract damage.

Her history may include PID, previous chlamydia or gonorrhoea, ectopic pregnancy, pelvic surgery, genital tuberculosis or recurrent pelvic infection.

Assessment may then involve ultrasound and evaluation of fallopian-tube patency.

Tests such as **hysterosalpingography (HSG)** or ultrasound-based contrast studies may help determine whether the tubes appear open. ASRM considers HSG a standard first-line method for assessing tubal patency, while recognizing that false-positive proximal obstruction can occur.

Laparoscopy is more invasive and is not automatically necessary for every infertile woman. Its use depends on clinical circumstances and suspected pelvic pathology.

The uploaded source provides a detailed discussion of HSG, contrast sonography and laparoscopy in assessing post-infectious tubal disease.

How Do We Investigate Possible Infection-Related Male Infertility?

The foundation of male assessment remains a careful reproductive history, examination and **semen analysis**.

WHO's laboratory manual provides standardized methods for examining semen and assessing parameters relevant to male fertility.

Depending on the findings, additional assessment may include hormone testing, genital or scrotal ultrasonography, microbiological testing or specialized evaluation for obstruction.

Sperm DNA fragmentation and oxidative-stress tests have roles in selected clinical situations, but they should not automatically be ordered for every man merely because he has a remote history of infection.

A test should answer a clinical question and ideally influence treatment.

Why Both Partners Should Be Evaluated

Fertility is a couple-level outcome.

I strongly discourage the practice of treating only one partner for months or years without assessing the other.

A woman may have tubal damage while her husband also has abnormal semen parameters. A man may have excellent semen findings while the female partner has ovulatory or tubal disease. Sometimes both partners have contributing factors.

WHO's 2025 global infertility guideline provides separate evidence-based pathways for tubal disease, ovulatory disease, uterine factors, male factors and unexplained infertility, reflecting the need to diagnose the actual cause rather than applying one treatment to everyone.

Can Pregnancy Still Occur After Infection-Related Infertility?

Very often, yes.

The treatment depends on the degree and type of reproductive damage.

A patient with active infection but no structural damage may have a very different prognosis from someone with bilateral severe tubal obstruction.

Some patients may conceive naturally after appropriate treatment. Some may be candidates for tubal or reproductive surgery. Others may benefit from assisted reproductive techniques such as IVF.

In severe tubal-factor infertility, IVF can bypass damaged fallopian tubes because fertilization occurs outside the body before an embryo is transferred into the uterus.

The 2025 WHO infertility guideline specifically describes a progressive approach to treatment—from fertility education and simpler interventions to intrauterine insemination or IVF according to diagnosis, clinical circumstances and patient preferences.

Male Obstruction and Assisted Reproductive Techniques

When a man produces sperm but has a severe obstruction preventing sperm from reaching the ejaculate, options depend on the site and cause.

Selected obstruction may sometimes be treated surgically.

In other circumstances, sperm can be retrieved from the epididymis or testis and used with assisted reproductive treatment, usually involving intracytoplasmic sperm injection.

The important point is that **treatment must match the mechanism**.

If the problem is obstruction, simply increasing nutritional or herbal support will not automatically reopen a scarred duct.

What Does Unani Medicine Say About Reproductive Inflammation?

The Unani system of medicine approaches reproductive health through concepts of **Mizaj**, or temperament, and balance among the four *Akhlat*: *Dam*, *Balgham*, *Safra* and *Sauda*.

Classical Unani literature describes female reproductive inflammation under terms such as **Waram-i-Rahim**, while male reproductive disorders may be discussed through concepts such as *Qillat-e-Mani*, *Riqqat-e-Mani* and *Zoaf-e-Bah*.

The background material provided for this article describes these classical concepts in relation to reproductive inflammation and infertility.

These terms represent a traditional diagnostic framework and should not be treated as direct equivalents of a laboratory-proven modern diagnosis.

For example, a traditional diagnosis of “hot uterine inflammation” cannot establish whether chlamydia, gonorrhoea or tuberculosis is present.

Modern diagnostic methods remain necessary.

Waram-i-Rahim in Official Unani Literature

The **Central Council for Research in Unani Medicine (CCRUM)** has published standard Unani treatment guidance discussing *Waram-i-Rahim*, broadly referring to inflammation of the uterus.

The traditional principles described include pain relief, management of inflammatory swelling, attention to abnormal material and dietary regulation.

This demonstrates that inflammatory female reproductive disorders have a developed place within formal Unani medical literature.

However, it is essential to interpret these principles responsibly today.

If uterine or pelvic inflammation is being caused by an active bacterial STI or tuberculosis, pathogen-specific treatment remains necessary. Traditional treatment should not delay it.

Where Unani Medicine Can Be Particularly Useful

As a Unani physician working in sexual disorders and infertility, I consider the greatest strength of Unani medicine to be **individualized supportive care rather than unsupported promises to reverse every structural abnormality**.

After an infection has been correctly treated, patients may continue to experience weakness, disturbed digestion, poor sleep, anxiety, nutritional deficiencies, urinary discomfort or reproductive concerns.

At this stage, Unani principles can help us look beyond the laboratory report and consider the patient's broader condition.

The system places significant emphasis on **Ilaj-bil-Ghiza**, or diet-based care; *Hifz-e-Sehat*, preservation of health; correction of lifestyle; sleep; physical activity; digestive function; and individualized constitutional assessment.

This can be especially useful during the recovery and fertility-preparation period when applied appropriately.

Unani Treatment Does Not Mean Ignoring Modern Diagnosis

I consider this one of the most important principles of contemporary Unani practice.

If a woman has bilateral tubal obstruction, I want to know that before prescribing months of treatment.

If a man has azoospermia, I want to determine whether the problem is sperm production, obstruction or another cause.

If there is active chlamydia, gonorrhoea or genital tuberculosis, I want the infection treated effectively.

This does not diminish Unani medicine.

On the contrary, **modern diagnosis allows Unani care to become more precise, safer and more responsible**.

Can Unani Medicines Reopen Scarred Fallopian Tubes?

There is currently insufficient high-quality evidence to claim that an oral Unani medicine can reliably reopen a severely fibrosed fallopian tube.

Traditional Unani texts contain *Muhallil* concepts relating to resolution of inflammatory swellings, and the uploaded research discusses these approaches.

However, established anatomical fibrosis should not be equated with active inflammatory swelling.

When severe structural damage exists, appropriate fertility procedures may be necessary.

The responsible role of Unani medicine is to contribute where evidence and clinical circumstances support it, not to promise an anatomical result that cannot be guaranteed.

Unani Support for Male Reproductive Health

The Unani tradition has an extensive pharmacological literature concerning male reproductive strength, semen production and general vitality.

Traditional categories include medicines considered *Muwallid-e-Mani* for supporting semen production and *Muqawwi-e-Bah* for sexual and reproductive vitality.

In modern practice, these approaches may be considered in selected patients after the actual cause of abnormal semen parameters has been established.

They should **not** be used as a substitute for investigating azoospermia, varicocele, endocrine disease, genetic abnormalities, severe infection or obstruction.

If a patient has a treatable nutritional or constitutional component, individualized Unani diet and supportive care may complement the overall plan.

Diet, Lifestyle and Fertility Recovery

Diet alone cannot reopen a blocked tube or cure an untreated STI.

Nevertheless, general health matters greatly in reproductive medicine.

WHO's first infertility guideline recommends attention to healthy diet, physical activity and tobacco cessation as part of fertility promotion.

This is an area where modern preventive medicine and traditional Unani concepts can work well together.

Unani medicine has long emphasized food, sleep, exercise, mental wellbeing and elimination as central components of health.

Importantly, WHO published a new fertility knowledge summary on **8 September 2026** reinforcing evidence that tobacco use is associated with poorer fertility outcomes in both women and men and may also reduce success of some fertility treatments.

For a couple trying to conceive, quitting tobacco, maintaining a healthy diet, managing body weight, sleeping adequately and controlling chronic medical conditions are not secondary issues—they are part of responsible fertility care.

The Psychological Legacy of Previous Infection

A previous STI can leave an emotional scar even when it leaves no physical scar.

Patients may experience guilt, fear of infecting a partner, concern about infertility or anxiety about marital relationships.

Men sometimes develop erectile difficulty after an STI because they become afraid of sexual contact or constantly monitor their performance.

Women may experience anxiety about tubal damage, ectopic pregnancy or future pregnancy.

WHO's 2025 infertility guideline specifically emphasizes that infertility may cause depression, anxiety and social isolation and recommends attention to psychosocial support as part of fertility care.

This is important at Saira Health Care because treating infertility should include the **person and the relationship**, not only semen numbers or scan findings.

The Specialized Approach of Dr. Nizamuddin Qasmi

When I assess a patient in whom a past infection may be contributing to present infertility, I use a **cause-based and stage-based approach**.

I first determine whether there is evidence of active infection. If there is, the infection should be treated according to current evidence-based guidance.

I then assess whether reproductive damage has actually occurred. For a woman, this may include evaluation of ovulation, uterus and fallopian tubes. For a man, it usually includes semen analysis, clinical examination and selected hormonal, imaging or microbiological investigation.

I assess both partners rather than placing the entire burden of infertility on one person.

Once urgent infection, structural disease and other treatable causes have been identified, I consider an individualized **Unani supportive plan** according to the patient's general health, constitution, nutritional status, digestive health, symptoms and reproductive objectives.

Where surgical treatment or assisted reproduction is more appropriate, I believe the patient should be informed clearly rather than continuing ineffective treatment indefinitely.

This is the integrative approach I consider most responsible for modern sexual and reproductive healthcare.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, our work focuses strongly on sexual disorders, male reproductive health and infertility.

One of our important contributions is helping patients understand conditions that are often surrounded by stigma, misinformation or unrealistic promises.

A patient with infertility may arrive carrying years of prescriptions but no clear diagnosis. Another may have a semen report but never have been examined. A woman may have been receiving repeated medicines without ever having her fallopian tubes evaluated.

Our aim is to move treatment toward a **structured, diagnosis-based and individualized process**.

Where an infection is suspected, appropriate testing and evidence-based treatment should receive priority.

Where Unani supportive care may contribute to general health, recovery or reproductive wellbeing, it can be integrated thoughtfully.

Where surgery, IVF, ICSI or another specialist procedure is indicated, patients should understand why.

The objective should always be **the patient's best reproductive outcome—not simply continuing one treatment system indefinitely**.

Why Prevention Is Better Than Treating Post-Infectious Damage

Some infertility caused by infection is preventable.

This is one of the strongest messages in WHO's new global infertility guideline. Untreated STIs are specifically recognized among modifiable or preventable causes that deserve greater public-health attention.

Testing after relevant exposure, appropriate treatment, partner treatment, correct condom use and timely management of PID can reduce the chance of later reproductive damage.

WHO's 2025 asymptomatic-STI guideline also emphasizes the challenge posed by infections that remain undetected in people without symptoms, particularly in women and in throat or rectal sites.

This is why waiting for severe symptoms is not always a safe strategy.

Frequently Asked Questions

Can an infection I had years ago cause infertility today?

Yes, in some cases. A previous infection may have caused scarring or structural damage that remains after the organism itself has disappeared. Chlamydia, gonorrhoea, PID and genital tuberculosis are important examples in appropriate clinical circumstances. However, a previous infection should not automatically be assumed to be the cause of infertility.

Which infections are most strongly linked with female infertility?

Untreated **chlamydia and gonorrhoea** are important because they may lead to PID and subsequent fallopian-tube damage. WHO explicitly identifies these infections as major causes of PID and female infertility.

Can chlamydia damage fertility without causing symptoms?

Yes. Chlamydia frequently remains asymptomatic, and untreated infection can cause PID, infertility and ectopic pregnancy in women.

Can a man become infertile after epididymitis?

Most men recover without infertility. However, severe reproductive-tract inflammation, particularly when bilateral, can sometimes cause obstruction or other complications. CDC includes infertility among potential complications that appropriate treatment aims to prevent.

Does every genital infection reduce sperm quality?

No. The 2026 EAU guideline states that evidence relating male accessory-gland infection and impaired natural conception is inconsistent. Infection should be treated appropriately, but not every abnormal semen result should be attributed to infection.

Can antibiotics reopen blocked fallopian tubes?

No. Antibiotics eradicate susceptible active infection; they do not reliably reverse mature fibrotic obstruction.

Can Unani medicine reopen blocked tubes?

There is not sufficient high-quality evidence to guarantee that Unani oral treatment can reopen severely scarred fallopian tubes. Unani medicine can be valuable for individualized supportive care, but structural infertility requires appropriate diagnostic and fertility management.

Can pregnancy occur with one healthy fallopian tube?

Yes, pregnancy may still occur naturally when one tube is healthy and functional, depending on other fertility factors.

Can IVF help if both tubes are badly damaged?

Yes. IVF can bypass the fallopian tubes and is an established treatment option for severe tubal-factor infertility. Treatment should be individualized according to age, ovarian reserve, male factors and other findings.

Can mumps cause infertility in men?

Mumps orchitis can damage testicular tissue and may cause testicular atrophy or abnormal sperm production in some patients. Permanent sterility is not inevitable, particularly when only one testicle is affected.

Can genital tuberculosis cause infertility?

Yes. Genital TB can produce severe inflammation, scarring or reproductive-tract obstruction, particularly in women in regions where tuberculosis is prevalent. Confirmed TB requires standard anti-tuberculosis treatment.

My Final Message to Patients

If you are struggling to conceive and had an infection many years ago, do not immediately assume that your fertility has been permanently lost.

At the same time, do not dismiss your medical history simply because the infection “went away.”

The correct question is:

Did the infection leave any reproductive damage behind?

That question can only be answered through appropriate evaluation.

If a woman has healthy fallopian tubes and normal reproductive findings, an old infection may not be relevant. If a man has normal semen parameters and no evidence of obstruction, his previous infection may have caused no lasting fertility problem.

But if structural damage is found, we then need to identify the best way forward rather than repeatedly treating an infection that is no longer present.

As a physician trained in Unani medicine and focused on **sexual disorders and infertility**, I believe strongly in personalized care. Unani medicine contributes valuable principles of constitution, diet, lifestyle, recovery and whole-person assessment. Official Unani literature also recognizes reproductive inflammatory conditions such as *Waram-i-Rahim* and provides a traditional framework for their supportive management.

At the same time, modern reproductive medicine gives us the ability to detect tubal obstruction, measure semen quality, diagnose active infection, treat tuberculosis, perform surgery and use assisted reproductive technologies when needed.

For me, these approaches should not compete.

First control active infection. Then identify any damage. Assess both partners. Use Unani supportive care where it can genuinely help. And use modern fertility treatment when structural or severe reproductive problems require it.

That is the patient-centred approach we follow at **Saira Health Care**—with the ultimate goal of protecting reproductive health and giving every couple a realistic, responsible and scientifically informed path toward conception.

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Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** focuses on sexual disorders and infertility, with emphasis on confidential consultation, appropriate diagnostic assessment, reproductive-health education and individualized integrative management.

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Medical Disclaimer

This article is intended for general education and public awareness. It does not constitute an individual diagnosis, prescription or guarantee of fertility outcome.

Active bacterial sexually transmitted infections and tuberculosis require appropriate evidence-based antimicrobial treatment. Unani, herbal or complementary therapies should not be used to delay or replace necessary antibiotics, anti-tuberculosis treatment, surgery or assisted reproductive care. Established reproductive scarring may not be reversible with medicine alone, and treatment should be selected after appropriate evaluation of both partners.