Anti-Sperm Antibodies (ASA): Causes, Symptoms, Diagnosis, Treatment, Infertility and the Role of Unani Medicine

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Introduction: "Doctor, My Report Says Anti-Sperm Antibodies Are Positive. Is My Own Body Attacking My Sperm?"

When a patient comes to me with a report showing:

Anti-Sperm Antibodies – Positive

he is often very worried.

Some patients ask:

"Doctor, is my immune system killing my sperm?"

Others ask:

"Can these antibodies make all my sperm weak?"

A couple may ask:

"Is this why we have not been able to achieve pregnancy?"

And another patient may have already been advised to take:

- steroids,
- immune-suppressing medicines,
- antioxidants,
- herbal medicines,

without first understanding whether the anti-sperm antibodies are actually clinically important.

Anti-sperm antibodies—commonly abbreviated as:

ASA

are antibodies that recognize proteins or other antigens associated with sperm.

In some men, these antibodies can bind to sperm and interfere with important reproductive functions such as:

- sperm movement,
- sperm agglutination,
- passage through cervical mucus,
- interaction with the egg,
- and fertilization.

However, one of the first things I explain is:

A positive anti-sperm-antibody test does not automatically mean that natural pregnancy is impossible.

Not every antibody:

- has the same biological effect,
- is present in the same amount,
- binds to the same part of the sperm,
- or causes clinically meaningful infertility.

Modern reproductive medicine therefore treats anti-sperm-antibody testing much more selectively than it did in the past.

The **AUA/ASRM Male Infertility Guideline, amended in 2024**, specifically states that anti-sperm-antibody testing should **not** be performed routinely during the initial evaluation of every infertile man.

A major 2026 review in *Fertility and Sterility* similarly describes ASA testing today as more of a:

targeted diagnostic or triage tool

than a universal infertility screening test.

This is the approach I prefer at **Saira Health Care**:

First understand whether the antibodies are clinically important—then decide what treatment, if any, is actually required.

What Are Anti-Sperm Antibodies?

Antibodies are proteins produced by the immune system.

Their normal role is to recognize and help defend the body against:

- viruses,
- bacteria,
- toxins,
- and other potentially harmful substances.

Most antibodies are helpful.

However, antibodies can sometimes react against:

the body's own structures

or against biological material that is normally protected from immune exposure.

Sperm are unusual cells because they develop only after puberty and carry many proteins that the immune system does not normally encounter freely.

The body therefore has protective mechanisms to prevent inappropriate immune attack on developing sperm.

The most important is the:

Blood-Testis Barrier

The Blood-Testis Barrier: Why the Immune System Normally Does Not Attack Sperm

Inside the testes, developing sperm cells are protected by specialized connections between:

Sertoli cells

forming the blood-testis barrier.

This barrier helps create a controlled environment for:

- meiosis,
- sperm development,
- and protection of later-stage germ cells from inappropriate immune recognition.

When this protective barrier—or related barriers in the reproductive tract—is disrupted, sperm antigens may become exposed to the immune system.

The immune system may then produce:

Anti-Sperm Antibodies

against those antigens.

A major 2026 review describes disruption of the blood-testis barrier due to:

- trauma,
- obstruction,
- or inflammation

as a principal biological mechanism behind the development of sperm autoimmunity.

Are Anti-Sperm Antibodies an Autoimmune Disease?

They can represent a form of:

reproductive autoimmunity

especially when a man's immune system produces antibodies against his own sperm.

However, ASA-positive infertility should not automatically be treated like a systemic autoimmune disease such as:

- lupus,
- rheumatoid arthritis,
- autoimmune thyroid disease.

Many affected men otherwise have a completely normal immune system.

The reproductive immune abnormality may be relatively localized.

How Common Are Anti-Sperm Antibodies?

Published estimates vary considerably.

This is partly because different studies use:

- different tests,
- different laboratory thresholds,
- different infertility populations.

Older reviews have reported anti-sperm antibodies in approximately:

2.6–6.6% of infertile men.

A newer 2026 review estimates that sperm autoimmunity may be identified in approximately:

5–12% of infertile men.

These estimates should be interpreted cautiously because there is still no single universally accepted diagnostic threshold that defines clinically important ASA infertility in every laboratory.

In other words:

ASA is a recognized cause of infertility, but it is not one of the explanations for every abnormal semen analysis.

What Types of Antibodies Are Involved?

The main immunoglobulin classes found on sperm include:

IgG

and:

IgA

IgG antibodies are commonly detected.

IgA antibodies can be particularly relevant because they may interfere with sperm movement through:

cervical mucus

and reproductive-tract secretions.

The exact clinical effect also depends on:

- how many sperm are antibody-coated,
- where on the sperm the antibody binds,
- what sperm antigen is targeted,
- antibody class.

Where Can Anti-Sperm Antibodies Bind?

Antibodies may attach to different sperm regions:

- head,
- midpiece,
- tail,
- multiple regions.

This matters because different locations may potentially interfere with different functions.

For example, antibodies affecting the sperm head may theoretically interfere with:

- sperm-egg recognition,
- zona pellucida interaction,
- fertilization.

Antibodies affecting the tail may interfere more with:

- motility,
- cervical-mucus penetration.

However:

the location alone does not perfectly predict infertility.

The complete clinical context is required.

Tail-Tip Binding Is an Important Exception

The WHO sixth-edition semen manual notes an important laboratory point:

antibody binding limited only to the extreme tail tip is not generally associated with impaired fertility

and can even occur in fertile men.

This is another reason why a laboratory report simply saying:

“ASA positive”

without describing:

- percentage,
- antibody class,
- and binding location

can be difficult to interpret.

Causes of Anti-Sperm Antibodies

Anti-sperm antibodies usually develop when sperm antigens become abnormally exposed to the immune system.

Important potential causes and associations include the following.

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1. Vasectomy

Vasectomy interrupts the:

vas deferens

and prevents sperm from entering the ejaculate.

After vasectomy, sperm continue to be produced inside the testes.

Changes associated with:

- obstruction,
- pressure,
- sperm leakage,
- immune exposure

can lead to anti-sperm-antibody formation.

ASA are therefore relatively common following vasectomy.

However:

having antibodies after vasectomy does not automatically mean fertility cannot return after successful vasectomy reversal.

The clinical importance varies substantially between men.

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2. Vasectomy Reversal

Men undergoing:

vasovasostomy

or:

vasoepididymostomy

may already have high anti-sperm-antibody levels from the period of obstruction.

These antibodies can sometimes contribute to reduced fertility even after sperm return to the semen.

But if pregnancy does not occur after technically successful reversal, the entire couple should still be evaluated rather than automatically blaming ASA.

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3. Testicular Trauma

Injury to the testes can disrupt the protective environment separating sperm antigens from the immune system.

Examples include:

- significant blunt trauma,
- penetrating injury,
- testicular rupture.

AUA/ASRM recognizes trauma as one potential setting for ASA development.

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4. Testicular Surgery

Surgery involving the:

- testis,
- epididymis,
- vas deferens

can potentially expose sperm antigens.

The risk depends on:

- procedure,
- degree of tissue disruption,
- healing,
- obstruction.

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5. Reproductive-Tract Obstruction

Blockage involving the:

- epididymis,
- vas deferens,
- other sperm-transport structures

may be associated with greater sperm antigen exposure and antibody production.

Vasal obstruction is specifically recognized in current AUA/ASRM guidance as a potential ASA-associated condition.

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6. Infection and Inflammation

Reproductive-tract infection may alter tissue barriers and expose sperm antigens.

Potential examples include:

- epididymitis,
- epididymo-orchitis,
- prostatitis,
- sexually transmitted infection.

However:

a positive ASA test does not prove that an infection exists.

And:

an infection does not automatically mean that ASA are the main cause of infertility.

The infection itself may impair fertility through:

- inflammation,
- oxidative stress,
- epididymal dysfunction,
- sperm injury.

Therefore, the two issues should be evaluated separately.

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7. Mumps Orchitis

Severe testicular inflammation caused by:

mumps orchitis

may disrupt testicular tissue and the blood-testis barrier.

AUA/ASRM includes mumps orchitis among events associated with ASA production.

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8. Testicular Malignancy

Testicular tumors may alter:

- testicular structure,
- local immune environment,
- reproductive barriers.

Testicular malignancy is another condition recognized in current male-infertility guidance as potentially associated with anti-sperm-antibody production.

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9. Testicular Torsion

Torsion interrupts testicular blood flow.

Severe ischemic injury and disruption of testicular tissue may alter local immune protection.

Its relationship with clinically significant ASA varies, but it is biologically plausible as a barrier-disrupting event.

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10. Previous Genital or Inguinal Surgery

Selected operations may affect:

- vas deferens,
- epididymal structures,
- spermatic cord,
- testicular tissues.

Therefore, I always ask infertile men about:

- childhood surgery,
- hernia surgery,
- scrotal surgery,
- vasectomy,
- reconstructive procedures.

11. Idiopathic Anti-Sperm Antibodies

In many men:

- no major trauma,
- no surgery,
- no obvious obstruction,
- no infection

is identified.

The ASA are then considered:

idiopathic

or unexplained.

This reflects one of the continuing knowledge gaps in reproductive immunology.

Do Anti-Sperm Antibodies Occur in Women?

Yes.

Women may occasionally develop antibodies that recognize sperm antigens.

However, clinically important female anti-sperm immunity is much less straightforward to diagnose and interpret.

Antibodies have historically been investigated in:

- blood,
- cervical mucus,
- reproductive-tract secretions.

But modern fertility practice does **not** recommend routine screening of every infertile woman for anti-sperm antibodies.

There remain significant uncertainties regarding:

- test methods,
- thresholds,
- clinical significance,
- treatment.

Therefore:

female ASA should not automatically be blamed for unexplained infertility.

Do Anti-Sperm Antibodies Cause Recurrent Miscarriage?

This claim requires caution.

Anti-sperm antibodies mainly interfere with events occurring:

before or during fertilization

such as:

- sperm transport,
- motility,
- sperm-egg interaction.

Current evidence does not support diagnosing anti-sperm antibodies as a routine cause of:

recurrent pregnancy loss

and current infertility/recurrent-loss guidelines do not use ASA testing as a standard first-line miscarriage investigation.

If a couple has recurrent pregnancy loss, evaluation should focus on established factors according to current guidelines rather than assuming that the woman's or man's ASA caused the miscarriages.

How Can Anti-Sperm Antibodies Affect Fertility?

There are several possible mechanisms.

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1. Sperm Agglutination

One recognizable feature is:

sperm agglutination

where sperm stick to one another.

They may attach:

- head-to-head,
- tail-to-tail,

- head-to-tail,
- in mixed groups.

This can interfere with effective forward movement.

However:

agglutination is not proof of anti-sperm antibodies.

The 2024 and 2026 literature emphasizes that sperm agglutination may raise suspicion for ASA, but antibodies may also be present:

- without visible agglutination.

Therefore, agglutination is:

a clue—not a diagnosis.

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2. Reduced Sperm Motility

ASA may interfere with:

- tail movement,
- membrane function,
- sperm progression.

Reduced motility—particularly asthenozoospermia—is among the more consistently reported semen abnormalities in men with clinically relevant ASA.

But:

every case of low motility is not caused by anti-sperm antibodies.

Low motility can also result from:

- varicocele,
- oxidative stress,
- infection,
- fever,
- genetic flagellar disorders,
- laboratory factors.

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3. Difficulty Penetrating Cervical Mucus

For natural pregnancy, sperm must travel through cervical mucus.

Sperm-bound antibodies—especially clinically significant IgA—may reduce this ability.

The WHO semen manual notes that substantial sperm antibody binding has historically been associated with poorer:

cervical-mucus penetration

and reduced in-vivo fertilization.

This provides one biological reason why:

IUI

may sometimes help selected couples by bypassing the cervix.

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4. Impaired Capacitation

After ejaculation, sperm undergo biochemical changes called:

capacitation

before they can fertilize an egg.

Certain antibodies may interfere with membrane processes involved in sperm functional maturation.

However, the exact effects depend on which antigen is targeted.

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5. Interference With the Acrosome Reaction

The acrosome is a specialized cap on the sperm head.

The:

acrosome reaction

helps sperm participate in fertilization.

Some ASA may interfere with sperm-head functions necessary for this process.

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6. Interference With Zona Pellucida Binding

The sperm must interact with the outer layer surrounding the egg called:

zona pellucida.

Antibodies directed against particular sperm-head antigens may reduce:

- recognition,
- binding,
- penetration.

This can result in:

reduced or failed fertilization during conventional IVF

in selected immunological-infertility cases.

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7. Interference With Sperm-Egg Fusion

Even after reaching the egg, sperm need to participate in highly specialized membrane interactions.

Modern research has identified several sperm proteins essential to sperm-oocyte interaction.

A 2024 review of ASA antigens noted that proteins involved in sperm-egg interaction are increasingly important targets in the study of immune infertility.

Do Anti-Sperm Antibodies Reduce Sperm Count?

Not necessarily.

A man with clinically relevant ASA may have:

- normal sperm concentration,
- but poor motility or agglutination.

Another may have additional male-fertility problems and consequently show:

- oligozoospermia,
- abnormal morphology,
- other abnormalities.

ASA should therefore not be treated as synonymous with low sperm count.

Do Anti-Sperm Antibodies Cause Abnormal Morphology?

They are not primarily a sperm-morphology disorder.

An antibody binds to sperm that has already developed.

It does not automatically mean the sperm was structurally malformed during spermatogenesis.

Therefore:

ASA, motility and morphology are different biological issues.

Symptoms of Anti-Sperm Antibodies

Most men with ASA experience:

no specific physical symptom.

The most common clinical presentation is simply:

difficulty achieving pregnancy.

The patient may otherwise have:

- normal libido,
- normal erection,
- normal ejaculation,
- normal orgasm,
- normal-looking semen.

This condition cannot be diagnosed from symptoms alone.

Anti-Sperm Antibodies Do Not Mean Impotence

A man can have clinically relevant anti-sperm antibodies and still have:

- excellent sexual desire,
- normal erection,
- normal ejaculation.

Conversely, a man can have erectile dysfunction without any anti-sperm antibodies.

This is particularly important in my practice because I work specifically with:

Sexual Disorders & Infertility

and the two areas must be evaluated separately.

Can Semen Look Normal?

Yes.

Anti-sperm antibodies cannot be identified by looking at semen.

The ejaculate may appear:

- completely normal,
- thick,
- white,
- normal in volume.

Only appropriate laboratory testing can detect sperm-bound immunoglobulins.

When Should Anti-Sperm Antibodies Be Suspected?

ASA testing may become more reasonable when there is a clinical context such as:

- significant sperm agglutination,
- previous vasectomy,
- vasectomy reversal,
- reproductive-tract obstruction,
- testicular trauma,
- testicular surgery,
- severe orchitis,
- unexplained poor sperm-mucus interaction,
- selected unexplained infertility,
- unexpected fertilization problems.

However:

ASA testing is not a routine first test for every infertile man.

The AUA/ASRM Male Infertility Guideline specifically states:

Clinicians should not perform anti-sperm-antibody testing in the initial evaluation of male infertility.

The initial evaluation should instead focus on:

- reproductive history,
- semen analysis,
- clinical examination,
- appropriate female-partner assessment.

Why Is ASA Testing Not Done Routinely?

There are several reasons.

1. ASA is relatively uncommon.

2. A positive result does not always cause infertility.

3. Testing methods vary.

4. Laboratory thresholds vary.

5. The result does not always change treatment.

6. ICSI can bypass many clinically important antibody-related fertilization problems.

This last point has changed reproductive practice significantly.

The 2026 Scientific View: ASA Testing as a Targeted Tool

One of the most important recent publications is the 2026 *Fertility and Sterility* review:

"Antisperm antibodies and autoimmunity in the era of assisted reproduction."

The authors explain that ASA testing has evolved from:

routine screening

toward:

targeted triage

because ICSI can bypass several major barriers produced by sperm-bound antibodies.

This reflects current clinical thinking very well.

Diagnosis of Anti-Sperm Antibodies

Several tests exist.

The most important modern approaches directly assess antibodies attached to sperm.

1. Semen Analysis

Before an ASA-specific test, the man usually needs a proper:

semen analysis.

This assesses:

- sperm concentration,
- total sperm number,
- progressive motility,
- total motility,
- morphology,
- semen volume,
- sperm agglutination.

The WHO sixth-edition semen manual remains the international laboratory standard.

Sperm Agglutination Is a Clue

The laboratory may report:

- head-to-head agglutination,
- tail-to-tail agglutination,
- mixed agglutination.

This should prompt consideration of ASA in the correct clinical setting.

But:

ASA can exist without agglutination, and agglutination can have other explanations.

Therefore, further testing is required when clinically justified.

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2. Mixed Antiglobulin Reaction – MAR Test

One of the most commonly used ASA tests is:

MAR Test

or:

Mixed Antiglobulin Reaction Test

The MAR test detects:

- IgG,
- or IgA

antibodies attached to the surface of motile sperm.

Special antibody-coated particles are mixed with semen.

If sperm carry corresponding antibodies, the particles attach to them.

The laboratory determines:

what percentage of motile sperm have particles attached.

The WHO describes the MAR test as:

- relatively inexpensive,
- quick,
- sensitive

for screening sperm-bound antibodies.

Is a MAR Result Above 50% Positive?

Older WHO manuals frequently used:

50% antibody-coated motile sperm

as a clinically important threshold.

The WHO sixth edition is more cautious.

It states that:

there are currently no evidence-based universal reference values for antibody-bound sperm in the MAR test.

Each laboratory should establish and validate its own reference range.

This is extremely important.

Therefore, a modern report should not be interpreted mechanically as:

49% = no problem

and:

50% = infertility.

Earlier evidence suggested that cervical-mucus penetration and in-vivo fertilization become more likely to be impaired when approximately half or more of motile sperm are antibody-bound.

But modern interpretation requires:

- percentage,
- antibody class,
- site of attachment,
- semen quality,
- fertility history.

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3. Immunobead Test – IBT

Another important method is the:

Immunobead Binding Test

In the direct immunobead test:

- sperm are washed,
- beads coated against human IgG or IgA are added.

Attachment shows where antibodies are present on the sperm.

The IBT may provide more information regarding:

- antibody class,
- sperm binding location

than a simple screening MAR test.

However, the WHO sixth edition also states that:

there is no evidence-based universal reference limit for IBT positivity.

Older manuals used approximately 50% binding as a threshold, but the current manual cautions against overinterpreting one specific percentage.

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4. Direct vs Indirect ASA Tests

This is another important distinction.

Direct Tests

Detect antibodies already bound to:

the patient's sperm.

Examples:

- direct MAR,
- direct immunobead test.

These are generally the most clinically meaningful when adequate motile sperm are available.

Indirect Tests

Can test:

- seminal plasma,
- serum,
- other biological fluids

by allowing antibodies from the patient's sample to react with donor sperm.

Indirect testing may be considered if the man's sample has too few motile sperm for a direct test.

However:

a blood antibody result alone does not prove that clinically significant antibodies are coating ejaculated sperm.

This is why blood testing should not be interpreted in isolation.

Does a Serum ASA Test Diagnose Infertility?

Not by itself.

The clinically important question is usually:

Are antibodies coating sperm in a way that interferes with reproductive function?

A circulating antibody detected in blood may not have the same significance as extensive sperm-bound IgA or IgG.

Therefore:

serum ASA should not be used as a stand-alone infertility diagnosis.

What About Anti-Sperm-Antibody Testing in Women?

Testing female blood or cervical mucus for sperm antibodies has historically been performed in reproductive immunology.

However, routine clinical use has become limited because:

- assay methods differ,
- clinically meaningful thresholds are uncertain,
- association with infertility is inconsistent,
- treatment decisions are rarely based on the result alone.

For most couples, a standard female infertility evaluation is more useful.

My Diagnostic Approach at Saira Health Care

If I suspect immunological male infertility, I prefer to ask several questions before ordering or interpreting an ASA test.

Step 1: Is the Couple Truly Experiencing Infertility?

I ask:

- How long have they been trying?
- Is intercourse regular?
- Is intercourse occurring around the fertile period?
- Has either partner conceived previously?

Step 2: Evaluate Both Partners

This is essential.

If a man has ASA but the female partner also has:

- blocked tubes,
- severe endometriosis,
- very low ovarian reserve,

- anovulation,

the fertility plan must address both partners.

Step 3: Review the Semen Analysis

I look specifically at:

- sperm concentration,
- progressive motility,
- total motility,
- morphology,
- agglutination.

Step 4: Look for a Clinical Reason for ASA

I ask about:

- vasectomy,
- vasectomy reversal,
- testicular trauma,
- testicular surgery,
- epididymal surgery,
- genital infection,
- orchitis,
- obstruction.

Step 5: Consider Direct ASA Testing

When clinically justified, I prefer direct assessment such as:

- MAR,
- appropriate immunobead testing

rather than relying only on serum antibodies.

Step 6: Interpret the Result Properly

I consider:

- IgG or IgA,
- percentage of antibody-bound sperm,
- site of binding,
- sperm agglutination,
- sperm count and motility,
- fertility history.

Step 7: Decide Whether the ASA Is Actually Changing Treatment

This is perhaps the most important question.

If treatment would be:

ICSI

because of another severe male or female fertility factor anyway, extensive immunological testing may add little.

Testing is most valuable when its result changes clinical decision-making.

Modern Treatment of Anti-Sperm-Antibody Infertility

There is no single treatment appropriate for every ASA-positive man.

Treatment depends on:

- severity,
- semen quality,
- female fertility,
- infertility duration,
- previous treatment.

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1. Treat the Underlying Cause Where Possible

If there is a genuine reversible cause, it should be addressed.

Examples include:

- genital infection,
- inflammatory reproductive disease,
- reconstructable obstruction.

However:

correcting the original cause does not guarantee that existing antibodies will immediately disappear.

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2. Lifestyle Improvement

Lifestyle modification cannot directly “wash antibodies off sperm.”

However, reproductive health should still be optimized.

I advise:

- no smoking,
- healthy body weight,
- appropriate physical activity,
- adequate sleep,
- healthy diet,
- diabetes control,
- avoidance of anabolic steroids,
- minimizing excessive alcohol.

This can improve the man's:

- overall sperm health,
- endocrine health,
- oxidative environment.

Lifestyle treatment is therefore supportive rather than ASA-specific immunotherapy.

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3. Sperm Washing

Laboratory sperm preparation can:

- remove seminal plasma,
- select more motile sperm,
- concentrate usable sperm.

However:

ordinary sperm washing does not reliably remove antibodies already attached firmly to the sperm surface.

This distinction is important.

Washing can prepare sperm for:

- IUI,
- IVF,
- ICSI,

but it does not necessarily cure the underlying immune coating.

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4. Timed Intercourse

Some men with low-level or biologically less important antibodies may still achieve:

natural pregnancy.

A positive ASA test alone is therefore not a reason to prohibit natural attempts.

Factors influencing the decision include:

- female age,
- duration of infertility,
- semen quality,
- degree of antibody binding.

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5. Intrauterine Insemination – IUI

IUI may be useful in selected patients.

During IUI:

- semen is processed,
- a concentrated sperm preparation is placed directly into the uterus.

This bypasses:

the cervix and cervical mucus

which is useful when sperm-antibody effects are mainly interfering with cervical-mucus penetration.

IUI may therefore be considered in:

- milder immunological infertility,
- adequate total motile sperm count,
- favorable female fertility.

However:

IUI is not guaranteed to overcome severe sperm-bound antibody effects.

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6. Conventional IVF

During conventional IVF:

- eggs are retrieved,
- many prepared sperm are placed around the egg,
- sperm still need to bind and penetrate the egg normally.

Clinically important ASA can sometimes interfere with:

- zona binding,
- sperm-egg interaction,
- fertilization.

Older and modern reproductive-immunology literature has therefore described reduced conventional IVF fertilization in selected patients with extensive sperm-bound antibodies.

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7. ICSI – Intracytoplasmic Sperm Injection

ICSI has changed the treatment of severe immunological infertility dramatically.

During:

ICSI

an embryologist selects a sperm and injects it directly into the egg.

This bypasses many stages that ASA can disrupt, including:

- cervical-mucus penetration,
- movement through the female reproductive tract,
- zona pellucida penetration,
- several sperm-egg binding steps.

Therefore:

ICSI is generally the most reliable ART technique for bypassing clinically significant sperm-bound anti-sperm-antibody effects.

The 2026 reproductive-immunology literature specifically describes ICSI as the main method that has reduced the need for routine ASA screening and immune-suppressive treatment.

Does Every Positive ASA Result Require ICSI?

No.

This is important.

A mildly positive test in a couple with:

- good semen parameters,
- young female partner,
- short infertility duration

does not automatically require ICSI.

Treatment should be proportional to the actual fertility problem.

ICSI becomes particularly relevant when there is:

- extensive antibody binding,
- significant impaired sperm function,
- previous fertilization failure,
- other severe male-factor infertility,
- failed simpler treatment.

What About Corticosteroids?

Historically, men with anti-sperm antibodies were sometimes treated with:

- prednisolone,

- prednisone,
- other corticosteroids

to suppress antibody production.

This sounds biologically logical.

However, clinical reality has been disappointing.

Controlled studies have not shown a reliable improvement in:

- pregnancy rates,
- IVF outcomes

sufficient to justify routine systemic steroid treatment.

ASRM's guideline on immunotherapy in IVF reports that corticosteroid treatment for men with anti-sperm antibodies did not reliably:

- reduce sperm-bound antibodies,
- improve IVF outcomes.

Older controlled trials similarly found:

- no meaningful pregnancy advantage,
- significant adverse effects.

Therefore:

I do not consider routine long-term corticosteroid or immunosuppressive treatment a preferred modern treatment for ASA-associated infertility.

Potential Side Effects of Corticosteroids

Unnecessary systemic steroid therapy can produce:

- weight gain,
- increased blood glucose,
- blood-pressure problems,
- mood changes,
- immune suppression,
- infection risk,
- bone effects,

- gastrointestinal problems,
- adrenal suppression

depending on:

- dose,
- duration.

These risks are particularly important because many infertility patients are otherwise healthy young men.

Is There a Medicine That Permanently Removes ASA?

At present:

there is no standard oral medicine proven to permanently eliminate clinically significant sperm-bound anti-sperm antibodies in every patient.

This is why modern treatment often focuses on:

- correcting reversible causes,
- improving overall sperm health,
- selecting appropriate reproductive techniques,
- bypassing the antibody effect when necessary.

Anti-Sperm Antibodies in the Unani System of Medicine

This topic requires a particularly careful explanation.

Classical Unani medicine developed centuries before the discovery of:

- immunoglobulins,
- sperm-surface antigens,
- MAR testing,
- immunobead testing,
- monoclonal antibodies,
- modern reproductive immunology.

Therefore:

there is no classical Unani diagnosis that should be described as an exact equivalent of modern anti-sperm-antibody infertility.

I believe making this distinction strengthens—not weakens—the scientific credibility of Unani medicine.

Traditional Unani Understanding of Male Fertility

Classical Unani medicine evaluates reproductive health through broader principles involving:

- **Mizaj – temperament**
- **Akhlat – humoral framework**
- strength of reproductive organs,
- nutrition,
- general health,
- digestion,
- activity,
- sleep,
- environmental influences.

Male infertility has traditionally been discussed through several reproductive-health concepts rather than through modern immunological categories.

Mizaj and Individualized Treatment

One strength of Unani medicine is:

individualization.

Two men with the same MAR result may be very different clinically.

For example:

Patient A

Has:

- sperm agglutination,
- poor diet,
- obesity,

- smoking,
- reduced motility.

Patient B

Has:

- positive antibodies after vasectomy reversal,
- excellent general health,
- normal testosterone.

Patient C

Has:

- positive ASA,
- severe oligozoospermia,
- clinical varicocele.

They should not automatically receive one identical treatment.

I therefore combine the traditional individualized assessment with:

- semen analysis,
- reproductive history,
- modern diagnostic information.

Akhlat and Modern Immunology Are Not the Same Thing

The four traditional humors are:

- Dam,
- Balgham,
- Safra,
- Sauda.

These are part of the historical Unani physiological model.

They should not be presented as if:

- IgG = one humor,
- IgA = another humor,

- ASA positivity = a particular humoral excess.

That would be scientifically inaccurate.

Modern antibodies are specific immune proteins.

Traditional humoral concepts are a different explanatory framework.

How Unani Medicine Can Be Useful in ASA-Associated Infertility

The most appropriate role of Unani care is:

supportive and individualized reproductive-health management.

It may help address associated factors such as:

- poor nutrition,
- general weakness,
- unhealthy lifestyle,
- metabolic dysfunction,
- associated semen abnormalities,
- sexual-health problems,
- stress and sleep.

This may help improve the overall reproductive environment.

However:

I do not claim that Unani medicine has been scientifically proven to eliminate sperm-bound IgG or IgA antibodies.

There is currently insufficient product-specific clinical evidence for that claim.

Major Unani Therapeutic Approaches

Unani medicine traditionally includes:

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bit-Tadbir

Regimenal Therapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical Treatment

This broad framework is useful because immune-related infertility may sometimes require:

- lifestyle treatment,
- medicines,
- reproductive procedures.

A responsible Unani practitioner should recognize when:

- IUI,
- IVF,
- ICSI

offers the patient the better chance.

Ilaj-bil-Ghiza – Dietotherapy

Diet cannot mechanically remove an antibody from the surface of sperm.

But a good fertility diet can support:

- metabolic health,
- antioxidant intake,
- sperm production,
- general reproductive function.

I commonly advise foods such as:

- vegetables,
- fruits,
- pulses,
- whole grains,
- nuts,
- seeds,

- adequate protein,
- healthy fats.

I advise reducing:

- smoking,
- excessive alcohol,
- sugary drinks,
- repeated fried foods,
- ultra-processed foods.

This is supportive male-fertility care rather than direct immune suppression.

Ilaj-bit-Tadbir – Regimenal Care

Depending on the patient, this may focus on:

- appropriate exercise,
- adequate sleep,
- healthy weight,
- stress management,
- general reproductive-health optimization.

These interventions are valuable for the patient as a whole.

They should not be advertised as proven methods of converting a MAR-positive test to negative.

Ilaj-bid-Dawa – Unani Pharmacotherapy

At Saira Health Care, traditional male-fertility medicines may be selected according to:

- semen profile,
- sperm count,
- motility,
- general health,
- Mizaj,

- associated reproductive complaints.

Two formulations relevant to Saira Health Care's male-fertility programme include:

Spermogenic Powder

and:

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

when clinically appropriate.

Spermogenic Powder

Saira Health Care Pharmacy currently describes:

Dr. Qasmi's Spermogenic

as a herbal formulation used for several male reproductive concerns, including:

- reduced sperm motility,
- low sperm count,
- semen-quality concerns.

The formulation contains multiple traditional herbs used in male reproductive-health practice.

Within my approach, Spermogenic may be considered when an ASA-positive patient also has:

- low motility,
- low sperm count,
- general fertility-health concerns

that may reasonably benefit from supportive traditional management.

However:

Spermogenic should not be described as a scientifically proven anti-sperm-antibody remover.

I have not identified a high-quality independent clinical trial demonstrating that it reliably:

- removes IgG or IgA from sperm,
- converts MAR-positive sperm to MAR-negative sperm,
- or eliminates immunological infertility.

Its role is better described as:

supportive male reproductive-health treatment within an individualized programme.

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

Saira Health Care Pharmacy currently describes:

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

as a Unani formulation used for:

- general vitality,
- weakness,
- and semen-quality support.

In selected infertile men, it may be incorporated according to:

- general health,
- semen abnormalities,
- individual Unani assessment.

But again:

there is no adequate evidence that Nuskha No. 129 specifically suppresses anti-sperm-antibody production.

Therefore its role should remain supportive rather than ASA-specific immunotherapy.

What About Semen Gold Plus, Spermzoa and Sperm Plus?

These medicines appear in older Saira Health Care material related to male infertility.

For scientific accuracy, current Saira Health Care Pharmacy listings identify:

Semen Gold Plus

as an:

Ayurvedic supplement

Spermzoa

as an:

Ayurvedic formulation

Sperm Plus

as an:

Ayurvedic/herbal formulation

rather than classical Unani medicines.

They may form part of a broader integrative male-fertility programme if appropriately selected, but:

they should not be described as proven ASA-specific therapies.

There are no high-quality product-specific studies demonstrating that these formulations remove sperm-bound antibodies.

Is There Published Unani Research Specifically on Anti-Sperm Antibodies?

I have not identified high-quality peer-reviewed Unani clinical trials specifically demonstrating successful treatment of:

laboratory-confirmed anti-sperm-antibody infertility

using:

- MAR,
- immunobead testing,
- clinically relevant pregnancy or live-birth outcomes.

CCRUM has published limited research on:

- oligospermia,
- male reproductive weakness,
- semen parameters.

For example, observational Unani studies have reported improvement in:

- sperm count,
- motility

with selected classical formulations in men with oligospermia.

That research is encouraging.

But:

oligospermia research is not evidence of ASA clearance.

This distinction is essential.

Why Unani Medicine Can Still Be Valuable

Unani medicine does not have to claim direct antibody suppression in order to contribute meaningfully.

Its value may lie in:

- individualized fertility assessment,
- dietary improvement,
- lifestyle modification,
- general reproductive-health support,
- treatment of associated sexual-health concerns,
- supportive management of semen abnormalities.

The patient may therefore benefit from:

integrative care

without making scientifically unsupported claims.

Dr. Nizamuddin Qasmi's Special Individualized Approach to Anti-Sperm-Antibody Infertility

When a patient comes to me with:

ASA Positive

my approach is structured.

Step 1: Confirm Why the Test Was Performed

I first ask:

Why did the doctor order ASA testing?

Was there:

- sperm agglutination?
- vasectomy reversal?
- genital trauma?

- unexplained infertility?
- IVF fertilization failure?

This helps determine whether the result is meaningful.

Step 2: Review the Test Type

I ask:

- MAR?
- Immunobead?
- Direct or indirect?
- Blood only?

A blood ASA result is not identical to sperm-bound antibodies.

Step 3: Assess the Amount of Sperm Binding

I review:

- percentage of antibody-bound sperm.

I do not interpret one number as an absolute fertile/infertile threshold because the WHO sixth edition does not provide a universal evidence-based reference cut-off.

Step 4: Identify the Immunoglobulin

Is the antibody:

- IgG?
- IgA?
- both?

This can provide additional clinical context.

Step 5: Identify Binding Location

I look for:

- head,

- midpiece,
- tail.

Tail-tip-only binding may not be clinically important.

Step 6: Review the Full Semen Analysis

I assess:

- sperm concentration,
- progressive motility,
- morphology,
- agglutination,
- total motile sperm count.

Step 7: Look for the Underlying Cause

I ask about:

- vasectomy,
- reversal,
- trauma,
- genital infection,
- orchitis,
- surgery,
- obstruction.

Step 8: Evaluate the Female Partner

This is critical.

I consider:

- female age,
- ovulation,
- ovarian reserve,

- fallopian tubes,
- uterine health,
- other infertility factors.

Step 9: Correct Reversible Health Factors

I address:

- tobacco,
- obesity,
- diabetes,
- excessive alcohol,
- unhealthy diet,
- poor sleep,
- harmful reproductive exposures.

These do not directly eliminate ASA but support the fertility pathway.

Step 10: Add Individualized Unani Support Where Appropriate

When suitable, I may incorporate:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised Ilaj-bid-Dawa,
- Spermogenic,
- Nuskha No. 129

according to the complete fertility profile.

The goal is:

supporting reproductive health—not pretending to erase antibodies without evidence.

Step 11: Consider Timed Intercourse or IUI in Mild Cases

If:

- semen is reasonably good,
- enough motile sperm remain,
- female factors are favorable,

less invasive treatment may still be appropriate.

Step 12: Do Not Continue Ineffective Treatment Indefinitely

If the couple repeatedly fails:

- natural attempts,
- IUI,

and clinically significant immunological infertility remains likely, continuing the same treatment indefinitely may waste reproductive time.

Step 13: Consider IVF/ICSI According to Severity

For severe sperm-bound antibody effects:

ICSI

is generally the most effective way of bypassing antibody-related interference with fertilization.

Step 14: Avoid Unnecessary Long-Term Steroid Therapy

I do not recommend routine systemic immunosuppression simply to make an antibody test negative.

The risks can outweigh uncertain benefit.

Step 15: Judge Success by Pregnancy Outcomes, Not Only Antibody Numbers

The real goal is not:

“MAR became negative.”

The real reproductive goals are:

- adequate sperm function,
- fertilization,

- pregnancy,
- live birth.

A laboratory antibody percentage is only one part of that journey.

Can Anti-Sperm Antibodies Disappear Naturally?

They can:

- decrease,
- persist,
- fluctuate.

This depends on:

- underlying cause,
- ongoing exposure,
- immune response.

After vasectomy, for example, antibodies may remain for a long period.

There is no predictable time in which every positive antibody test becomes negative.

Can Natural Pregnancy Occur With Positive ASA?

Yes.

Some men with sperm antibodies remain capable of natural conception.

Probability depends on:

- antibody burden,
- sperm motility,
- sperm concentration,
- antibody location,
- female fertility.

Therefore:

ASA positive does not automatically equal sterile.

Does Positive ASA Mean IUI Will Fail?

No.

IUI can work in selected cases.

It may be particularly useful when the main antibody effect involves:

- cervical-mucus penetration

and adequate motile sperm remain.

However, severe antibody-related sperm dysfunction can reduce success.

Does Positive ASA Mean Conventional IVF Will Fail?

Not automatically.

But extensive sperm-bound antibodies can interfere with:

- zona binding,
- fertilization.

Conventional IVF fertilization may therefore be poorer in selected highly antibody-positive cases.

Does ICSI Bypass Anti-Sperm Antibodies?

It bypasses many of their most important functional effects.

ICSI directly places sperm inside the egg and therefore avoids:

- cervical mucus,
- zona penetration,
- several sperm-egg binding steps.

This is why ICSI is generally considered the most dependable fertility treatment when clinically significant sperm-bound antibodies are causing major fertilization problems.

Does ICSI Remove the Antibodies?

No.

This is an important distinction.

ICSI does not necessarily make the antibody disappear.

It:

bypasses the fertility barrier created by the antibody.

This is a different therapeutic concept.

Should the Couple Delay ART Until ASA Becomes Negative?

Usually there is no reason to insist that an antibody test must become negative before proceeding with appropriate ART.

This is particularly important when:

- the female partner is older,
- ovarian reserve is declining,
- infertility has been prolonged.

Reproductive time can be more important than laboratory normalization.

Common Myths About Anti-Sperm Antibodies

Myth 1: A positive ASA test means all sperm are being destroyed.

Fact: ASA can have different effects. Many sperm remain alive and some men remain naturally fertile.

Myth 2: Anti-sperm antibodies always reduce sperm count.

Fact: Their major effects more commonly involve sperm function, motility, agglutination and fertilization rather than simply sperm production.

Myth 3: Sperm agglutination proves ASA.

Fact: Agglutination raises suspicion but is not diagnostic.

Myth 4: No agglutination means no ASA.

Fact: ASA can be present even without visible sperm agglutination.

Myth 5: A blood ASA test proves immunological infertility.

Fact: Sperm-bound antibodies are usually more clinically informative than serum antibodies alone.

Myth 6: Every infertile man should be tested for ASA.

Fact: AUA/ASRM specifically recommends against routine ASA testing in the initial male-infertility evaluation.

Myth 7: MAR above exactly 50% always means infertility.

Fact: WHO's sixth edition no longer provides one universal evidence-based MAR threshold and recommends laboratory-specific reference ranges.

Myth 8: Corticosteroids are the standard cure.

Fact: Controlled studies have not demonstrated sufficient reliable benefit to justify routine systemic steroid therapy.

Myth 9: Antibiotics treat ASA.

Fact: Antibiotics treat genuine bacterial infection. They do not directly eliminate sperm antibodies.

Myth 10: Female ASA is a common proven cause of miscarriage.

Fact: The clinical relationship is uncertain, and routine ASA testing is not a standard recurrent-miscarriage investigation.

Myth 11: One herbal medicine can remove all sperm antibodies.

Fact: No herbal formulation has been conclusively demonstrated to remove clinically significant sperm-bound IgG/IgA in every patient.

Myth 12: Unani medicine has no role at all.

Fact: Unani medicine can contribute meaningfully to individualized diet, lifestyle and broader reproductive-health support. Its role should be described accurately rather than making unsupported antibody-clearing claims.

Myth 13: Positive ASA means biological fatherhood is impossible.

Fact: Natural pregnancy, IUI, IVF or ICSI may remain possible depending on severity and couple factors.

Frequently Asked Questions

What are anti-sperm antibodies?

They are immune proteins that recognize antigens associated with sperm.

Are anti-sperm antibodies dangerous to general health?

Usually not.

Their main clinical concern is:

fertility.

Are ASA common?

Estimates vary. Recent literature suggests sperm autoimmunity may occur in approximately **5–12% of infertile men**, depending heavily on the population and testing method.

What causes ASA?

Possible causes include:

- vasectomy,
- vasal obstruction,
- reproductive surgery,
- trauma,
- orchitis,
- genital inflammation,
- testicular malignancy.

Some cases remain unexplained.

Does vasectomy cause ASA?

It frequently leads to immune exposure to sperm antigens and anti-sperm antibodies may develop.

Can pregnancy happen after vasectomy reversal despite ASA?

Yes.

Many men can achieve pregnancy after successful reversal even when sperm antibodies are present.

Does ASA lower sperm motility?

It can.

Poor motility is one of the more commonly reported sperm abnormalities in immunological male infertility.

Does ASA cause sperm agglutination?

It can.

But agglutination is neither completely sensitive nor specific for ASA.

Which is the best test?

When testing is clinically indicated and enough motile sperm exist, direct:

- MAR,
- or immunobead testing

is generally more useful than relying only on blood antibody testing.

What is MAR?

MAR stands for:

Mixed Antiglobulin Reaction.

It determines the proportion of motile sperm carrying IgG or IgA antibodies.

Is 50% the official modern positive cut-off?

Not exactly.

Older WHO manuals used approximately 50% as a clinically meaningful threshold.

The WHO sixth edition states that there is currently **no evidence-based universal reference value** and laboratories should establish validated reference ranges.

Is tail-tip binding important?

Binding limited to the extreme sperm tail tip is generally not considered associated with impaired fertility.

Should every infertile man undergo ASA testing?

No.

AUA/ASRM recommends against ASA testing as part of the routine initial evaluation.

Can ASA be treated with steroids?

Steroids have been studied historically, but routine systemic corticosteroid treatment is not favored because:

- benefit is inconsistent,
- side effects can be significant.

Can IUI work?

Yes, particularly in selected mild cases with adequate motile sperm.

Can IVF work?

Yes.

However, some clinically important antibodies may interfere with conventional fertilization.

Is ICSI better for severe ASA?

When ASA causes major fertilization problems, ICSI is generally the most reliable technique because it bypasses many antibody-sensitive steps.

Does ICSI guarantee pregnancy?

No.

Pregnancy also depends on:

- egg quality,
- female age,
- embryo development,
- uterine factors,
- other fertility conditions.

Can lifestyle reduce ASA?

There is no reliable evidence that a specific lifestyle measure directly clears sperm antibodies.

Healthy lifestyle still supports overall sperm and reproductive health.

Can Unani medicine help?

Unani medicine may be useful as individualized supportive care through:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- lifestyle management,
- supervised traditional pharmacotherapy.

It should be combined with appropriate fertility diagnostics.

Does Unani medicine remove IgG and IgA from sperm?

There is currently insufficient clinical evidence to claim that a specific Unani treatment reliably eliminates sperm-bound IgG or IgA.

What is the role of Spermogenic?

At Saira Health Care, Spermogenic may be used as part of an individualized programme for associated semen-quality and male-fertility concerns.

It should not be described as a proven ASA-clearing medicine.

What is the role of Nuskha No. 129?

Nuskha No. 129 – Vitasem Max is used within Saira Health Care's individualized Unani programme for general vitality and semen-quality support.

Its role is supportive rather than proven immune suppression of ASA.

Latest Scientific Perspective: 2024–2026

Anti-sperm-antibody medicine has changed considerably in the ART era.

2024 AUA/ASRM Male Infertility Guideline

The current AUA/ASRM guideline states clearly:

Anti-sperm-antibody testing should not be performed in the initial male-infertility evaluation.

Testing should be targeted rather than routine.

The guideline identifies possible ASA-associated conditions including:

- trauma,
- mumps orchitis,
- testicular malignancy,
- vasal obstruction,
- vasectomy,
- genital-tract infection.

WHO Sixth-Edition Laboratory Guidance

WHO continues to include:

- MAR,

- immunobead testing

among extended semen examinations.

However, the sixth edition makes a major methodological change:

It does not establish an evidence-based universal positive threshold for MAR or immunobead tests.

Laboratories should determine and validate appropriate reference ranges.

This is a more scientifically careful approach than simply calling every result over an arbitrary percentage infertile.

2024 Immunological Infertility Review

A 2024 review emphasized that ASA can interfere with several sperm functions but also noted that:

- study results remain inconsistent,
- the exact role in male infertility is still incompletely defined,
- management depends on the individual patient's clinical context.

2026 Fertility and Sterility Review

The May 2026 review:

“Antisperm antibodies and autoimmunity in the era of assisted reproduction”

is especially relevant.

It reports that ASA may affect approximately:

5–12% of infertile men

and describes antibody formation primarily after disruption of immune barriers through:

- trauma,
- obstruction,
- inflammation.

The authors describe important effects on:

- sperm motility,
- cervical-mucus penetration,

- gamete interaction.

Most importantly, the review explains how the availability of:

ICSI

has shifted ASA testing away from routine screening toward selected diagnostic use.

This is the most useful modern message for patients.

Dr. Nizamuddin Qasmi and Saira Health Care

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with focused clinical practice in:

Sexual Disorders & Infertility

My professional education and additional training include:

- **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**

Saira Health Care's current physician profile describes my clinical focus as including:

- male infertility,
- azoospermia,
- oligospermia,
- low sperm motility,
- abnormal morphology,
- necrospermia,
- positive sperm agglutination,
- varicocele,
- other male and female reproductive-health disorders.

My work in both:

sexual medicine

and:

infertility

is particularly relevant because immunological infertility may occur in a man who otherwise has completely normal:

- libido,
- erections,
- ejaculation.

Saira Health Care's Contribution to Sexual Disorders & Infertility

One of the most important contributions a fertility clinic can make is:

correct diagnosis before treatment.

In ASA-related infertility, this means avoiding both extremes.

The first extreme is:

“ASA does not matter at all.”

This is incorrect because clinically significant sperm-bound antibodies can impair fertility.

The second extreme is:

“Every positive antibody test is the entire cause of infertility and must be cured with immune-suppressive medicine.”

That is also incorrect.

At Saira Health Care, I prefer to evaluate:

- both partners,
- complete semen analysis,
- antibody test type,
- percentage of sperm affected,
- IgG/IgA class,
- antibody-binding location,
- possible cause,

- female age,
- ovarian reserve,
- reproductive timeline.

Why Saira Health Care's Integrative Approach Is Relevant

A patient with ASA may simultaneously require several forms of care.

Modern fertility diagnostics

to confirm whether antibodies are clinically significant.

Lifestyle and nutrition

to support general sperm health.

Treatment of infection

when genuine infection exists.

Unani supportive care

for individualized reproductive-health management.

IUI

in selected milder cases.

IVF/ICSI

in more severe cases.

The correct treatment is not determined by loyalty to one medical system.

It is determined by:

what gives the individual couple the safest and most realistic chance of conception.

My Final Message to Patients

If your report says:

Anti-Sperm Antibody Positive

do not panic.

And do not immediately begin strong immune-suppressive treatment.

Instead ask:

Why was my ASA tested?

Do I have sperm agglutination?

Was the test MAR or immunobead?

Was the test direct or indirect?

What percentage of sperm is antibody-bound?

Is it IgG, IgA or both?

Where is the antibody attached?

Is the binding only at the tail tip?

What is my sperm concentration?

What is my progressive motility?

Do I have a history of vasectomy or vasectomy reversal?

Did I have trauma, surgery, infection or obstruction?

How is my wife's fertility?

Can we continue trying naturally?

Would IUI make sense?

Would ICSI be more appropriate?

Can Unani treatment support my general reproductive health without delaying necessary fertility treatment?

These questions produce a much better fertility plan than simply saying:

"Your immunity is attacking sperm, so take a medicine to suppress it."

Conclusion

Anti-sperm antibodies are immune proteins directed against sperm antigens and can contribute to:

immunological infertility.

They may develop following disruption of the protective reproductive barriers because of conditions such as:

- vasectomy,
- obstruction,

- trauma,
- reproductive surgery,
- orchitis,
- inflammation,
- testicular malignancy.

In some men, no specific cause is identified.

ASA may interfere with fertility by causing or contributing to:

- sperm agglutination,
- reduced motility,
- impaired cervical-mucus penetration,
- abnormal capacitation,
- impaired sperm-egg interaction,
- reduced conventional fertilization.

However:

a positive antibody result does not automatically mean infertility.

Modern AUA/ASRM guidance therefore recommends:

against routine ASA testing during the initial male-infertility evaluation.

When testing is appropriate, direct assays such as:

- MAR,
- immunobead testing

can detect sperm-bound:

- IgG,
- IgA.

Importantly, the **WHO sixth-edition semen manual no longer gives one universal evidence-based positive threshold** for ASA testing.

Older literature frequently used:

50% antibody-bound motile sperm

as a clinically important level, but modern interpretation should consider:

- laboratory reference ranges,
- antibody class,
- binding site,
- semen quality,
- reproductive history.

Treatment should be individualized.

Possible options include:

- correcting an underlying infection or obstruction,
- lifestyle optimization,
- timed intercourse,
- IUI,
- IVF,
- ICSI.

Routine systemic corticosteroid therapy is no longer considered a preferred approach because:

- pregnancy benefit is inconsistent,
- significant adverse effects can occur.

When sperm-bound antibodies substantially interfere with fertilization:

ICSI is generally the most dependable ART method for bypassing the antibody effect.

The **Unani system of medicine** may offer useful supportive care through:

- Mizaj-based individualization,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- lifestyle improvement,
- nutritional support,
- general reproductive-health management.

At **Saira Health Care**, formulations such as:

- **Spermogenic**
- **Dr. Qasmi's Nuskha No. 129 – Vitasem Max**

may be considered when clinically appropriate as part of an individualized male-fertility programme.

However:

there is currently insufficient clinical evidence to state that these formulations specifically remove sperm-bound IgG or IgA or cure immunological infertility in every patient.

Other products sometimes mentioned in older Saira Health Care infertility material—such as:

- Semen Gold Plus,
- Spermzoa,
- Sperm Plus

are currently classified on Saira Health Care Pharmacy as Ayurvedic/herbal formulations rather than classical Unani medicines and should be represented accurately.

My clinical approach can therefore be summarized as:

Do not test ASA routinely without a reason.

Confirm what type of test was performed.

Do not diagnose immunological infertility from serum antibodies alone.

Interpret sperm agglutination as a clue, not proof.

Assess IgG/IgA and sperm-binding location.

Evaluate both partners.

Treat reversible underlying causes.

Use Unani medicine as individualized supportive reproductive care.

Avoid unnecessary long-term corticosteroids.

Consider IUI in selected mild cases.

Use IVF/ICSI when the reproductive situation requires it.

Do not waste valuable reproductive time waiting for an antibody number to become negative.

And never promise pregnancy from one antibody result or one medicine.

For every patient who asks me:

“Doctor, my anti-sperm antibodies are positive. Can we still have a child?”

my answer is:

Yes, pregnancy may still be entirely possible. The important question is not simply whether antibodies are present—it is whether they are actually interfering with sperm function, how severe that interference is, and which fertility pathway gives you and your partner the best chance of conception.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Professional Education & Training

- **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**

Saira Health Care's current professional profile identifies Dr. Nizamuddin Qasmi as Founder and Chief Physician with focused clinical practice in sexual disorders and infertility and lists reproductive-health conditions including male infertility and positive sperm agglutination among the areas managed within the clinic.

His clinical approach combines:

- traditional Unani assessment,
- male-infertility evaluation,
- semen-analysis interpretation,
- lifestyle management,
- sexual-health care,

- and timely use or referral for modern assisted reproduction.

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Medical Disclaimer

This article is intended for:

- patient education,
- fertility awareness,
- professional health information.

It is not a substitute for:

- individual medical consultation,
- semen analysis,

- MAR testing,
- immunobead testing,
- physical examination,
- reproductive-urology evaluation,
- female infertility evaluation,
- assisted-reproduction consultation.

A positive:

- serum ASA test,
- MAR test,
- or immunobead result

should not be interpreted in isolation.

Anti-sperm-antibody testing is not recommended routinely in the initial evaluation of every infertile man.

Do not independently start:

- prednisolone,
- prednisone,
- corticosteroids,
- immunosuppressants,
- antibiotics,
- fertility hormones,
- herbal preparations,
- Unani medicines,
- Ayurvedic medicines,
- supplements

solely because an ASA result is positive.

Dr. Qasmi's Spermogenic, Nuskha No. 129 or other traditional fertility formulations should not be interpreted as scientifically proven treatments for eliminating sperm-bound anti-sperm antibodies.

Where:

- IUI,
- IVF,
- or ICSI

offers the more appropriate fertility pathway, timely treatment should form part of responsible integrative fertility care.

The choice between:

- natural conception,
- IUI,
- IVF,
- ICSI

depends on both partners and should not be determined by the ASA result alone.

Saira Health Care
www.sairahealthcare.com

Medical literature reviewed and updated: September 2026