

Fertility Preservation for Women

Egg Freezing, Embryo Freezing, Ovarian Tissue Preservation, Cancer and Medical Treatment, Endometriosis, Age-Related Fertility Decline and the Supportive Role of Unani Medicine

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Understanding Fertility Preservation

When a woman asks me:

“Doctor, I do not want pregnancy now, but I may want children later. Can I preserve my fertility?”

my first response is:

Sometimes, yes—but fertility preservation is not a guarantee of future pregnancy.

Modern reproductive medicine now allows us to preserve:

- mature eggs,
- embryos,
- ovarian tissue

before fertility is threatened or before reproductive ageing becomes more advanced.

In selected patients, we can also protect ovarian function through procedures such as:

- ovarian transposition before pelvic radiotherapy,
- fertility-sparing cancer surgery.

The field has developed rapidly.



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The **2026 American Society for Reproductive Medicine—ASRM—guidance** recognizes mature oocyte cryopreservation, embryo cryopreservation and ovarian tissue cryopreservation as established fertility-preservation strategies for appropriately selected females.

The **2025 ASCO guideline** similarly recommends established fertility-preservation options for women at risk from cancer treatment and stresses that fertility counselling should occur both before treatment and during survivorship.

Fertility preservation is therefore no longer a rare or purely experimental part of medicine.

But it must be understood correctly.

Fertility preservation stores reproductive potential; it does not freeze the entire woman's biological age.

A woman who freezes eggs at 30 may preserve eggs with the reproductive characteristics of approximately that age.

However, if she eventually becomes pregnant at 43, her body is still experiencing pregnancy at age 43.

Similarly:

freezing eggs is not the same as freezing a guaranteed future child.

Not every stored egg will:

- survive warming,
- fertilize,
- develop into an embryo,
- implant,
- result in a live birth.

These distinctions are fundamental to responsible counselling.

What Is Fertility Preservation?

Fertility preservation refers to medical strategies used to protect or store reproductive potential for possible future family building.

It may be undertaken because:

Fertility is about to be threatened by medical treatment



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For example:

- chemotherapy,
- radiotherapy,
- stem-cell transplantation,
- ovarian surgery.

A disease itself may threaten fertility

For example:

- extensive ovarian endometriosis,
- certain genetic disorders associated with premature ovarian insufficiency.

Reproductive organs may need to be removed

For example:

- bilateral ovarian surgery,
- treatment of selected gynecological cancers.

A woman expects to delay childbearing

This is generally called:

Planned Oocyte Cryopreservation

or:

Planned Egg Freezing.

ASRM considers planned oocyte cryopreservation ethically acceptable when performed with appropriate informed consent, but emphasizes that its effectiveness, cost, risks and limitations must be communicated clearly.

Fertility Preservation Is Different From Infertility Treatment

This distinction is very important.

Fertility preservation

attempts to store reproductive material **before future fertility is lost or reduced.**

Examples:

- freezing eggs at age 30,
- freezing embryos before chemotherapy,



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- freezing ovarian tissue before highly gonadotoxic therapy.

Infertility treatment

attempts to achieve pregnancy when conception is already difficult.

Examples:

- ovulation induction,
- IUI,
- IVF,
- ICSI.

The same technology—such as IVF—may sometimes be used for both purposes, but the objectives are different.

Why Women's Fertility Needs Preservation

Female fertility is particularly time-sensitive because women are born with a finite ovarian follicle pool.

Throughout life:

- follicles are continuously lost,
- ovarian reserve declines,
- reproductive ageing continues.

With increasing age, not only does the number of remaining eggs fall, but the proportion of eggs capable of creating chromosomally normal embryos also declines.

ACOG's 2025 guidance emphasizes the importance of counselling women about ovarian-factor fertility decline before infertility actually occurs, particularly when childbearing is expected to be delayed.

This biological reality is why fertility preservation is most effective when discussed **before reproductive potential has already declined substantially.**

Egg Quantity and Egg Quality Are Different

Patients frequently ask me:

“If I freeze ten eggs, does that mean ten future babies?”

No.



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Each mature egg represents an opportunity.

But every egg does not become:

- a fertilized egg,
- an embryo,
- a blastocyst,
- a pregnancy,
- a baby.

Age influences the probability that an egg is chromosomally competent.

Therefore:

the age at which eggs are frozen matters greatly.

ASRM's evidence review concludes that ongoing pregnancy and live-birth outcomes are generally better when planned oocyte cryopreservation is performed at a younger rather than older age.

Is There a Perfect Age to Freeze Eggs?

No universal age can be recommended for every woman.

ASRM specifically states that evidence is insufficient to define one ideal age for planned egg freezing.

The decision depends on:

- current age,
- reproductive plans,
- desired number of children,
- ovarian reserve,
- medical history,
- likelihood of using the frozen eggs,
- personal circumstances,
- treatment cost.

However, one general biological principle is clear:

younger eggs generally have greater reproductive potential than older eggs.



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Therefore, a woman considering egg freezing at 30 is biologically in a different position from a woman first considering it at 40.

Egg Freezing Is Not an Insurance Policy

I am cautious with the phrase:

“fertility insurance.”

It can create false confidence.

A woman may freeze several eggs and assume:

“Now I can definitely have children whenever I want.”

That is not medically accurate.

ASRM specifically warns that planned egg freezing can create misplaced confidence if patients are not given realistic information about success rates.

I therefore prefer to describe egg freezing as:

preserving additional reproductive options.

Not:

guaranteeing future motherhood.

Who Should Consider Fertility Preservation?

Fertility preservation may be appropriate in several very different situations.

Women facing cancer treatment

Women receiving gonadotoxic treatment for non-cancer diseases

Women facing significant ovarian surgery

Selected women with extensive ovarian endometriosis

Women with genetic conditions associated with premature ovarian insufficiency

Women requiring removal of ovaries

Women planning to delay pregnancy

Selected children and adolescents at high risk of future infertility

ASRM's 2026 guidance includes medical indications such as:

- cancer,



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- sickle-cell disease,
- thalassemia,
- rheumatologic disease,
- autoimmune disease,
- conditions associated with premature ovarian insufficiency,
- certain hereditary cancer syndromes.

Cancer and Fertility Preservation

Cancer is one of the most important medical reasons for fertility preservation.

Cancer treatment can damage fertility through:

- chemotherapy,
- pelvic radiotherapy,
- ovarian surgery,
- stem-cell transplantation,
- hormonal treatment,
- removal of reproductive organs.

The amount of fertility damage depends upon:

- treatment type,
- cumulative dose,
- treatment location,
- age,
- ovarian reserve before treatment.

The **2025 ASCO guideline** recommends discussing reproductive risk as early as possible and referring women interested in—or uncertain about—future fertility to reproductive specialists before cancer-directed therapy whenever feasible.

Fertility Preservation Should Be Discussed Before Treatment

A common problem in survivorship care is that patients tell me:

“No one discussed fertility with me before chemotherapy.”



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Sometimes treatment has to begin urgently.

But whenever medically possible, fertility counselling should occur **before**:

- chemotherapy,
- pelvic radiation,
- highly gonadotoxic treatment,
- surgery removing reproductive organs.

This gives the woman the widest range of options.

Fertility Preservation Does Not Mean Delaying Life-Saving Cancer Treatment

Cancer control always comes first.

Fortunately, modern ovarian-stimulation protocols can often begin immediately without waiting for a particular phase of the menstrual cycle.

The **2026 ASRM guidance** supports:

immediate-start or random-start ovarian stimulation.

These protocols can begin regardless of menstrual-cycle phase and produce reproductive outcomes similar to conventional-start stimulation, with negligible treatment delay in appropriate cases.

Therefore:

urgent referral is better than assuming there is no time.

Mature Egg Freezing

The most widely recognized fertility-preservation method for postpubertal women is:

Mature Oocyte Cryopreservation

commonly called:

Egg Freezing.

The process generally involves:

1. ovarian assessment;
2. hormonal ovarian stimulation;
3. monitoring follicles;



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4. triggering final egg maturation;
5. retrieving eggs through a procedure;
6. identifying mature eggs;
7. vitrifying and storing them.

ASRM recognizes mature oocyte cryopreservation as an established fertility-preservation technique for postpubertal females.

What Is Vitrification?

Modern eggs are usually frozen through:

vitrification.

This is an ultra-rapid cryopreservation process designed to minimize damaging ice-crystal formation within the egg.

Vitrification significantly improved the usefulness of egg freezing and helped move oocyte cryopreservation from an experimental technology into routine reproductive medicine.

What Happens When Frozen Eggs Are Used?

When the woman later wishes to attempt pregnancy:

- eggs are warmed,
- surviving eggs are fertilized,
- embryos are cultured,
- appropriate embryos may be transferred to the uterus.

Because freezing and warming affect the egg's outer layers, ICSI is commonly used with warmed oocytes in many reproductive programs.

Does Every Frozen Egg Survive?

No.

This is one reason patients should never equate:

one frozen egg = one future baby.



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Some eggs may not:

- survive warming,
- fertilize,
- develop normally.

The number of mature eggs stored therefore influences cumulative reproductive opportunity.

How Many Eggs Should Be Frozen?

There is no single number that guarantees a child.

ASRM concludes that available evidence is insufficient to prescribe an absolute number of frozen mature eggs required to guarantee a reasonable live-birth probability for women of every age.

The appropriate counselling depends upon:

- age at freezing,
- number of mature oocytes obtained,
- clinic-specific outcomes,
- desired number of future children.

Some women may consider more than one stimulation cycle.

Age Is More Important Than AMH for Egg Quality

AMH can help estimate how strongly the ovaries may respond to stimulation.

It may help answer:

“How many eggs might we retrieve?”

It does not directly answer:

“How good are those eggs?”

ASRM defines ovarian-reserve tests as primarily measures of **egg quantity**, noting that they are poor independent predictors of reproductive potential compared with age.

Therefore:

a 30-year-old woman with low AMH



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and

a 40-year-old woman with the same AMH

do not have the same fertility-preservation prognosis.

Can AMH Tell Me Whether I Should Freeze Eggs?

AMH can contribute useful information.

But it should not decide the entire plan.

A low AMH may indicate:

- fewer eggs per stimulation cycle.

It does not automatically mean:

- all eggs are poor quality,
- pregnancy is impossible.

A high AMH may indicate:

- a higher egg yield.

It does not mean:

- fertility can safely be postponed indefinitely.

ACOG's 2025 guidance describes AMH as a useful but imperfect measure of ovarian reserve when counselling women who plan delayed childbearing.

Antral Follicle Count

Another important ovarian-reserve assessment is:

Antral Follicle Count — AFC.

During transvaginal ultrasound, small developing follicles are counted in both ovaries.

Together with:

- age,
- AMH,
- medical history,

AFC can help estimate how many follicles may respond during ovarian stimulation.



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Again:

it estimates expected egg quantity—not guaranteed future pregnancy.

Embryo Freezing

Another established fertility-preservation method is:

Embryo Cryopreservation.

The woman undergoes ovarian stimulation and egg retrieval.

Instead of freezing unfertilized eggs:

- eggs are fertilized using partner or donor sperm,
- resulting embryos are cryopreserved.

ASRM recognizes embryo cryopreservation as an established fertility-preservation technique.

Egg Freezing Versus Embryo Freezing

Neither option is universally better.

They offer different advantages.

Egg freezing

allows the woman to:

- choose a sperm source later,
- retain sole decision-making regarding her unfertilized gametes.

Embryo freezing

provides more biological information because we already know:

- fertilization occurred,
- embryo development reached a particular stage.

ASRM recommends that the choice between eggs and embryos reflect patient preferences and shared decision-making.

Some women may preserve:

both eggs and embryos.



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Embryo Freezing and Relationship Considerations

Embryos contain genetic material from:

- the egg provider,
- the sperm provider.

Their future use may therefore involve:

- consent,
- relationship,
- legal considerations.

Egg freezing avoids some of these issues because the eggs remain unfertilized.

This is one reason some women prefer oocyte rather than embryo preservation.

PGT-M and Hereditary Disease

Some women carry pathogenic genetic variants associated with:

- serious inherited disorders,
- hereditary cancer syndromes.

If embryos are created, selected couples may consider:

Preimplantation Genetic Testing for Monogenic Disease — PGT-M.

ASRM states that PGT-M can be offered when known mutations predispose offspring to serious inherited conditions, including selected hereditary cancer syndromes.

Genetic counselling should be part of these decisions.

Ovarian Tissue Cryopreservation

A major advance in reproductive medicine is:

Ovarian Tissue Cryopreservation — OTC.

This involves removing and freezing thin portions of:

ovarian cortex,

which contains large numbers of primordial follicles.

Importantly:



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ovarian tissue cryopreservation is no longer considered experimental.

The **2026 ASRM guideline** recognizes it as an established fertility-preservation option in carefully selected patients.

The **2025 ASCO update** similarly recognizes ovarian tissue cryopreservation as an established option for women with cancer.

Who May Benefit From Ovarian Tissue Freezing?

It may be particularly valuable when:

- cancer treatment must start too urgently for ovarian stimulation,
- chemotherapy is expected to be highly gonadotoxic,
- the patient is a prepubertal girl,
- additional fertility preservation is desired in a very high-risk case.

Unlike egg freezing, ovarian tissue cryopreservation does not require mature eggs before the tissue is removed.

How Ovarian Tissue Cryopreservation Works

Usually:

1. ovarian cortical tissue is obtained surgically;
2. tissue is divided into thin pieces;
3. tissue is cryopreserved;
4. after cancer treatment and appropriate medical clearance, tissue may later be transplanted back.

The aim is to restore:

- follicular activity,
- fertility potential.

ASRM reports that transplantation of cryopreserved ovarian tissue has resulted in pregnancies and live births, although effectiveness is still lower and less predictable than standard egg/embryo preservation and patient selection is important.

Ovarian Tissue Is Not a Permanent New Ovary



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After transplantation, ovarian tissue may function for a period of time.

It is not necessarily permanent.

ASRM notes that ovarian-function recovery can occur after transplantation, but the duration is variable; ovarian tissue transplantation is generally intended primarily to restore fertility rather than guarantee lifelong endocrine function.

Cancer-Cell Contamination Is an Important Concern

In some cancers, malignant cells may theoretically be present in ovarian tissue.

Transplanting that tissue later could potentially reintroduce malignant cells.

Therefore, ovarian tissue cryopreservation and transplantation require cancer-specific assessment and oncology involvement.

This is especially important in some:

- hematological malignancies,
- ovarian malignancies.

Fertility Preservation in Prepubertal Girls

A young girl cannot ordinarily undergo standard mature egg freezing because the reproductive system has not yet undergone puberty.

For prepubertal girls facing highly gonadotoxic treatment:

ovarian tissue cryopreservation is currently the principal established fertility-preservation strategy.

ASRM specifically recognizes OTC for this population.

This represents one of the most important advances in pediatric oncofertility.

Ovarian Transposition Before Pelvic Radiotherapy

Women who require pelvic radiotherapy may sometimes undergo:

Ovarian Transposition

also called:

Oophoropexy.



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The ovaries are surgically moved away from the region receiving the highest radiation exposure.

ASRM recognizes ovarian transposition as a fertility-preservation strategy for selected women undergoing pelvic radiotherapy.

However:

- it does not guarantee ovarian protection;
- scattered radiation may still reach the ovaries;
- the procedure can make future transvaginal egg retrieval technically more difficult.

In some cases, transabdominal egg retrieval may later be needed.

Ovarian Transposition Does Not Protect the Uterus

This is a very important distinction.

Moving the ovaries away from radiation can protect:

ovarian follicles.

It may not protect:

the uterus

if the uterus remains within the radiation field.

A woman may therefore preserve egg production but later face pregnancy risks because of radiation-related uterine injury.

Fertility preservation must consider both:

- gametes,
- ability to carry pregnancy.

Fertility-Sparing Cancer Surgery

Some selected women with:

- early cervical cancer,
- selected endometrial cancer,
- selected ovarian cancer,



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- borderline ovarian tumours

may qualify for fertility-sparing treatment rather than immediate removal of all reproductive organs.

Both ASRM and ASCO recognize appropriately selected conservative gynecologic surgery as part of fertility preservation.

However:

cancer safety always comes first.

Fertility-sparing surgery is appropriate only when oncologically safe.

GnRH Agonists During Chemotherapy

Some women receive medications called:

Gonadotropin-Releasing Hormone Agonists — GnRHa

during chemotherapy.

These temporarily suppress ovarian function.

Studies—particularly in women with breast cancer—suggest they may reduce the chance of premature ovarian insufficiency in some patients.

However:

GnRH agonists should not replace egg, embryo or ovarian tissue preservation.

Both the 2025 ASCO guideline and 2026 ASRM guidance make this distinction.

They may be considered as an:

adjunct,

not a substitute for established cryopreservation strategies.

Women With Breast Cancer

Breast cancer requires special fertility-preservation planning because many tumours are:

- estrogen receptor positive.

Traditional ovarian stimulation raises estrogen levels.

Modern protocols can use:



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- aromatase inhibitors such as letrozole,
- other estrogen-modulating approaches

during stimulation.

The 2026 ASRM guidance reports reassuring observational data regarding ovarian stimulation in women with breast cancer, including estrogen-receptor-positive disease, when appropriate estrogen modulation is used.

These decisions should occur in close cooperation with oncology.

Fertility Preservation for Non-Cancer Medical Conditions

Fertility preservation is not only for cancer patients.

ASRM's 2026 guidance identifies several non-malignant conditions in which fertility may be threatened by:

- disease,
- treatment.

Examples include:

- sickle-cell disease,
- thalassemia,
- rheumatologic disease,
- autoimmune disease,
- conditions requiring stem-cell transplantation.

Some treatments for these diseases can be highly gonadotoxic.

Autoimmune and Rheumatological Disease

Women with conditions such as severe autoimmune or rheumatologic disease may require medications that threaten ovarian function.

In such situations, fertility-preservation counselling may be appropriate before treatment.

The decision depends upon:

- treatment planned,



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- age,
- ovarian reserve,
- medical stability.

Fertility preservation itself should never create an unacceptable medical risk.

Hematological Disorders

Women with:

- sickle-cell disease,
- thalassemia

may require:

- stem-cell transplantation,
- intensive systemic treatment.

ASRM recognizes these conditions among medical indications for fertility-preservation counselling.

Because these patients can be medically complex, treatment requires coordination between:

- hematology,
 - reproductive medicine,
 - anesthesia where appropriate.
-

Genetic Risk of Premature Ovarian Insufficiency

Some genetic conditions increase the risk that ovarian function will decline prematurely.

ASRM lists examples including:

- fragile-X premutation,
- mosaic Turner syndrome,
- selected X-chromosome abnormalities,
- galactosemia,
- certain rare genetic syndromes.



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For selected patients, fertility preservation may be discussed before ovarian reserve becomes severely depleted.

Turner Syndrome and Fertility Preservation

Girls and women with Turner syndrome vary greatly in ovarian function.

Some—particularly those with mosaic forms—may still have follicles or spontaneous puberty.

Fertility-preservation decisions are highly individualized because these patients may also have important:

- cardiovascular risks

that affect the safety of future pregnancy.

Therefore, fertility preservation should not be considered separately from pregnancy safety.

BRCA and Hereditary Cancer Syndromes

Women carrying pathogenic variants such as:

- BRCA1,
- BRCA2

may face future reproductive decisions involving:

- cancer risk-reducing surgery,
- fertility timing,
- PGT-M.

ASRM recognizes hereditary cancer mutations as one group in whom fertility-preservation counselling may be relevant.

Genetic counselling is particularly important.

Endometriosis and Fertility Preservation

Another increasingly discussed area is:

Endometriosis.



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Women with extensive ovarian endometriosis—particularly:

- bilateral endometriomas,
- recurrent ovarian endometrioma,
- previous ovarian surgery

may be at risk of reduced ovarian reserve.

Importantly:

surgery itself can further reduce ovarian reserve.

The ESHRE endometriosis guideline recommends discussing the advantages and disadvantages of fertility preservation with women who have **extensive ovarian endometriosis**, while clearly acknowledging that the true overall benefit remains uncertain.

Should Every Woman With Endometriosis Freeze Eggs?

No.

There is not enough evidence to recommend routine egg freezing for every woman with endometriosis.

Factors that may make the discussion more relevant include:

- bilateral ovarian disease,
- recurrent endometrioma,
- single functioning ovary,
- previous ovarian surgery,
- planned repeat ovarian surgery,
- age,
- ovarian reserve,
- reproductive plans.

ESHRE specifically emphasizes counselling rather than universal treatment because patient-selection criteria and cost-effectiveness remain uncertain.

Fertility Preservation Before Ovarian Surgery



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This is particularly important.

Whenever ovarian surgery is being planned, I ask:

Could this operation reduce ovarian reserve?

For example, surgery for:

- endometrioma,
- bilateral ovarian cysts,
- recurrent ovarian disease

may remove or damage healthy ovarian tissue.

Therefore, in selected women who strongly desire future biological children, fertility-preservation discussion **before surgery** may be valuable.

Diminished Ovarian Reserve and Egg Freezing

Patients often ask:

“My AMH is already low. Should I freeze eggs immediately?”

The answer depends heavily upon:

- age,
- AFC,
- actual expected egg yield,
- family-building plans.

Low ovarian reserve may mean that each stimulation retrieves relatively few eggs.

This can reduce the efficiency of egg freezing.

However, low AMH does not mean:

zero chance.

Again, the decision must be individualized.

Egg Freezing Does Not Increase Ovarian Reserve

This is an important concept.

Egg freezing does not:



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- restore ovaries,
- raise the primordial follicle pool,
- stop ovarian ageing.

It removes and stores some mature eggs that were available during that stimulation cycle.

The woman's natural ovarian reserve continues ageing afterward.

Does Egg Retrieval Use Up Future Eggs Faster?

Patients frequently worry:

“If the doctor takes 10 eggs, have I lost 10 months of future fertility?”

That is not how ovarian physiology works.

During each menstrual cycle, multiple follicles begin development.

Usually only one becomes the dominant ovulatory follicle, while many others undergo natural atresia.

Ovarian stimulation recruits more follicles from that cycle's available cohort.

It does not ordinarily remove years of future follicles from the primordial reserve.

Planned Egg Freezing for Delayed Childbearing

Some women do not have a medical disease but expect to delay childbearing because of:

- personal circumstances,
- education,
- career,
- relationship circumstances,
- family planning choices.

ASRM uses the term:

Planned Oocyte Cryopreservation

rather than terms such as “social freezing.”



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ASRM considers planned OC ethically permissible because it may preserve reproductive autonomy, but stresses that patients need realistic information regarding uncertain benefit and future usage.

Is Planned Egg Freezing Recommended for Every Woman?

No.

ACOG's current patient guidance remains cautious about routine egg freezing solely to delay childbearing, while its 2025 professional guidance recommends discussing reproductive ageing and considering referral to reproductive endocrinology for those expecting delayed childbearing.

Therefore, planned egg freezing should be:

an informed personal decision,

not:

a routine obligation.

Younger Is Generally Better—but Earlier Is Not Always Automatically Better

Biologically, younger eggs generally have greater reproductive potential.

However, if a woman freezes eggs very young, she may never need them because she later conceives naturally.

Therefore, fertility-preservation decisions balance:

- biological efficiency,
- likelihood of future use,
- cost,
- physical burden,
- reproductive plans.

This is why major guidelines do not give one universal “best age.”

What Happens During an Egg-Freezing Cycle?

The woman first undergoes assessment that may include:

- medical history,



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- ultrasound,
- AMH,
- infectious-disease testing,
- other laboratory tests as required.

She then receives injectable gonadotropins to stimulate multiple ovarian follicles.

Follicular development is monitored using:

- ultrasound,
- sometimes hormone measurements.

When follicles are appropriately developed, final maturation is triggered.

Egg retrieval is then performed using a needle, usually guided through the vagina by ultrasound.

Retrieved mature eggs are vitrified.

Is Egg Retrieval Painful?

The procedure is usually performed with:

- sedation,
- anesthesia

depending upon the centre and patient circumstances.

Afterward, some women experience:

- pelvic cramping,
- bloating,
- light spotting.

Serious complications are uncommon but possible.

Risks of Ovarian Stimulation and Egg Retrieval

Potential risks include:

- ovarian hyperstimulation syndrome—OHSS,
- bleeding,



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- infection,
- complications related to anesthesia,
- ovarian torsion, rarely.

In medically complex patients, these risks require additional consideration.

ASRM specifically recommends strategies to minimize OHSS in fertility-preservation cycles so that necessary medical therapy is not delayed.

What Is OHSS?

OHSS means:

Ovarian Hyperstimulation Syndrome.

It occurs when the ovaries respond excessively to stimulation.

Symptoms can range from:

- abdominal bloating,
- discomfort

to rare severe complications involving:

- fluid shifts,
- breathing difficulty,
- blood-clot risk.

Modern stimulation and trigger protocols have reduced the frequency of severe OHSS.

Random-Start Stimulation

Traditional IVF stimulation often began near the start of menstruation.

That may be impractical for a cancer patient who needs treatment urgently.

Modern fertility preservation can often use:

random-start stimulation,

meaning treatment begins regardless of cycle phase.

ASRM reports comparable reproductive outcomes with negligible delays compared with conventional-start protocols.



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This is one of the reasons fertility specialists should be contacted immediately after a fertility-threatening diagnosis.

Can Two Egg-Freezing Cycles Be Done Quickly?

Sometimes.

In selected women, more than one stimulation may be considered when:

- the first cycle yielded few eggs,
- age is more advanced,
- more eggs are desired,
- PGT-M is planned.

ASRM also describes:

DuoStim,

in which more than one ovarian stimulation may be completed within a relatively short time in selected cases.

The benefit, burden and available treatment window must be weighed carefully.

Post-Treatment Fertility Preservation

A woman who missed fertility preservation before chemotherapy should not automatically believe it is too late.

The 2025 ASCO and 2026 ASRM guidance now recognize:

post-treatment fertility preservation

for selected survivors who retain ovarian function but may have a shortened reproductive window.

Possible options can include:

- egg freezing,
 - embryo freezing.
-

Do Not Rush Egg Retrieval Immediately After Chemotherapy

Timing after gonadotoxic treatment requires specialist advice.



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ASRM states that ovarian stimulation:

- during,
- immediately after

gonadotoxic therapy is generally not recommended.

There is no firmly established universal “safe interval” for post-chemotherapy egg or embryo cryopreservation, and ovarian response may continue recovering for some time after treatment.

Cancer-specific oncology advice remains essential.

Fertility Preservation and Future Pregnancy Safety

Preserving eggs does not automatically mean the woman will later be medically safe to carry pregnancy.

Some conditions threaten:

- fertility,
- pregnancy safety

separately.

For example:

- substantial pelvic radiation,
- serious cardiac disease,
- certain cancer histories

may affect whether pregnancy is advisable.

In such circumstances, frozen eggs or embryos may potentially be used with a:

gestational carrier,

where medically and legally appropriate.

Does Storage Time Damage Frozen Eggs?

Available ASRM evidence indicates that longer oocyte storage time has not been associated with lower survival or pregnancy rates within studied storage periods.

The more important biological factor is typically:



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age at the time the eggs were frozen,

rather than the age of the woman when they are later warmed.

Does Egg Freezing Make Pregnancy at 45 the Same as Pregnancy at 30?

No.

An egg frozen at 30 retains younger egg biology.

But the woman carrying the pregnancy at 45 has:

- 45-year-old cardiovascular physiology,
- 45-year-old metabolic physiology.

Therefore, risks such as:

- hypertension,
- diabetes,
- other age-related pregnancy complications

can still be relevant.

Fertility preservation protects eggs.

It does not freeze the rest of the body in time.

Can Frozen Eggs Guarantee a Genetically Normal Baby?

No.

Younger egg age generally lowers the probability of chromosome abnormalities compared with older eggs.

But no individual egg can be guaranteed to be:

- genetically normal,
- fertilizable,
- capable of becoming a healthy child.

This is why responsible fertility preservation requires probability-based counselling.

PGT-A Is Not a Guarantee

When embryos are eventually formed, some patients ask about:

PGT-A

or preimplantation genetic testing for aneuploidy.

PGT-A can provide information about chromosome number in tested embryo cells.

It cannot:

- improve egg quality,
- convert an abnormal embryo into a normal one,
- guarantee implantation,
- guarantee a healthy baby.

ASRM does not support routine PGT-A for every IVF patient.

Fertility Preservation Is Also About Desired Family Size

A woman may say:

“I only want one child.”

Another may want:

- two,
- three children.

This matters.

One successful pregnancy does not automatically preserve fertility for future siblings.

When counselling about how many eggs or embryos to attempt to store, desired family size is an important part of planning.

The Unani Perspective on Fertility Preservation

As a physician trained in **Unani medicine** and focused clinically on **Sexual Disorders & Infertility**, I consider fertility preservation within a broader concept of reproductive health.

Traditional Unani medicine emphasizes:

- **Mizaj** or constitutional temperament,
- balanced nutrition,



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- digestion,
- menstrual health,
- sleep,
- metabolic wellbeing,
- physical vitality,
- psychological wellbeing,
- sexual health.

These are meaningful parts of reproductive preparation.

However, fertility preservation requires an important distinction:

supporting fertility is not the same as storing fertility.

Modern fertility-preservation procedures physically preserve:

- eggs,
- embryos,
- ovarian tissue.

An oral medicine cannot perform that same function.

How Unani Medicine May Be Useful

When medically appropriate, individualized Unani treatment may be useful as **supportive integrative care** for women who are planning future pregnancy or undergoing fertility treatment.

Possible areas of support may include:

- nutritional wellbeing,
- digestive health,
- appropriate body weight,
- menstrual wellbeing,
- sleep,
- stress management,
- sexual wellbeing,
- general preconception health.



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A woman's overall health matters when preparing for:

- ovarian stimulation,
- future pregnancy.

This is where Unani medicine can make a useful contribution within a coordinated reproductive plan.

Unani Medicine Cannot “Freeze” Egg Age

This needs to be stated very clearly.

No Unani, herbal, vitamin or nutritional medicine has been scientifically established as a method that can:

- freeze ovarian ageing,
- stop normal follicle depletion permanently,
- preserve 30-year-old eggs inside the ovary until age 45,
- recreate eggs after ovarian failure.

If a woman wants to preserve eggs at their current biological age, the established method is:

oocyte cryopreservation.

Can Unani Medicine Increase Ovarian Reserve Before Freezing?

There is currently insufficient high-quality evidence that Unani therapy can reliably regenerate the primordial ovarian follicle pool.

A woman with low AMH should therefore not postpone time-sensitive fertility preservation for many months solely in the hope that a medicine will substantially rebuild ovarian reserve.

This becomes particularly important when:

- age is advancing,
 - ovarian surgery is planned,
 - gonadotoxic treatment is approaching.
-

Traditional Fertility Research Is Not the Same as Fertility-Preservation Research



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Research in traditional medicine sometimes evaluates:

- ovulation,
- menstrual cycles,
- general infertility.

That should not automatically be interpreted as evidence for:

fertility preservation.

For example, improving ovulation in a woman with anovulatory infertility does not demonstrate that a treatment can:

- preserve eggs through chemotherapy,
- prevent age-related follicular depletion,
- replace egg freezing.

These are very different biological objectives.

Unani Medicine and Endometriosis

A woman with endometriosis may benefit from individualized management of:

- symptoms,
- menstrual health,
- general wellbeing.

However, current ESHRE guidance states that evidence is insufficient to recommend non-medical approaches, including nutritional or complementary interventions, as a means of improving fertility in endometriosis.

If a woman has extensive ovarian endometriosis and is at risk from ovarian surgery, fertility-preservation counselling should therefore not be delayed while relying on an unproven ovarian-reserve treatment.

Unani Medicine During Cancer Treatment Requires Special Caution

Women considering fertility preservation because of cancer should disclose **every herbal or Unani medicine** to their oncology and reproductive teams.

Cancer therapy can interact with:

- herbs,



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- supplements,
- antioxidants,
- other traditional preparations.

Fertility-preservation treatment should never interfere with:

- chemotherapy,
- radiotherapy,
- immunotherapy,
- endocrine therapy,
- targeted cancer treatment.

Cancer safety takes priority.

What “Special Treatment” Means in My Practice

When I use the phrase:

individualized or specialized fertility-preservation planning,

I do **not** mean that every woman receives one secret fertility medicine.

I mean that we identify:

- why fertility is at risk,
- how rapidly it may decline,
- which preservation option is appropriate,
- whether fertility treatment should happen immediately.

At Saira Health Care, I begin by asking:

How old are you?

Do you currently want children?

How many children may you want?

Are your periods regular?

What is your AMH?

What is your AFC?

Have you had ovarian surgery?



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Do you have endometriosis?

Are you facing chemotherapy or radiotherapy?

Is an ovary going to be removed?

Is there a family history of premature menopause?

Is there a known genetic condition affecting ovarian reserve?

How much time is available before treatment?

These questions determine the plan.

My Approach at Saira Health Care

At **Saira Health Care**, I look at fertility preservation through several steps.

Step One — Identify the fertility threat

Is the major concern:

- age,
 - chemotherapy,
 - radiation,
 - ovarian surgery,
 - endometriosis,
 - genetic risk,
 - another medical treatment?
-

Step Two — Estimate current reproductive potential

This may involve:

- age,
- AMH,
- AFC,
- menstrual history,
- pelvic ultrasound,
- previous reproductive history.



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Step Three — Determine urgency

A woman preparing for chemotherapy next week requires a different approach from a healthy 29-year-old considering planned egg freezing.

Step Four — Select the preservation strategy

Depending upon circumstances:

- egg freezing,
 - embryo freezing,
 - ovarian tissue cryopreservation,
 - ovarian transposition,
 - fertility-sparing surgery.
-

Step Five — Support overall reproductive health

Where clinically appropriate, individualized Unani supportive treatment may address:

- nutrition,
 - digestion,
 - menstrual wellbeing,
 - sleep,
 - stress,
 - sexual health.
-

Different Women Need Different Plans

Consider some examples.

Patient One — Age 29, Delaying Parenthood

Healthy.

Normal ovarian reserve.

No current partner.



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She expects to postpone pregnancy for many years.

Planned egg freezing may be discussed.

She should understand:

- younger age is favourable,
 - egg freezing does not guarantee a future child,
 - she may never need the frozen eggs.
-

Patient Two — Age 38, Wants to Freeze Eggs

Egg freezing remains possible if follicles are available.

But expectations must be very different from a 28-year-old patient.

Age-related decline in egg competence has already occurred.

She may:

- retrieve fewer usable eggs,
- need more than one cycle,
- obtain fewer embryos in the future.

She deserves realistic counselling rather than a guarantee.

Patient Three — Breast Cancer Before Chemotherapy

Age 31.

Cancer treatment must begin soon.

Possible options may include:

- random-start ovarian stimulation,
- egg freezing,
- embryo freezing,
- possibly ovarian tissue cryopreservation depending on circumstances.

The fertility team should work directly with oncology.

Patient Four — Prepubertal Girl Facing Highly Gonadotoxic Therapy

Standard mature egg freezing is not ordinarily possible.

Ovarian tissue cryopreservation may be the principal established fertility-preservation strategy.

Patient Five — Bilateral Ovarian Endometriomas

Age 28.

Future pregnancy desired.

Bilateral ovarian surgery is being considered.

Because both:

- endometriosis,
- ovarian surgery

may affect ovarian reserve, discussion of egg freezing before surgery may be reasonable.

ESHRE specifically recommends discussing fertility-preservation advantages and disadvantages in extensive ovarian endometriosis.

Patient Six — Very Low AMH Before Surgery

Age 35.

AMH very low.

Egg freezing may produce only a small number of eggs.

The treatment plan requires honest discussion about:

- likely yield,
- age,
- whether surgery can be modified,
- whether conception should be prioritized instead.

Simply telling her:

“Freeze eggs”

without discussing the expected yield would not be adequate counselling.



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Patient Seven — Genetic Risk of Early Ovarian Failure

A young woman carries a genetic condition associated with premature ovarian insufficiency.

She may deserve reproductive counselling before ovarian function declines severely.

This can provide options that may not remain available later.

Fertility Preservation Should Not Become Commercial Pressure

I strongly believe fertility awareness is important.

But women should not be frightened into procedures.

Statements such as:

“Freeze your eggs now or you will never become a mother”

are inappropriate.

Likewise:

“Freeze ten eggs and your future baby is guaranteed”

is inappropriate.

The decision should be based on:

- medical facts,
 - personal reproductive goals,
 - realistic probabilities.
-

Fertility Preservation Is About Choice

A woman may decide:

- to freeze eggs,
- not to freeze eggs,
- to try pregnancy earlier,
- to freeze embryos,
- to remain child-free.

Good fertility counselling supports informed decision-making.



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It should not decide a woman's reproductive life for her.

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, our role in fertility preservation is to help patients identify risk early rather than only meeting them after reproductive opportunity has already been lost.

Our approach emphasizes:

- fertility education,
- ovarian-reserve interpretation,
- reproductive-age counselling,
- endometriosis-related planning,
- cancer survivorship awareness,
- coordination with IVF specialists,
- sexual-health assessment,
- individualized supportive Unani care.

The purpose is to provide women with enough information to make decisions at the right time.

Fertility Preservation and Sexual Health

Sexual health and fertility are related but not identical.

A woman may have:

- completely normal sexual function

while ovarian reserve is declining.

Another may have adequate ovarian reserve but difficulty conceiving because of:

- vaginismus,
- painful intercourse,
- reduced sexual activity.

Because my clinical practice focuses on both **Sexual Disorders & Infertility**, I consider these issues together when appropriate.



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Fertility Preservation Does Not Mean Infertility

A healthy woman freezing eggs is not necessarily infertile.

She may be preserving reproductive potential because of anticipated:

- age-related fertility decline,
- medical treatment,
- future surgery.

This distinction is important psychologically.

Egg freezing should not make a woman feel:

“something is already wrong with me.”

Frequently Asked Questions

What is fertility preservation?

Fertility preservation includes methods used to preserve eggs, embryos, ovarian tissue or reproductive function for possible future pregnancy.

What are the main established methods for women?

Current ASRM guidance recognizes:

- mature oocyte cryopreservation,
- embryo cryopreservation,
- ovarian tissue cryopreservation,
- selected fertility-sparing gynecologic treatment.

Ovarian transposition can also preserve ovarian function in selected patients requiring pelvic radiation.

Is egg freezing experimental?

No.

Mature oocyte cryopreservation is an established reproductive technology.



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Is ovarian tissue freezing experimental?

No.

It is now an established fertility-preservation option for appropriately selected females.

Does egg freezing guarantee pregnancy?

No.

It preserves reproductive opportunities but cannot guarantee:

- fertilization,
 - embryo formation,
 - implantation,
 - live birth.
-

What age is best for egg freezing?

There is no universally accepted ideal age.

However, reproductive outcomes are generally better when eggs are frozen at younger ages.

Is 35 too late to freeze eggs?

No.

Egg freezing can still be considered.

But expected egg quality and future success are generally lower than they would have been at a younger age.

Can eggs be frozen at 40?

Potentially, yes, if ovarian function remains.

But counselling must be realistic because age-related chromosomal abnormalities are substantially more common.

The expected benefit may be limited.



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Does high AMH mean I can wait many years before pregnancy?

No.

AMH mainly reflects follicle quantity.

It does not make eggs biologically younger.

Does low AMH mean egg freezing is impossible?

No.

But fewer eggs may be retrieved per stimulation cycle.

The likely benefit should be individualized.

How many eggs should I freeze?

There is no universal number that guarantees a child.

Age and egg number both matter, and clinic-specific counselling is important.

Should I freeze eggs or embryos?

Both are established.

Eggs preserve greater future flexibility regarding sperm source.

Embryos provide information about successful fertilization and early development.

The decision depends upon personal and medical circumstances.

Can I freeze both eggs and embryos?

Yes, in selected circumstances.

How long can eggs stay frozen?

Within available data, storage duration has not been shown to meaningfully reduce oocyte survival or pregnancy rates.

Do frozen eggs continue ageing?

No.

Their biological characteristics largely reflect the age at which they were retrieved.

The woman herself continues ageing, however.

If I freeze eggs at 30 and use them at 42, are they 30-year-old eggs?

In terms of oocyte age, essentially yes—the eggs were collected at age 30.

But pregnancy at 42 still occurs in a 42-year-old body and carries age-related maternal risks.

Will egg freezing delay menopause?

No.

Removing eggs for freezing does not stop ovarian ageing or postpone menopause.

Does egg freezing reduce future fertility?

Standard ovarian stimulation recruits follicles that would mostly otherwise undergo atresia during that cycle.

Egg retrieval is not generally considered to accelerate ovarian ageing by “using up” years of future eggs.

Can ovarian stimulation cause cancer?

Current evidence is reassuring in properly selected patients.

Even in women with breast cancer, observational data using specialized estrogen-modulated protocols have not shown worse cancer outcomes in the available evidence.

Cancer patients still require oncology approval.

What is random-start stimulation?

It means beginning ovarian stimulation immediately rather than waiting for the next menstrual period.

It is particularly useful when medical treatment must start quickly.



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Does fertility preservation delay chemotherapy?

Modern random-start protocols can often keep delay minimal.

Whether treatment can safely wait even briefly must be decided with oncology.

Can women with breast cancer freeze eggs?

Yes, selected women can.

Special stimulation protocols using agents such as letrozole may help limit estrogen exposure.

Treatment requires coordination between reproductive medicine and oncology.

Can GnRH injections preserve fertility during chemotherapy?

They may reduce ovarian failure risk in selected women, particularly with breast cancer.

However, they should not replace established options such as:

- eggs,
 - embryos,
 - ovarian tissue freezing.
-

Can girls before puberty preserve fertility?

Yes, selected prepubertal girls at high risk can undergo ovarian tissue cryopreservation.

It is currently the principal established female fertility-preservation strategy before puberty.

Can women with endometriosis freeze eggs?

Yes.

Fertility preservation may be discussed particularly in extensive ovarian endometriosis.

ESHRE emphasizes, however, that the exact overall benefit remains uncertain and routine freezing is not recommended for every woman with endometriosis.

Should I freeze eggs before endometrioma surgery?

It may be reasonable in selected women, especially when ovarian reserve is at risk.

Important factors include:

- bilateral disease,
 - recurrent disease,
 - single ovary,
 - age,
 - ovarian reserve.
-

Can ovarian surgery lower AMH?

Yes.

Ovarian surgery—particularly for endometrioma—can reduce ovarian reserve.

This is one reason fertility preservation may deserve discussion before major or repeated ovarian surgery.

Can fertility be preserved after chemotherapy?

Sometimes.

Post-treatment egg or embryo freezing can be considered in selected women who retain ovarian function but have a reduced future reproductive window.

Can I freeze eggs immediately after chemotherapy?

Not automatically.

ASRM generally advises against ovarian stimulation during or immediately after gonadotoxic treatment, and the optimal safe timing remains uncertain.

What is ovarian tissue transplantation?

Previously frozen ovarian tissue is transplanted back into the body after treatment.

It may restore ovarian activity and allow pregnancy in selected patients.



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Does transplanted ovarian tissue work forever?

No.

Its functional duration varies and is generally limited.

It should not be considered permanent ovarian replacement.

Can ovarian tissue transplantation reintroduce cancer?

Potentially in some malignancies.

This is why ovarian tissue preservation and later transplantation must be evaluated with the oncology team.

What is ovarian transposition?

The ovaries are surgically moved away from the area receiving pelvic radiation.

This may reduce radiation injury.

Does ovarian transposition guarantee fertility?

No.

Some scattered radiation exposure may remain, and ovarian function may still be lost.

Can women with autoimmune disease preserve fertility?

Yes, fertility preservation may be appropriate when:

- the disease,
- its treatment

poses substantial risk to ovarian function.

ASRM specifically includes autoimmune and rheumatologic conditions among potential medical indications.

Can women with sickle-cell disease or thalassemia preserve fertility?

Yes, particularly when highly gonadotoxic stem-cell transplantation or other treatment is planned.



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These are specifically recognized by ASRM as medical indications for fertility-preservation consideration.

Can women with Turner syndrome preserve fertility?

Some selected patients—particularly those with residual ovarian function—may be candidates.

The decision must also consider the serious cardiovascular risks that Turner syndrome may create during pregnancy.

Can BRCA carriers freeze eggs?

Yes.

Fertility preservation may be considered before:

- cancer treatment,
- risk-reducing ovarian surgery.

PGT-M may also be discussed for known hereditary cancer variants.

Can fertility preservation prevent menopause?

Egg or embryo freezing does not prevent menopause.

Ovarian tissue transplantation may temporarily restore ovarian endocrine activity in selected patients, but it is not permanent hormone replacement.

Can I become pregnant naturally even after freezing eggs?

Yes.

Freezing eggs does not mean they must be used.

Many women may later conceive naturally and never need their stored oocytes.

Can IUI use frozen eggs?

No.

Frozen eggs must be:

- warmed,
- fertilized in the laboratory,
- developed into embryos.

This requires IVF laboratory procedures.

IUI uses sperm rather than previously frozen eggs.

Can Unani medicine preserve my eggs?

Unani medicine may support general reproductive wellbeing but is not an established method of physically preserving eggs.

To preserve eggs outside the body, the established procedure is:

oocyte cryopreservation.

Can Unani medicine stop ovarian ageing?

There is currently insufficient scientific evidence that Unani medicines can permanently stop age-related depletion of ovarian follicles.

Can Unani medicine increase AMH before egg freezing?

Some biological and laboratory values can fluctuate, but there is insufficient high-quality evidence that Unani medicines can regenerate the depleted primordial follicle pool.

A woman should not unnecessarily postpone time-sensitive egg freezing solely to increase an AMH result.

Can Unani treatment still be useful?

Yes, as appropriately selected supportive care.

It may help address:

- nutrition,
- digestion,
- sleep,



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- menstrual wellbeing,
 - metabolic health,
 - infertility-related stress,
 - sexual health,
 - general preconception wellbeing.
-

Can Unani treatment replace egg freezing?

No.

These interventions have completely different purposes.

A Message From Dr. Nizamuddin Qasmi

When a woman comes to me and says:

“Doctor, should I freeze my eggs?”

I do not answer:

“Yes”

simply because she is 35.

And I do not answer:

“No”

simply because her AMH is low.

I first ask:

Why are you considering fertility preservation?

Is it because:

- pregnancy will be delayed?
- chemotherapy is starting?
- ovarian surgery is planned?
- endometriosis is damaging the ovaries?
- there is a family history of early menopause?
- a genetic condition threatens ovarian function?



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Then I ask:

How old are you?

Because age matters.

Then:

What is your AMH?

What is your AFC?

Because egg quantity matters.

Then:

How many children may you want?

Because family-size goals matter.

That is how fertility preservation becomes:

personalized medicine,

rather than simply:

egg freezing for everyone.

What I Tell Young Women Considering Planned Egg Freezing

I explain:

“You are not infertile simply because you are freezing eggs.”

The purpose may simply be to preserve additional options.

But I also explain:

You may never need these eggs.

That is not a treatment failure.

It may mean you later conceived naturally.

What I Tell Women in Their Late Thirties

If a woman first considers egg freezing at 38 or 39, I do not tell her:

“It is too late.”

But I also do not create false reassurance.



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I explain:

- age matters strongly,
- more eggs may be needed,
- multiple cycles may be necessary,
- success is less predictable.

Realistic information allows better decisions.

What I Tell Patients With Low AMH

I explain:

“Low AMH tells us mainly that we may retrieve fewer eggs.”

It does not automatically mean:

- every egg is abnormal,
- there is no chance of future pregnancy.

But when both:

- age is increasing,
- ovarian reserve is low,

I become more concerned about unnecessary delay.

What I Tell Patients Before Ovarian Surgery

I ask:

Could this operation damage healthy ovarian tissue?

If the answer is yes and biological parenthood is important, fertility preservation may deserve discussion **before the operation**.

Once ovarian tissue has been surgically removed, that opportunity may no longer be recoverable.

What I Tell Patients Before Chemotherapy

I explain:

“Cancer treatment comes first—but fertility should still be discussed immediately.”

Modern random-start stimulation means that some women can preserve eggs or embryos without waiting for a particular menstrual cycle.

For very urgent or prepubertal situations, ovarian tissue preservation may provide another option.

My Clinical Philosophy

At **Saira Health Care**, my principle is:

Preserve fertility before it is unnecessarily lost—but never oversell what preservation can achieve.

A good fertility-preservation plan should answer:

What is the threat?

How urgent is it?

What reproductive potential remains?

Which established preservation method fits this woman?

What is her realistic future chance?

How can we support her overall reproductive and sexual health at the same time?

This allows modern reproductive technology and individualized Unani supportive care to be used responsibly within the same patient-centred framework.

Latest Medical Understanding — 2026 Update

1. Egg and embryo freezing are established fertility-preservation methods

The latest 2026 ASRM guidance recognizes both mature oocyte and embryo cryopreservation as established treatments.

2. Ovarian tissue cryopreservation is also established

It is no longer classified as experimental and is particularly important when treatment cannot wait or in prepubertal girls.

3. Fertility preservation should not be delayed unnecessarily

Random-start ovarian stimulation can often begin immediately rather than waiting for menstruation.

4. Age at egg freezing is a major determinant of success



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ASRM reports better outcomes when oocytes are cryopreserved at younger ages, although no single universally optimal age has been established.

5. There is no guaranteed number of eggs

Evidence remains insufficient to give every age group one absolute egg number that guarantees live birth.

6. AMH predicts expected egg yield better than future live birth

Ovarian-reserve tests estimate egg quantity and response to stimulation but should not be interpreted as a guarantee of future reproductive success.

7. Post-treatment fertility preservation is increasingly recognized

Selected cancer and medical-treatment survivors may still freeze eggs or embryos when ovarian function remains but the future reproductive window is shortened.

8. Endometriosis requires individualized counselling

ESHRE recommends discussing fertility preservation in extensive ovarian endometriosis but acknowledges that the true benefit remains uncertain.

9. GnRH agonists are adjuncts—not replacements

For selected women receiving chemotherapy, ovarian suppression may help preserve ovarian function, but it should not replace established egg, embryo or ovarian-tissue preservation.

10. Fertility preservation is now part of preventive reproductive care

ACOG's 2025 guidance emphasizes earlier counselling about age-related ovarian fertility decline so that people can make informed family-building decisions rather than discovering the limits of fertility only after infertility develops.

Conclusion

Fertility Preservation for Women is one of the most important developments in modern reproductive medicine.

It allows selected women to preserve:

- mature eggs,
- embryos,
- ovarian tissue,

before reproductive potential is threatened by:

- cancer treatment,
- radiotherapy,
- stem-cell transplantation,
- ovarian surgery,
- selected medical disease,
- genetic risk,
- reproductive ageing.

The principal established techniques include:

Mature Oocyte Cryopreservation

Embryo Cryopreservation

Ovarian Tissue Cryopreservation

with additional strategies including:

- ovarian transposition before selected pelvic radiotherapy,
- fertility-sparing gynecological surgery.

For women freezing eggs, two major factors affect future reproductive opportunity:

age at freezing

and:

the number of mature eggs stored.

Younger oocytes generally provide better reproductive potential than eggs frozen at older ages.

But:

egg freezing does not guarantee a baby.

Not every egg survives warming.

Not every surviving egg fertilizes.

Not every fertilized egg becomes a viable embryo.

Not every embryo implants.

Therefore, egg freezing should be understood as:

preservation of opportunity,



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not:

guaranteed future motherhood.

AMH and antral follicle count can help estimate expected egg yield.

They do not directly determine egg quality or guarantee future live birth.

For medically urgent fertility preservation, modern:

random-start ovarian stimulation

often allows treatment to begin without waiting for the next menstrual cycle, reducing delays before cancer or other urgent medical treatment.

Ovarian tissue cryopreservation has become especially important.

It is now an established option for carefully selected patients and is currently the principal fertility-preservation method for prepubertal girls facing highly gonadotoxic therapy.

For women with:

extensive ovarian endometriosis,

fertility preservation deserves discussion—particularly before potentially damaging ovarian surgery—although current ESHRE guidance appropriately emphasizes that the true benefit is not yet known for every patient.

From the **Unani perspective**, reproductive health can be supported through attention to:

- Mizaj,
- nutrition,
- digestion,
- menstrual health,
- metabolic wellbeing,
- sleep,
- psychological wellbeing,
- sexual health.

These can contribute meaningfully to whole-person reproductive care.

However:

Unani medicine should not be presented as a substitute for fertility-preservation technology.

There is currently insufficient scientific evidence that any Unani or herbal medicine can reliably:

- stop ovarian ageing,
- preserve eggs through chemotherapy,
- regenerate a depleted primordial follicle pool,
- recreate ovarian tissue after surgical removal.

At **Saira Health Care**, my approach is therefore integrative but evidence-based:

identify women at risk before fertility is lost, assess reproductive age and ovarian reserve appropriately, recognize cancer, endometriosis, ovarian surgery and genetic risks early, coordinate established fertility-preservation procedures when indicated, avoid unnecessary delay, and integrate individualized Unani supportive care for nutritional, menstrual, metabolic, sexual and general reproductive wellbeing.

My most important message to women is:

Fertility preservation works best when it is discussed before the opportunity has disappeared.

Do not assume you need egg freezing simply because you have reached a particular birthday.

But do not assume that fertility technology can completely compensate for waiting indefinitely.

Do not panic because AMH is low.

But do not spend valuable reproductive years solely trying to increase a laboratory number.

And if you are facing:

- cancer treatment,
- major ovarian surgery,
- extensive endometriosis,
- a genetic risk of premature ovarian failure,

ask about fertility preservation **before treatment whenever medically possible.**



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The best fertility-preservation decision is one based on:

your age, your ovarian reserve, your medical risk, your reproductive goals and realistic evidence—not fear or guarantees.

About the Author

Dr. Nizamuddin Qasmi

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

Qualifications & Professional 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

Dr. Nizamuddin Qasmi is a well-qualified physician whose clinical work at **Saira Health Care** has a focused emphasis on:

- sexual disorders,
- male infertility,
- female infertility,
- reproductive-health counselling.

His approach to fertility preservation emphasizes **early recognition of fertility risk and individualized reproductive planning** rather than recommending the same procedure to every woman.

Depending upon the patient, assessment may include:

- detailed reproductive history,
- future family-building goals,
- menstrual history,
- AMH,
- antral follicle count,



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- ovarian and pelvic ultrasound,
- review of endometriosis or ovarian surgery,
- review of cancer and medical treatment,
- assessment of genetic or family risk for premature ovarian insufficiency,
- coordination with reproductive endocrinology and IVF services,
- oncology coordination where cancer is involved.

Where clinically appropriate, individualized principles of Unani medicine may be incorporated to support:

- nutritional health,
- digestion,
- menstrual wellbeing,
- metabolic health,
- sleep,
- sexual wellbeing,
- psychological and general reproductive health

without delaying established fertility-preservation treatment.

Medical Disclaimer

This article is intended for general health education and public awareness. It does not establish an individual diagnosis or recommend a specific fertility-preservation procedure for any particular patient.

Women considering fertility preservation should receive individualized assessment by an appropriately qualified reproductive-medicine specialist.

Patients facing:

- cancer treatment,
- chemotherapy,
- radiotherapy,
- stem-cell transplantation,
- ovarian surgery,



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- another fertility-threatening medical intervention

should discuss reproductive risks with their treating specialist **before treatment whenever medically possible.**

Cancer treatment should never be delayed or modified without oncology approval.

Egg freezing, embryo freezing and ovarian tissue preservation improve reproductive options but do **not** guarantee future pregnancy or live birth.

AMH should not be interpreted as a direct egg-quality test or a guarantee of future fertility.

Planned egg freezing should not create a false sense that pregnancy can safely be delayed indefinitely.

No Unani medicine, herbal preparation, supplement, dietary programme, PRP procedure or other complementary therapy has been established as a substitute for:

- oocyte cryopreservation,
- embryo cryopreservation,
- ovarian tissue cryopreservation

when true fertility preservation is medically required.

Women taking Unani medicines, herbs or supplements during treatment for serious medical disease should disclose them to their treating medical team to minimize potential interactions and ensure coordinated care.

