Irregular Menstruation and Anovulatory Infertility: Causes, Diagnosis, Modern Treatment and the Role of Unani Medicine

By Dr. Nizamuddin Qasmi

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

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

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Introduction: "Doctor, My Periods Are Irregular—Does That Mean I Am Not Ovulating?"

This is one of the most common questions women ask me in fertility practice.

A patient may say:

"Doctor, sometimes my period comes after 35 days, sometimes after 50 days. Can I still become pregnant?"

Another woman asks:

"I bleed every month, so I must be ovulating, right?"

And another says:

"My periods have stopped for three months. Is this because of PCOS, thyroid, stress or low AMH?"

These questions are important because menstruation and ovulation are closely connected—but they are not exactly the same thing.

The research supplied for this article correctly emphasizes that irregular menstruation can be an important visible clue to disturbances in the hormonal system controlling ovulation and that ovulatory dysfunction is an important contributor to female infertility.

However, there are two important corrections:

Irregular periods do not automatically mean that every cycle is anovulatory.

And:

Bleeding every month does not absolutely prove that ovulation occurred in every cycle.

Most women with regular predictable cycles are ovulating, while women with oligomenorrhea or amenorrhea are much more likely to have ovulatory dysfunction. ASRM states that a history of oligomenorrhea or amenorrhea is generally sufficient to establish that ovulatory dysfunction is present and should prompt investigation into its cause.

When a woman has irregular menstruation and wishes to become pregnant, the correct question is therefore not simply:

“How can we make the period come?”

The more useful questions are:

- Why are the periods irregular?
- Is ovulation occurring?
- Is PMOS/PCOS present?
- Is there a thyroid problem?
- Is prolactin elevated?
- Is the woman under-eating or over-exercising?
- Is ovarian function declining?
- Is there another endocrine disorder?
- Are the fallopian tubes open?
- Is the male partner's semen normal?

At Saira Health Care, my approach is to treat:

the cause of menstrual and ovulatory dysfunction—not merely produce withdrawal bleeding with medicine.

What Is a Normal Menstrual Cycle?

In most reproductive-age women who are ovulating regularly, menstrual cycles usually occur approximately every:

21–35 days.

There can still be some normal variation from month to month. ASRM notes that variability of several days is common even among healthy women.

A menstrual cycle is counted from:

the first day of one period to the first day of the next.

A perfectly regular:

28-day cycle

is not required for fertility.

Women can normally ovulate with cycles such as:

- 25 days,
- 29 days,
- 32 days,
- 34 days.

What concerns me more is a persistent pattern such as:

- cycles repeatedly longer than about 35 days,
- very few periods per year,
- months without menstruation,
- marked unpredictability.

What Is Irregular Menstruation?

The term irregular menstruation can describe several patterns.

These may include:

Oligomenorrhea

Periods that occur infrequently, often with long intervals between cycles.

Amenorrhea

Absence of menstruation.

Frequent menstrual cycles

Cycles occurring unusually close together.

Unpredictable bleeding

Bleeding occurring without a regular pattern.

Abnormal uterine bleeding

Bleeding that is:

- excessively heavy,
- prolonged,
- irregular,
- occurring between periods.

Irregular bleeding has many possible causes and should not automatically be attributed to:

“hormonal imbalance.”

What Is Amenorrhea?

Amenorrhea means:

absence or abnormal cessation of menstruation.

ASRM's 2024 guidance defines secondary amenorrhea as:

- absence of periods for more than **3 months** in someone who previously had regular cycles,
- or approximately **6 months** in someone whose cycles were already irregular.

Such a pattern requires evaluation.

Primary amenorrhea—when menstruation never begins—also requires evaluation, generally by age 15 when normal secondary sexual development is present.

The First Test in a Missed Period Is Pregnancy

This sounds obvious, but it is extremely important.

Whenever a reproductive-age woman develops:

- a delayed period,
- amenorrhea,
- unexpected cycle change,

pregnancy should be considered first.

ASRM emphasizes that pregnancy must remain at the forefront of the evaluation of secondary amenorrhea.

A woman should not immediately take:

- hormone tablets,
- emmenagogue herbs,
- menstrual stimulants,
- Unani *Mudir-e-Haiz* medicines

before pregnancy has been appropriately excluded.

Understanding Ovulation

Ovulation is:

the release of a mature egg from the ovary.

Pregnancy through natural intercourse requires an egg to be available for fertilization.

If no egg is released during a particular cycle:

natural conception cannot occur during that cycle.

This failure to release an egg is called:

anovulation.

If ovulation happens occasionally but not regularly, we may describe it as:

oligo-ovulation.

How the Normal Menstrual Cycle Works

The menstrual cycle depends on communication between:

- the brain,
- pituitary gland,
- ovaries,
- uterus.

This communication network is known as:

the hypothalamic-pituitary-ovarian axis – HPO axis.

Step 1: Hypothalamus

The hypothalamus in the brain releases:

GnRH – gonadotropin-releasing hormone

in pulses.

These pulses stimulate the pituitary gland.

Step 2: Pituitary Gland

The pituitary releases:

- FSH – follicle-stimulating hormone,
- LH – luteinizing hormone.

Step 3: Follicular Growth

FSH helps ovarian follicles develop.

One follicle usually becomes dominant.

As it grows, it produces:

estradiol.

Step 4: Ovulation

When estradiol rises sufficiently, the brain and pituitary respond with an:

LH surge.

The mature follicle ruptures and releases the egg.

Step 5: Corpus Luteum

After ovulation, the empty follicle becomes the:

corpus luteum.

The corpus luteum produces:

progesterone.

Progesterone helps prepare and stabilize the endometrium for possible implantation.

Step 6: Menstruation

If pregnancy does not occur:

- the corpus luteum regresses,
- progesterone and estrogen fall,
- the endometrial lining sheds.

This produces normal menstrual bleeding.

What Happens When Ovulation Does Not Occur?

When an egg is not released:

- no normal corpus luteum forms,
- normal luteal progesterone production does not occur.

The endometrium may continue to be stimulated by estrogen in an irregular way.

Eventually the lining may become unstable and bleed unpredictably.

This is one mechanism of:

abnormal uterine bleeding due to ovulatory dysfunction – AUB-O.

ACOG recognizes that lack of ovulation can cause irregular and sometimes heavy bleeding and that repeated anovulation can allow the endometrium to become excessively thick.

Is Every Bleed a True Menstrual Period?

Not necessarily.

A woman may bleed because the endometrium has become unstable even though:

ovulation never occurred.

Therefore, a woman with anovulatory cycles may say:

“But doctor, I had bleeding last month.”

The presence of blood alone does not always prove that the complete ovulatory cycle occurred normally.

Can a Woman Have Regular Periods but Occasionally Not Ovulate?

Yes.

Occasional anovulatory cycles can occur even in otherwise regularly menstruating women.

However, they are relatively uncommon.

ASRM reports that sporadic anovulation in regularly menstruating women is generally in the range of approximately 1–14%, and menstrual history is highly predictive of ovulation in women without hirsutism.

How Common Is Ovulatory Dysfunction in Infertility?

Ovulatory problems are one of the major identifiable female fertility factors.

ASRM estimates that ovulatory dysfunction is found in approximately:

15% of infertile couples

and accounts for up to:

40% of infertility in women

in some clinical populations.

The exact percentage differs between populations and diagnostic definitions.

What Are the Symptoms of Anovulation?

Anovulation itself may not cause pain.

Common clues include:

- irregular cycles,
- cycles longer than 35 days,
- missed periods,
- very few periods per year,
- infertility,
- unpredictable bleeding.

Associated symptoms can point toward the underlying cause.

For example:

PMOS/PCOS

- facial hair,
- acne,
- weight/metabolic problems.

Hyperprolactinemia

- milk discharge from the breasts,
- amenorrhea.

Thyroid disease

- weight change,
- cold or heat intolerance,
- heart-rate changes.

Functional hypothalamic amenorrhea

- significant exercise,
- low calorie intake,
- low weight,
- psychological stress.

Primary ovarian insufficiency

- absent periods,
- hot flushes,
- vaginal dryness in some women.

Major Causes of Irregular Menstruation and Anovulatory Infertility

There is no single cause.

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1. PMOS – Formerly PCOS

The condition traditionally called:

Polycystic Ovary Syndrome – PCOS

is now increasingly referred to in current international professional terminology as:

Polyendocrine Metabolic Ovarian Syndrome – PMOS.

It is one of the most common causes of:

- oligomenorrhea,
- chronic anovulation,
- infertility.

ASRM's current fertility and amenorrhea guidance now uses PMOS terminology.

PMOS can involve:

- irregular ovulation,
- androgen excess,
- insulin resistance,
- altered follicular development,
- metabolic abnormalities.

PMOS Does Not Mean "Ovarian Cysts Stop the Egg"

This is an important misunderstanding.

The many small structures commonly seen on ultrasound are generally:

small developing follicles

rather than ordinary pathological ovarian cysts.

The problem is often:

failure of normal dominant follicle maturation and ovulation.

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2. Functional Hypothalamic Amenorrhea

Functional hypothalamic amenorrhea—FHA—can occur when the brain reduces reproductive signaling because of:

- insufficient energy intake,
- significant weight loss,
- excessive physical training,
- psychological stress,
- eating disorders,

- combinations of these factors.

The ovaries may be structurally normal.

The problem is:

reduced GnRH and gonadotropin signaling from the brain.

ASRM notes that FHA is characterized by low estrogen and usually low-to-normal gonadotropin levels.

This is fundamentally different from PMOS.

Why Telling an FHA Patient to "Lose Weight" Can Be Harmful

If menstruation stopped because the woman:

- eats too little,
- exercises excessively,
- has inadequate energy availability,

further weight loss may worsen:

- amenorrhea,
- low estrogen,
- bone health,
- infertility.

Therefore the same treatment cannot be given to every woman with irregular menstruation.

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3. Thyroid Disease

Both:

- hypothyroidism,
- hyperthyroidism

can interfere with menstrual and ovulatory function.

ASRM recommends thyroid-stimulating hormone—TSH—as an important early test in women with menstrual abnormalities or amenorrhea.

Treatment should address the actual thyroid disease.

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4. Hyperprolactinemia

Prolactin is the hormone involved in milk production.

When prolactin becomes abnormally elevated outside pregnancy or breastfeeding, it can suppress reproductive signaling and cause:

- oligomenorrhea,
- amenorrhea,
- anovulation,
- infertility,
- sometimes galactorrhea.

ASRM includes prolactin testing in the evaluation of amenorrhea and menstrual irregularity.

Causes of High Prolactin

These may include:

- pituitary prolactinoma,
- medicines,
- hypothyroidism,
- physiological factors,
- other pituitary conditions.

Therefore:

high prolactin is not a disease name by itself—the cause matters.

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5. Primary Ovarian Insufficiency – POI

Primary ovarian insufficiency occurs when ovarian function becomes impaired before the usual age of menopause.

It may present with:

- irregular periods,
- amenorrhea,
- infertility,
- low estrogen.

FSH may be elevated.

This is fundamentally different from PMOS because the problem is not simply irregular follicle release; ovarian follicular function has become significantly reduced.

Can Unani Medicine Recreate a Depleted Ovarian Reserve?

There is no high-quality evidence showing that any:

- herbal medicine,
- Unani formulation,
- supplement,
- diet

can generate a new normal ovarian reserve after genuine ovarian depletion.

Supportive treatment may improve:

- nutrition,
- wellbeing,
- associated symptoms,

but should not be advertised as:

“making new eggs.”

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6. Significant Weight Gain and Metabolic Disease

Obesity and metabolic dysfunction can disrupt:

- insulin signaling,
- ovarian endocrine function,
- ovulation.

This is particularly relevant in PMOS.

Lifestyle treatment may therefore be very important for selected patients.

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7. Significant Weight Loss or Undernutrition

Low energy availability can suppress reproductive hormones.

Patients may experience:

- delayed periods,
- absent periods,
- infertility.

Again, this requires:

nutritional restoration—not additional dieting.

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8. Excessive Exercise

Exercise is healthy.

But very high exercise load combined with inadequate food intake may suppress:

- GnRH,
- estrogen,
- ovulation.

The issue is generally:

energy deficiency

rather than exercise itself.

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9. Perimenopause and Reproductive Aging

As ovarian function changes with age:

- cycles may become less predictable,
- ovulation may become less consistent.

Female age is also the single most important general predictor of natural fecundity.

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10. Medications

Some medicines can affect menstrual cycles.

ASRM lists medication categories associated with amenorrhea including:

- antipsychotics,
- some antiepileptics,

- gonadotoxic chemotherapy,
- steroid hormones,
- GnRH analogues,
- certain drugs of abuse.

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11. Pituitary or Hypothalamic Disease

Less commonly, structural disease of the:

- hypothalamus,
- pituitary gland

can disrupt ovulation.

A patient with:

- significant headaches,
- visual symptoms,
- persistent hyperprolactinemia

may need pituitary evaluation.

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12. Uterine or Outflow-Tract Problems

Not every absent period is caused by lack of ovulation.

Scar tissue such as:

Asherman syndrome

or cervical/outflow obstruction can interfere with menstrual bleeding.

ASRM notes that uterine instrumentation followed by new amenorrhea should raise suspicion for intrauterine scarring.

Irregular Menstruation Does Not Automatically Equal PMOS

This is a common problem in fertility practice.

A woman misses two periods and is told:

“You have PCOD.”

That diagnosis may be wrong.

Before labelling PMOS, clinicians should consider:

- pregnancy,
- thyroid disease,
- high prolactin,
- FHA,
- POI,
- other endocrine disease.

Why Chronic Anovulation Matters Even if Pregnancy Is Not Desired

Some women say:

"Doctor, I am not trying to become pregnant, so why should I treat irregular periods?"

Because chronic anovulation can affect:

endometrial health.

When endometrial tissue is exposed for long periods without normal cyclic progesterone, excessive thickening can occur.

ACOG recognizes:

- endometrial overgrowth,
- abnormal heavy bleeding

as complications of repeated anovulation.

In PMOS, long-standing untreated anovulation is also associated with increased endometrial-hyperplasia risk.

Hypoestrogenic Amenorrhea Has Different Risks

A woman with:

- FHA,
- POI

may have insufficient estrogen rather than prolonged estrogen exposure.

Her concerns can include:

- bone health,
- vaginal health,
- cardiovascular implications depending on diagnosis.

This illustrates why simply giving every amenorrheic woman:

the same period medicine

is poor medical practice.

How Is Anovulatory Infertility Diagnosed?

Diagnosis should proceed logically.

Step 1: Detailed Menstrual History

I ask:

- At what age did periods begin?
- Were cycles ever regular?
- How many days apart are they now?
- How many periods occur per year?
- Has bleeding recently changed?
- Is bleeding heavy?
- Is there facial hair?
- Acne?
- Milk discharge?
- Pelvic pain?
- Major weight change?
- Excessive exercise?
- Eating restriction?

Often, the history gives the first major diagnostic clue.

Step 2: Pregnancy Test

Before investigating hormonal disease:

exclude pregnancy.

This is the first principle of secondary-amenorrhea evaluation.

Step 3: Is Additional Ovulation Testing Needed?

If a woman has clear:

- oligomenorrhea,
- amenorrhea,

ASRM states that this history itself is sufficient evidence of ovulatory dysfunction.

The next task is to identify:

why she is not ovulating.

What If Cycles Look Regular but Ovulation Is Uncertain?

A luteal progesterone measurement may sometimes help.

The correct timing is usually approximately:

one week before the expected next period

rather than automatically calling it a:

“day-21 progesterone test”

for every woman.

A woman with a 35-day cycle does not have the same ovulation day as one with a 28-day cycle.

Step 4: Thyroid Testing

TSH is commonly included when menstrual abnormalities are present.

Both low and high thyroid function can disrupt ovulation.

Step 5: Prolactin

Prolactin should be checked particularly in:

- oligomenorrhea,
- amenorrhea,
- galactorrhea.

Persistent elevation may require further evaluation.

Step 6: FSH and Estradiol in Amenorrhea

These can help distinguish different biological patterns.

For example:

POI

- FSH tends to be elevated,
- estrogen low.

FHA

- FSH/LH may be low or normal,
- estradiol low.

ASRM uses these hormonal patterns as an important component of amenorrhea evaluation.

Step 7: Androgen Testing When Indicated

If the woman has:

- hirsutism,
- severe acne,
- scalp hair thinning,
- virilization,

the clinician may investigate:

- testosterone,
- DHEAS,
- 17-hydroxyprogesterone

depending on the presentation.

Rapid Virilization Is a Red Flag

Very rapid development of:

- severe facial hair,
- deepening voice,
- clitoral enlargement,
- increased muscle mass

is not typical ordinary PMOS.

An androgen-producing:

- ovarian,
- adrenal tumor

may need exclusion.

Step 8: Pelvic Ultrasound

Ultrasound can provide information about:

- ovaries,
- endometrium,
- fibroids,
- ovarian masses,
- PMOS morphology,
- uterine anatomy.

ASRM considers pelvic ultrasound highly informative in secondary amenorrhea evaluation when available.

Does Ultrasound Prove Ovulation?

Not always.

Serial follicular monitoring can demonstrate:

- follicular growth,
- follicular rupture

when needed.

But most women do not need repeated scans simply to prove normal ovulation when their menstrual pattern is clearly regular.

Step 9: Ovarian Reserve Testing

Depending on the fertility situation:

- AMH,
- antral follicle count

may be useful.

But:

AMH is not an ovulation test.

And it should not be interpreted as a simple:

“fertility percentage.”

ASRM states that ovarian-reserve testing is a poor stand-alone predictor of natural fertility and should be used as an adjunct in fertility evaluation.

Step 10: Evaluate the Male Partner

If pregnancy is the goal:

the husband should also be evaluated.

A woman may have anovulation while the male partner simultaneously has:

- low sperm count,
- poor motility,
- azoospermia.

Correcting ovulation alone may then be insufficient.

ASRM recommends parallel evaluation of the male partner when appropriate.

Step 11: Tubal Patency

If infertility has persisted and ovulation treatment is planned, the clinician should consider whether at least one fallopian tube is functional.

Tests may include:

- HSG,
- HyCoSy.

There is little benefit in repeatedly stimulating ovulation if:

both tubes are severely blocked.

Modern Treatment of Anovulatory Infertility

Treatment depends on:

the underlying diagnosis.

There is no universal “period tablet.”

Treatment of PMOS-Related Anovulatory Infertility

This is one of the most important current guideline updates.

WHO's first global infertility guideline, published in November 2025, recommends:

letrozole

over:

- clomiphene citrate,
- metformin

as first-line pharmacological treatment for infertility caused by PMOS/PCOS-related ovulatory dysfunction.

WHO also suggests letrozole alone rather than routinely combining it with metformin.

What Is Letrozole?

Letrozole is:

an aromatase inhibitor.

By temporarily reducing estrogen synthesis, it alters hormonal feedback and encourages the ovary to develop a mature follicle.

It is usually taken for several days early in the cycle under medical supervision.

Why Does Letrozole Need Monitoring?

Ovulation-induction treatment can cause:

- multiple follicles,
- multiple pregnancy,
- ovarian over-response.

Ultrasound monitoring may therefore be appropriate depending on:

- patient,
- dose,
- treatment setting.

Is Metformin a Fertility Medicine for Every PMOS Patient?

No.

Metformin can be useful particularly where:

- metabolic dysfunction,
- insulin resistance,
- glucose abnormalities

are important.

But WHO currently prefers letrozole over metformin alone when the main goal is:

ovulation induction and pregnancy.

What If Oral Ovulation Treatment Fails?

WHO suggests:

gonadotrophins

over routine laparoscopic ovarian drilling for PMOS-related infertility that has not responded to appropriate oral pharmacological treatment.

These injectable treatments require careful fertility monitoring.

What If Gonadotrophins Also Fail?

WHO suggests moving to:

IVF

rather than continuing expectant management indefinitely after unsuccessful appropriate pharmacological therapy.

Treatment of Hyperprolactinemia

When high prolactin is the cause of anovulation, treatment should:

lower prolactin and treat its cause.

WHO's 2025 infertility guideline suggests:

cabergoline over bromocriptine

for infertility due to hyperprolactinemic ovulatory dysfunction, based on available effectiveness and tolerability evidence.

Treatment of Thyroid-Related Ovulatory Dysfunction

When thyroid disease is the cause:

treat the thyroid disease.

Correcting thyroid function may allow normal menstrual and ovulatory function to resume in many women.

Taking ovulation medicines without addressing major thyroid dysfunction is not an ideal strategy.

Treatment of Functional Hypothalamic Amenorrhea

Treatment should focus on reversing the energy and physiological stress deficit.

This may require:

- increasing calorie intake,
- improving nutrition,
- reducing excessive exercise,
- restoring healthy energy availability,
- psychological/eating-disorder treatment where needed.

This patient does not primarily need:

“stronger menstrual stimulation.”

She needs restoration of normal hypothalamic reproductive signaling.

Treatment of Primary Ovarian Insufficiency

POI requires a completely different fertility discussion.

Depending on:

- age,
- residual ovarian activity,
- fertility goals,

management may involve:

- hormonal health management,
- reproductive counselling,
- assisted reproduction,
- donor-oocyte discussion in appropriate patients.

No ethical treatment should promise that herbs will:

reliably regenerate depleted follicles.

Treating Abnormal Bleeding Is Not the Same as Treating Infertility

Hormonal treatments such as:

- combined oral contraceptives,
- progestogens

may regulate bleeding and protect the endometrium.

But if a woman is trying to conceive:

the treatment objective is different.

We need to restore or induce:

ovulation

rather than simply create regular withdrawal bleeding.

The Unani Understanding of Irregular Menstruation and Infertility

The Unani system has described:

- menstrual disorders,
- amenorrhea,
- infertility

for centuries.

Classical terminology includes:

Haiz

menstruation.

Ihtibas-e-Tams

suppressed or absent menstruation.

Qillat-e-Tams

scanty menstruation.

Kasrat-e-Tams

excessive menstruation.

‘Uqr

infertility.

The supplied research explains irregular menstruation and infertility through the traditional doctrines of:

- Mizaj,
- Akhlat,
- uterine temperament,
- reproductive faculties.

Mizaj – Temperament

In Unani theory, health depends partly on:

Mizaj

or temperament.

Traditional qualities include:

- Hararat – heat,
- Barudat – cold,
- Rutubat – moisture,
- Yubusat – dryness.

Alterations are described as:

Su-e-Mizaj.

The Four Akhlat

Traditional Unani medicine describes four humors:

Dam

Blood.

Balgham

Phlegm.

Safra

Yellow bile.

Sauda

Black bile.

The supplied research describes menstrual disease through changes in these traditional humoral states.

An Important Scientific Distinction

Traditional Unani concepts should not be falsely translated into modern endocrine statements.

For example:

Balgham is not insulin.

Safra is not estrogen.

Su-e-Mizaj Barid is not hypothyroidism.

Uterine dryness is not scientifically identical to low AMH.

These are:

different medical frameworks.

A patient can be assessed within both systems without pretending that one traditional term represents one modern hormone.

Haiz as "Purification": How Should We Explain This Today?

Classical Unani physiology historically describes menstruation as an important form of:

Istifragh

or evacuation.

The supplied text presents Haiz as a traditional route through which excess or unwanted humoral material is removed.

This is appropriate when describing:

classical Unani theory.

But modern medicine does not describe menstruation as a process for removing generalized:

- toxins,
- metabolic poisons

from the body.

Modern physiology explains menstruation through:

- ovarian hormones,
- endometrial growth,
- progesterone withdrawal.

Therefore, I would not tell a patient:

"Your toxins are accumulating because your period did not come."

Instead I explain both perspectives separately.

Su-e-Mizaj Barid

In traditional Unani literature, a cold temperament may be associated with:

- delayed cycles,
- reduced reproductive vigor,
- sluggishness.

The supplied paper relates some of these traditional presentations to conditions such as PMOS or hypothyroid-type symptom patterns.

But this should be interpreted as:

a traditional clinical analogy

rather than a scientifically proven one-to-one correlation.

Su-e-Mizaj Ratab

The traditional wet/moist temperament may be associated with:

- discharge,
- obesity,
- constitutional laxity.

Some contemporary Unani writers use it when describing PMOS-like presentations.

Again:

traditional Rutubat is not scientifically identical to insulin resistance or obesity.

Su-e-Mizaj Yabis

Traditional dryness is associated with:

- scanty menses,
- constitutional dryness,
- reduced reproductive nourishment.

This can be discussed within Unani practice.

But it should not be equated automatically with:

- POI,
- hypothalamic amenorrhea.

Unani Diagnosis: What Is Useful and What Are Its Limits?

A Unani physician may assess:

- Nabz – pulse,
- Baul – urine,
- Baraz – stool,
- menstrual characteristics,
- diet,
- sleep,
- body constitution,
- lifestyle,
- traditional Mizaj.

The supplied research details these classical diagnostic methods.

These methods are part of traditional clinical assessment.

However:

they cannot replace a pregnancy test, TSH, prolactin, FSH/estradiol, ultrasound or fertility testing when these investigations are medically indicated.

For example:

- pale urine cannot diagnose hypothyroidism,
- a particular pulse cannot diagnose PMOS,
- menstrual clots cannot prove a specific Akhlat imbalance in modern laboratory terms.

The strongest integrative model is:

traditional assessment plus appropriate modern diagnostics.

Main Unani Treatment Approaches

Classical Unani treatment broadly includes:

Ilaj-bil-Ghiza

Dietotherapy.

Ilaj-bit-Tadbir

Regimenal therapy.

Ilaj-bid-Dawa

Pharmacotherapy.

Ilaj-bil-Yad

Surgical/manual treatment where appropriate.

For irregular menstruation and fertility, the first three may provide useful supportive strategies.

Ilaj-bil-Ghiza – Dietotherapy

Diet is especially important when ovulatory dysfunction is related to:

- PMOS,
- obesity,
- insulin resistance,
- undernutrition.

A practical individualized diet may include:

- adequate protein,
- vegetables,
- pulses,
- whole grains where suitable,
- fruit,
- nuts,
- seeds,
- healthy fats.

Patients should usually reduce:

- excess refined sugar,
- sugar-sweetened beverages,
- ultra-processed foods.

Should Every PMOS Patient Avoid Milk, Yogurt, Cucumber and Citrus?

No.

The supplied traditional report recommends strict avoidance of certain foods described as:

cold and moist.

That can be described as:

traditional Mizaj-based dietetics.

But there is no modern clinical evidence that all women with PMOS or anovulation must avoid:

- yogurt,
- cucumber,
- citrus fruits,
- milk

to restore ovulation.

A balanced diet should remain:

- nutritionally adequate,
- culturally practical,
- individualized.

Ilaj-bit-Tadbir – Regimenal Therapy

Regimenal treatment may involve attention to:

- exercise,
- sleep,
- daily routine,
- stress,
- traditional procedures.

These lifestyle components can be genuinely useful.

For example, physical activity can improve:

- insulin sensitivity,
- metabolic health

in PMOS.

Hijama and Anovulatory Infertility

The supplied material presents Hijama as a treatment intended to:

- remove morbid material,
- improve blood flow,
- assist infertility.

Hijama has an established place within traditional Unani regimenal practice.

However:

there is not yet strong enough clinical evidence to call Hijama a proven ovulation-induction treatment.

I would not claim that Hijama has been scientifically shown to:

- normalize FSH/LH in all women,
- cure PMOS,
- restore ovarian reserve,
- replace letrozole,
- produce a predictable pregnancy rate.

It may be considered:

complementary regimenal care

for appropriately selected patients under trained supervision.

Abzan

Traditional sitz baths may provide:

- warmth,
- comfort,
- relaxation.

The source describes Abzan for pelvic and menstrual problems.

But there is insufficient evidence that an external or vaginal herbal bath can:

- reopen fallopian tubes,
- dissolve pelvic adhesions,
- induce normal ovulation.

Active PID requires appropriate antimicrobial treatment.

Humool and Vaginal Preparations

Traditional Humool preparations are described in classical and contemporary Unani practice.

However:

fertility patients should be particularly cautious with intravaginal or intrauterine herbal preparations.

Non-sterile or irritating substances may cause:

- vaginal irritation,
- infection,
- ascending reproductive infection.

No local preparation should replace modern evaluation of:

- cervical disease,
- tubal disease.

Munzij-Mushil and "Detoxification"

The supplied paper gives a detailed traditional sequence of:

- Munzij,
- Mushil,
- Tanqiya

before fertility treatment.

This represents an authentic traditional Unani therapeutic concept.

But modern scientific evidence does not show that purgation:

- clears ovarian cysts,
- removes infertility toxins,
- induces ovulation reliably.

Aggressive purgation can potentially cause:

- dehydration,
- electrolyte disturbances,
- weakness.

It should therefore never be used casually in:

- underweight women,
- pregnant women,
- medically vulnerable patients.

Ilaj-bid-Dawa – Unani Pharmacotherapy

Traditional fertility practice includes herbs and formulations categorized as:

- Mudir-e-Haiz – menstrual stimulants/emmenagogues,
- Muqawwi-e-Rahim – uterine tonics,
- Muwallid-e-Mani – reproductive-support medicines,
- Mufattih – deobstruent medicines.

These categories belong to:

traditional pharmacology.

They should not automatically be translated into:

“proven ovulation-inducer equivalent to letrozole.”

Asgand – Withania somnifera

Asgand/Ashwagandha is widely used in traditional medicine.

Research suggests effects on:

- stress physiology,
- metabolic pathways

in some contexts.

But high-quality evidence demonstrating that it reliably induces ovulation and increases live birth in women with anovulatory infertility is insufficient.

Hulba – Fenugreek

Fenugreek has metabolic research relevant to PMOS.

A randomized trial comparing fenugreek with metformin found improvements in some parameters, but:

fenugreek did not substitute for metformin

for overall PMOS metabolic management.

This is an excellent example of why a promising herb should be described as:

potentially supportive

rather than equivalent to established pharmacological treatment.

Satawar / Shatavari – Asparagus racemosus

Satawar is important in traditional reproductive medicine and has now been studied clinically.

A small 2016 NIUM randomized study compared Asparagus racemosus with clomiphene in 40 women with anovulatory infertility.

Ovulation occurred in some women in both groups, but:

- no pregnancies occurred in the Asparagus group,
- pregnancies occurred in the clomiphene group.

The study concluded that Asparagus showed follicular/ovulatory activity but was not as effective as the control treatment for conception.

This does not justify calling Satawar:

a proven replacement for modern ovulation induction.

Newer Shatavari Research: 2025–2026

More recent research is encouraging but still preliminary.

A 2025 randomized placebo-controlled study of a standardized Asparagus racemosus extract in 60 women with PCOS found improvements in:

- ovarian morphology,
- some metabolic parameters,
- modest menstrual-pattern changes

over 84 days; the authors called for larger and longer studies.

A separate 2026 randomized double-blind placebo-controlled trial involving 70 women found that Shatavari extract improved:

- follicular count,
- endometrial thickness,
- perceived stress,

but did **not** produce significant differences in:

- ovarian volume,
- reproductive hormones,
- several metabolic laboratory measures.

No serious treatment-related adverse events were reported.

These studies show:

active modern research—not proof of a fertility cure.

Neither study establishes that Shatavari:

- replaces letrozole,
- reliably restores ovulation,
- increases pregnancy,
- increases live birth.

A 2024 Unani PCOS Study

A 2024 open-label study of 30 women with PCOS evaluated a Unani decoction containing:

- Aneesun,
- Hulba,
- Suddab,

- Majeeth,
- Lobia Surkh.

Approximately:

73%

achieved improved menstrual cyclicity.

However, the study:

- had only 30 participants,
- lacked a placebo/control group,
- primarily measured menstrual cyclicity rather than pregnancy or live birth.

Therefore this is:

promising preliminary evidence

rather than proof of superiority to modern treatment.

The 2013 NIUM Ovulation Study

The supplied report refers to an earlier small randomized trial from the National Institute of Unani Medicine.

The study involved approximately:

- 20 women receiving a Unani formulation,
- 10 receiving clomiphene.

Ovulation occurred in both groups over three treatment cycles.

The formulation included:

- Withania somnifera,
- Anogeissus latifolia,
- Nymphaea alba,
- Barleria prionitis.

The study is interesting historically.

But because the groups were:

- very small,

- unequal,

and live-birth outcomes were not established:

it is not sufficient evidence to claim that the Unani formulation is clinically equivalent to modern ovulation-induction therapy.

What Does the Unani Evidence Really Mean?

The fair conclusion is:

There is preliminary clinical evidence suggesting that selected traditional Unani herbs and formulations may influence menstrual cyclicity, follicular development, metabolic health or related symptoms in some women.

But we still need larger high-quality studies measuring:

- confirmed ovulation,
- clinical pregnancy,
- live birth,
- miscarriage,
- long-term safety.

This is the scientifically responsible way to show Unani medicine as:

useful and promising

without turning preliminary evidence into a cure claim.

Traditional Formulations Such as Majun Moine Hamal

Majun Moine Hamal is traditionally used in female reproductive practice.

Its intended traditional role is commonly described as:

- reproductive support,
- uterine strengthening,
- fertility assistance.

However:

a traditional indication does not equal proof of increased live birth.

It should be prescribed according to:

- patient constitution,
- diagnosis,
- treatment phase,
- pregnancy status.

Habbe Hamal

Habbe Hamal is another traditional formulation historically used around conception.

Because formulations in fertility practice can contain:

- pharmacologically active substances,

patients should not self-prescribe them according to an internet calendar.

Any medicine with:

Mudir-e-Haiz

or uterine-stimulating properties requires particularly careful review when pregnancy is:

- possible,
- suspected,
- confirmed.

Why “Natural” Does Not Mean “Safe in Pregnancy”

A herb may stimulate menstruation precisely because it has biological activity.

The same biological activity may not be desirable:

after conception.

Therefore, once a period is missed:

- do a pregnancy test,
- review all fertility medicines.

I do not advise continuing every preconception herbal preparation automatically into pregnancy.

Dr. Nizamuddin Qasmi's Special Approach at Saira Health Care

When a woman comes to me with:

- irregular periods,
- amenorrhea,
- infertility,

I do not simply prescribe:

“medicine to bring the period.”

My approach is structured.

Step 1: Understand the Menstrual Pattern

I document:

- cycle length,
- number of periods per year,
- duration of irregularity,
- amount of bleeding.

Step 2: Exclude Pregnancy

Before treating delayed menstruation:

pregnancy must be considered.

Step 3: Determine Whether Anovulation Is Likely

Persistent:

- oligomenorrhea,
- amenorrhea

strongly suggests ovulatory dysfunction.

Step 4: Look for the Cause

I consider:

- PMOS,

- thyroid disease,
- prolactin,
- FHA,
- POI,
- medicines,
- age,
- metabolic disease.

Step 5: Assess Clinical Signs

I look for:

- hirsutism,
- acne,
- acanthosis nigricans,
- thyroid signs,
- galactorrhea,
- weight changes,
- excessive exercise,
- signs of low estrogen.

Step 6: Use Appropriate Investigations

Depending on the individual:

- pregnancy test,
- TSH,
- prolactin,
- FSH/E2,
- androgen testing,
- pelvic ultrasound

may be appropriate.

Step 7: If Pregnancy Is Desired, Evaluate the Couple

I review:

- male semen analysis,
- female age,
- duration of infertility,
- tubal status.

This prevents months of treating periods when another fertility barrier is present.

Step 8: Assess Mizaj and Lifestyle

I then consider traditional:

- Mizaj,
- diet,
- sleep,
- digestion,
- daily habits,
- constitutional symptoms.

This is where Unani medicine can provide:

individualized supportive care.

Step 9: Ilaj-bil-Ghiza

Diet is tailored according to:

- metabolic status,
- weight,
- nutritional needs,
- fertility goals.

I do not impose unnecessary restrictive diets merely from a diagnostic label.

Step 10: Ilaj-bit-Tadbir

I address:

- physical activity,
- sleep,
- stress,
- routine.

Selected regimenal treatments may be considered when appropriate.

Step 11: Individualized Ilaj-bid-Dawa

Traditional medicines are selected according to the patient's:

- menstrual condition,
- diagnosis,
- pregnancy goal,
- safety profile.

I do not recommend one universal:

“irregular period package.”

Step 12: Use Modern Cause-Specific Treatment When Needed

Examples:

PMOS infertility

Letrozole may be appropriate.

Hyperprolactinemia

Cabergoline may be indicated.

Thyroid dysfunction

Treat thyroid disease.

FHA

Restore energy availability.

POI

Provide specialized reproductive counselling.

Step 13: Monitor Ovulation Objectively

Depending on the treatment:

- cycle tracking,
- progesterone,
- follicular ultrasound

may be used.

A period becoming regular is encouraging.

But in a fertility patient, we sometimes need to know:

did ovulation actually occur?

Step 14: Protect Reproductive Time

A 24-year-old and a:

39-year-old

with irregular ovulation cannot be treated with the same timeline.

Female age remains a major fertility determinant.

Step 15: Escalate Fertility Treatment at the Correct Time

If appropriate ovulation-induction treatment repeatedly fails, further options may include:

- gonadotrophins,
- IUI in selected situations,
- IVF.

Traditional treatment should not become an excuse to postpone necessary reproductive treatment indefinitely.

Saira Health Care's Contribution to Irregular Menstruation and Infertility Care

Saira Health Care publicly lists:

- irregular menstrual cycles,
- PCOD/PCOS,
- decreased AMH,
- male and female infertility

among the reproductive-health areas addressed within its practice.

The clinic describes its broader model as:

- patient-centered,
- individualized,
- combining traditional knowledge,
- contemporary diagnostic understanding,
- lifestyle guidance.

This model can be particularly useful in irregular menstruation because:

the symptom may arise from several very different disorders.

About Dr. Nizamuddin Qasmi

I am:

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused 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 public professional profile confirms BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK, and identifies my principal clinical focus as sexual disorders and infertility, including irregular menses and female fertility problems.

Saira Health Care's current published physician byline also includes the additional training in:

- Male Infertility – MasterHealthPro,
- Integrated Sexual and Reproductive Health – ISRH, UNFPA.

Why Male-Infertility Training Matters in Anovulatory Infertility

A woman may not be ovulating regularly.

But her husband may simultaneously have:

- low sperm count,
- poor motility,
- abnormal morphology,
- azoospermia.

If I focus only on:

making her ovulate

while ignoring severe male-factor infertility, months can be lost.

Infertility should therefore be evaluated as:

a couple's reproductive condition.

When Should a Woman With Irregular Periods Seek Medical Care?

Do not wait for 12 months of infertility if menstrual cycles are already clearly abnormal.

ASRM recommends starting fertility evaluation without delay when known risk factors such as:

- irregular cycles,
- oligomenorrhea,
- amenorrhea

are present.

Seek Evaluation Promptly If

- periods suddenly stop,
- cycles repeatedly exceed 35 days,
- there are very few periods each year,
- periods become extremely heavy,
- infertility is present,
- facial hair/acne develops,
- breast milk appears without breastfeeding,
- severe weight change occurs,
- hot flushes develop at a young age.

Urgent Medical Attention May Be Needed If

Bleeding is so heavy that you develop:

- dizziness,
- fainting,
- severe weakness,
- breathlessness,
- rapidly soaking menstrual protection.

Also seek urgent care for:

- severe pelvic pain,
- positive pregnancy test with bleeding/pain,
- suspected ectopic pregnancy.

Common Myths About Irregular Periods and Anovulation

Myth 1: Every woman should have a 28-day cycle.

Fact: Healthy adult cycles commonly fall between approximately 21 and 35 days.

Myth 2: Irregular bleeding always means PCOS.

Fact: Thyroid disease, prolactin, FHA, POI and other disorders can cause irregular menstruation.

Myth 3: If I bleed, I definitely ovulated.

Fact: Anovulatory bleeding can occur without egg release.

Myth 4: Every irregular cycle is anovulatory.

Fact: Not necessarily. Some irregular cycles still contain ovulation.

Myth 5: A woman with irregular periods can never become pregnant naturally.

Fact: Many women ovulate intermittently and can conceive.

Myth 6: The only treatment is to make the period come.

Fact: The cause of irregular menstruation should be identified.

Myth 7: Birth-control pills cure anovulatory infertility.

Fact: They can regulate bleeding in selected patients but do not serve as ovulation-induction treatment while attempting conception.

Myth 8: Metformin is the best fertility treatment for every PMOS patient.

Fact: WHO currently prefers letrozole for PMOS-related anovulatory infertility.

Myth 9: Clomiphene is always first-line treatment.

Fact: Current WHO guidance prefers letrozole for PMOS-related anovulatory infertility where available.

Myth 10: If letrozole fails, ovarian drilling should always be next.

Fact: WHO currently suggests gonadotrophins over routine laparoscopic ovarian drilling after failed appropriate oral treatment.

Myth 11: All amenorrhea is due to low hormones.

Fact: PMOS, POI, hyperprolactinemia, thyroid disease, FHA and anatomical causes have very different hormonal patterns.

Myth 12: Low AMH causes every irregular period.

Fact: AMH is an ovarian-reserve marker and does not by itself explain every menstrual abnormality.

Myth 13: Unani "cold temperament" is scientifically the same as hypothyroidism.

Fact: Mizaj is a traditional physiological concept and should not be treated as a modern laboratory diagnosis.

Myth 14: Balgham means insulin resistance.

Fact: They are not scientifically equivalent concepts.

Myth 15: Hijama has been proven to restore ovulation.

Fact: Evidence is currently insufficient to make this claim.

Myth 16: Purgation removes PCOS toxins.

Fact: Modern evidence does not show that gastrointestinal purgation removes ovarian pathology.

Myth 17: Satawar is scientifically proven to replace letrozole.

Fact: Small studies show interesting biological effects, but pregnancy/live-birth evidence is insufficient.

Myth 18: If a herbal medicine brings bleeding, fertility is cured.

Fact: Fertility requires ovulation, functional tubes, adequate sperm and several additional reproductive processes.

Frequently Asked Questions

My periods come every 40–50 days. Am I ovulating?

You may be ovulating occasionally, but persistent long cycles strongly suggest:

- oligo-ovulation,
- anovulation.

A proper evaluation is appropriate.

Can irregular periods cause infertility?

Yes, when the irregularity reflects:

irregular or absent ovulation.

Can I get pregnant if I have periods only every two months?

Yes, pregnancy may still be possible if ovulation occurs.

But fewer ovulations generally mean:

fewer opportunities for conception.

How can I know whether I ovulated?

Depending on the case:

- menstrual history,
- ovulation predictor,
- luteal progesterone,
- follicular ultrasound

can help.

Is day-21 progesterone correct for everyone?

No.

It should generally be timed approximately:

seven days before the expected next period.

What is the most common cause of chronic anovulation?

PMOS/PCOS is one of the most common causes in reproductive-age women.

Can thyroid disease cause infertility?

Yes.

Both overactive and underactive thyroid states can disturb:

- menstruation,
- ovulation.

Can high prolactin stop periods?

Yes.

Hyperprolactinemia can cause:

- amenorrhea,
- oligo-ovulation,
- infertility.

Which medicine is preferred for high-prolactin infertility?

WHO currently suggests:

cabergoline

over bromocriptine.

What is the best medicine to induce ovulation in PMOS?

Current WHO guidance favors:

letrozole

as first-line pharmacological treatment in appropriate patients.

Can metformin help?

Yes, particularly when metabolic dysfunction is important.

It is not automatically the best fertility drug for every woman.

Can stress stop ovulation?

Significant physiological or psychological stress—especially when combined with:

- calorie deficiency,
- weight loss,
- excessive exercise

can contribute to functional hypothalamic amenorrhea.

Can excessive exercise stop periods?

Yes, especially when exercise creates:

chronic energy deficiency.

Can obesity cause irregular ovulation?

It can contribute, particularly in PMOS and metabolic dysfunction.

But normal-weight women can also have PMOS.

Can low weight cause amenorrhea?

Yes.

Severe dietary restriction and insufficient energy availability can suppress reproductive signaling.

What is Ihtibas-e-Tams?

It is a traditional Unani term commonly used for:

suppressed/absent menstruation.

What is ‘Uqr?

‘Uqr is a broad traditional Unani term for:

infertility.

Can Unani medicine help irregular menstruation?

It may provide useful individualized support through:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised pharmacotherapy,
- lifestyle care.

Some small clinical studies report improvements in menstrual cyclicity and follicular parameters.

However:

the evidence remains preliminary and cause-specific modern treatment should not be delayed.

Is there scientific research on Unani medicines for anovulation?

Yes.

Small NIUM-associated clinical studies have evaluated:

- Unani polyherbal formulations,
- Satawar/Asparagus racemosus

for follicular growth and ovulation.

The studies are encouraging but too small to establish equivalence with modern fertility drugs.

What does the latest Shatavari research show?

2025 and 2026 randomized studies suggest potential effects on:

- ovarian morphology,
- follicular measures,

- menstrual/metabolic features,
- stress.

But they do not yet prove:

- reliable ovulation induction,
- pregnancy benefit,
- live-birth benefit.

Can Hijama cure anovulation?

Current evidence does not establish Hijama as a reliable stand-alone ovulation-induction treatment.

Can Unani treatment be combined with modern fertility treatment?

Yes, when:

- medications are disclosed,
- safety is reviewed,
- traditional treatment does not delay necessary modern care.

Latest Scientific Perspective: 2025–2026

WHO's First Global Infertility Guideline

On:

28 November 2025

WHO issued its first global guideline covering:

- infertility diagnosis,
- ovulatory dysfunction,
- tubal disease,
- male factors,
- unexplained infertility.

PMOS/PCOS-Related Anovulation

WHO suggests:

letrozole over clomiphene or metformin

as first-line pharmacological treatment.

If oral treatment fails:

gonadotrophins

are suggested over routine ovarian drilling.

If appropriate pharmacological treatment remains unsuccessful:

IVF

may be considered.

Hyperprolactinemia

WHO now specifically favors:

cabergoline

over bromocriptine for infertility caused by hyperprolactinemic ovulatory dysfunction.

Amenorrhea Evaluation Has Become More Cause-Specific

ASRM's updated 2024 guidance emphasizes:

- pregnancy first,
- detailed history,
- FSH/E2,
- TSH,
- prolactin,
- targeted androgen testing,
- pelvic ultrasound

depending on presentation.

Botanical Research Is Expanding

Traditional herbs such as:

Asparagus racemosus

are now being studied in better-designed randomized trials.

Recent 2025–2026 evidence suggests possible benefits in some PMOS-related:

- ovarian,
- metabolic,
- menstrual

outcomes, but pregnancy/live-birth evidence remains inadequate.

This is exactly how integrative medicine should progress:

traditional knowledge → clinical hypothesis → controlled research → cautious implementation.

My Final Message to Women With Irregular Periods

If your periods are irregular, do not immediately conclude:

"I am infertile."

But do not ignore the problem either.

Ask:

How long are my cycles?

Am I ovulating?

Could I be pregnant?

Do I have PMOS?

Should thyroid be checked?

Should prolactin be checked?

Have I lost or gained significant weight?

Am I under-eating?

Am I exercising excessively?

Could I have POI?

What does my ultrasound show?

If I want pregnancy, has my husband's semen been checked?

Are my tubes open?

Can individualized Unani diet and lifestyle treatment help my overall reproductive health?

Do I need letrozole?

Do I need treatment for high prolactin or thyroid disease?

At what point should we consider advanced fertility treatment?

These questions are much more valuable than simply asking:

“Which medicine will make my period come?”

Conclusion

Irregular menstruation and anovulatory infertility are closely related but:

they are not identical conditions.

Irregular menstruation may be one of the most visible signs that ovulation is occurring unpredictably or not occurring at all.

The reproductive cycle depends on a coordinated interaction between:

- hypothalamus,
- pituitary,
- ovaries,
- uterus.

Disruption can result from:

- PMOS/PCOS,
- thyroid disease,
- hyperprolactinemia,
- functional hypothalamic amenorrhea,
- primary ovarian insufficiency,
- metabolic disease,
- nutritional deficiency,

- excessive exercise,
- medicines,
- reproductive aging,
- anatomical disorders.

ASRM emphasizes that oligomenorrhea or amenorrhea strongly suggests ovulatory dysfunction and requires investigation of the cause.

Modern treatment should therefore be:

cause specific.

For PMOS-related anovulatory infertility, current WHO guidance prefers:

letrozole

as first-line pharmacological treatment.

When oral treatment fails:

- gonadotrophins may be used,
- IVF may eventually become appropriate.

For hyperprolactinemia:

cabergoline

is currently favored over bromocriptine by WHO.

Thyroid disease requires thyroid treatment.

Functional hypothalamic amenorrhea requires:

- restoration of adequate nutrition,
- healthy energy balance,
- appropriate exercise,
- psychological support where needed.

The **Unani system of medicine** contributes a valuable whole-person perspective using traditional concepts such as:

- Mizaj,
- Akhlat,
- Ihtibas-e-Tams,
- ‘Uqr,

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa.

The supplied Unani research emphasizes this constitutional approach rather than viewing irregular menstruation only as an isolated ovarian malfunction.

Small Unani and botanical studies have reported promising effects on:

- menstrual regularity,
- follicular development,
- some PMOS-related metabolic outcomes.

For example, a 2024 open-label Unani study reported improved menstrual cyclicity in approximately 73% of 30 participants, while recent randomized studies of Asparagus racemosus have found selected ovarian and metabolic changes.

But these findings should not be interpreted as proof that traditional medicine:

- universally restores ovulation,
- replaces letrozole,
- guarantees conception,
- guarantees live birth.

At **Saira Health Care**, my approach as **Dr. Nizamuddin Qasmi** is therefore:

Take a detailed menstrual history.

Exclude pregnancy first.

Determine whether ovulatory dysfunction is present.

Identify PMOS, thyroid disease, hyperprolactinemia, FHA, POI or other causes.

Use appropriate modern laboratory and ultrasound evaluation.

Assess both partners when pregnancy is desired.

Use individualized Unani Mizaj assessment, dietotherapy and lifestyle management where appropriate.

Use supervised traditional pharmacotherapy rather than self-medication.

Do not equate humoral concepts directly with modern hormones.

Do not call purgation a scientifically proven ovarian detox.

Do not promise that Hijama or herbs can replace evidence-based ovulation induction.

Use letrozole, endocrine treatment or other modern therapy when medically indicated.

Monitor whether ovulation actually returns.

Protect the woman's reproductive time.

And escalate fertility treatment when conservative treatment is not achieving the desired result.

For every patient who asks me:

“Doctor, can my irregular periods and anovulation be treated, and can I become pregnant?”

my answer is:

In many women, yes. Anovulation is often treatable once we identify why ovulation is not occurring. The correct treatment may be lifestyle and metabolic correction, treatment of thyroid or prolactin disease, evidence-based ovulation induction, individualized Unani support, or a combination of these. The goal is not simply to make bleeding occur; the goal is to restore the healthiest possible reproductive function and, when pregnancy is desired, to create the best realistic chance of ovulation, conception and a healthy live birth.

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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 describes Dr. Nizamuddin Qasmi's focused clinical work in male and female sexual disorders and infertility and specifically includes irregular menses among the reproductive-health problems addressed in practice.

Medical Disclaimer

This article is intended for:

- patient education,
- menstrual-health awareness,
- fertility education.

It does not replace:

- pregnancy testing,
- gynecological consultation,

- endocrine assessment,
- thyroid testing,
- prolactin testing,
- FSH/estradiol testing,
- ultrasound,
- semen analysis,
- tubal assessment,
- specialist infertility care.

Do not independently start:

- letrozole,
- clomiphene,
- metformin,
- gonadotrophins,
- cabergoline,
- progesterone,
- oral contraceptive hormones,
- Unani emmenagogues,
- Habbe Hamal,
- Majun preparations,
- Munzij-Mushil therapy,
- herbal supplements,
- Hijama

simply because periods are irregular.

A delayed period should first prompt consideration of:

pregnancy.

Women with:

- amenorrhea,
- very heavy bleeding,

- severe pelvic pain,
- rapid virilization,
- galactorrhea,
- very low body weight,
- suspected eating disorder,
- symptoms of POI,
- infertility

should receive appropriate medical evaluation.

No modern, Unani, hormonal or herbal treatment can ethically guarantee:

- ovulation,
- conception,
- implantation,
- pregnancy,
- live birth.

Saira Health Care
www.sairahealthcare.com