

Fertility Care After Age 35

Understanding Age-Related Fertility Decline, Egg Quality, AMH, Natural Conception, IUI, IVF, Egg Freezing, Pregnancy Risks and the Supportive Role of Unani Medicine

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A Message From Dr. Nizamuddin Qasmi

One of the most common concerns I hear from women is:

“Doctor, I am 35 now. Is it already too late for pregnancy?”

Another woman may be 37 and say:

“Should I stop trying naturally and go directly for IVF?”

A woman of 40 may ask:

“My periods are still regular. Does that mean my fertility is normal?”

These are very important questions, and they deserve a balanced answer.

My first message is:

Age 35 is not a sudden fertility cliff.

A woman does not become fertile at age 34 and infertile on her 35th birthday.

Fertility declines gradually across reproductive life. The decline begins before 35 and generally becomes more pronounced through the mid-to-late 30s.

ACOG's updated 2025 guidance explains that fertility declines because both the **number and quality of ovarian follicles decrease with age**, and this process accelerates during the later reproductive years.

Therefore, the significance of age 35 is mainly that:



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reproductive time becomes more valuable.

The goal of fertility care after 35 is not to frighten a woman.

It is to avoid wasting time when:

diagnosis,

treatment,

fertility preservation,

assisted reproduction

may become increasingly time-sensitive.

At the same time:

being 35 or older does not automatically mean IVF is required.

Many women in their later 30s conceive naturally.

The correct approach is:

understand the couple's reproductive situation early and choose treatment according to the actual cause.

Why Does Female Fertility Decline With Age?

A woman is born with the ovarian follicles she will have throughout her reproductive life.

Unlike sperm production in men, the ovaries do not continually produce a new large supply of eggs.

Over time:

the number of available follicles decreases.

But quantity is only part of the story.

The remaining oocytes also experience age-related biological changes.

ACOG explains that ovarian ageing affects both:

egg quantity

and:

egg quality.

Older oocytes have a higher probability of chromosomal errors during cell division.

This can contribute to:



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reduced fertilization potential,
reduced embryo implantation,
miscarriage,
chromosomal abnormalities.

This is why reproductive ageing cannot be understood simply by asking:

“Are periods still coming?”

Regular Periods Do Not Mean the Ovaries Are Biologically Young

A woman may have:

completely regular periods at 39,
predictable ovulation at 41.

That is encouraging because it suggests ovarian function continues.

But it does not mean:

the eggs are biologically the same as they were at age 25.

A menstrual period tells us that the reproductive hormonal cycle is continuing.

It does not directly measure:

chromosome quality of the egg,
probability of fertilization,
probability of implantation,
probability of miscarriage.

Therefore:

regular menstruation is good information, but it does not cancel age-related fertility decline.

How Much Does Natural Fertility Change With Age?

ACOG estimates that for healthy couples in their 20s and early 30s, approximately:

1 in 4 women may conceive in a menstrual cycle.

By approximately age 40:



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around 1 in 10 may conceive per cycle.

ACOG also notes that by around age 45, natural conception becomes unlikely for most women.

These are population estimates.

They should not be used to predict one individual woman's exact chance.

A healthy 39-year-old woman can still conceive naturally.

A 29-year-old woman can also have infertility.

Age modifies probability.

It does not determine destiny.

Why Does Fertility Fall More Quickly After the Mid-30s?

Two biological changes are occurring simultaneously.

First:

the follicle pool is becoming smaller.

Second:

a greater proportion of the remaining oocytes may have chromosomal abnormalities.

ACOG's 2025 fertility-decline statement describes the follicle pool falling dramatically across life and emphasizes that increasing age is associated with both declining ovarian reserve and declining oocyte quality.

This combination explains why:

time to conception may become longer,

miscarriage becomes more frequent,

IVF using the woman's own eggs becomes less successful as age advances.

Is 35 Really a Special Biological Cut-Off?

Not in the sense of:

a switch turning off.

The body does not recognize a birthday as an abrupt biological event.



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Thirty-five is better understood as:

a useful clinical threshold.

It tells doctors:

“Do not ask this patient to wait as long before starting an infertility evaluation.”

ASRM recommends starting fertility investigation after approximately:

6 months

of regular unprotected intercourse when the female partner is 35 or older.

When the woman is over 40:

more immediate evaluation may be warranted.

When Should a Woman Over 35 Seek Fertility Evaluation?

A useful guide is:

Female age When to seek fertility evaluation if no known risk factor exists

Under 35 After about 12 months of regular unprotected intercourse

35–40 After about 6 months

Over 40 Promptly / without unnecessary delay

ASRM and ACOG both support this age-based approach.

But this table should not be applied blindly.

Do Not Wait Six Months When a Fertility Problem Is Already Suspected

A 36-year-old woman does not need to wait six months if she already has:

very irregular periods,

absent menstruation,

known endometriosis,

previous severe PID,

hydrosalpinx,

blocked fallopian tubes,



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previous ectopic pregnancy,
significant ovarian surgery,
previous chemotherapy or radiation,
known diminished ovarian reserve.

Likewise, do not wait when the male partner has:

known azoospermia,
severe oligospermia,
major testicular disease,
erectile dysfunction preventing intercourse,
an ejaculatory disorder.

ASRM recommends immediate investigation when a known condition associated with infertility is already present.

The principle is:

once we already have a reason to suspect impaired fertility, the calendar should not delay diagnosis.

What Happens During Fertility Evaluation After 35?

A proper evaluation is still:

couple-based.

The woman's age is important, but infertility is not automatically a female problem.

A good initial evaluation asks three major questions:

Is ovulation occurring?

Are the female reproductive organs and fallopian tubes suitable for conception?

Is male fertility adequate?

ASRM recommends assessing:

ovulatory status,
female reproductive tract structure and tubal patency,
semen analysis of the male partner.

Male and female evaluation should occur in parallel where applicable.



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This parallel approach becomes particularly important after 35 because:

unnecessary sequential testing wastes time.

Male Fertility Should Not Be Ignored Because the Woman Is Over 35

Sometimes I meet a couple in which the woman is 38.

Everyone immediately assumes:

“Her age must be the problem.”

But semen analysis then shows:

severe oligospermia,

azoospermia,

very poor motility.

The woman's age still matters.

But it was not the only problem.

This is why I repeatedly tell couples:

age does not remove the need to investigate the male partner.

A semen analysis is generally one of the simplest and most informative early fertility tests.

Understanding Ovarian Reserve After 35

The term:

ovarian reserve

refers mainly to:

the remaining quantity of ovarian follicles/oocytes.

It does not directly mean:

egg quality.

Common ovarian-reserve assessments include:

AMH,

antral follicle count,



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early-cycle FSH in selected situations.

WHO's 2025 infertility guideline states that age is the most important predictor of low ovarian reserve and, when additional testing is undertaken, suggests:

AFC,

AMH,

Day-2 or Day-3 FSH

as possible tests.

What Is AMH?

AMH stands for:

Anti-Müllerian Hormone.

It is produced by cells associated with small ovarian follicles.

It is useful for estimating:

ovarian reserve

and particularly:

likely ovarian response during IVF stimulation.

A woman with higher AMH may often produce:

more follicles,

more eggs

during stimulation than a woman with a very low AMH.

But there is an extremely important limitation.

AMH Is Not an Egg-Quality Test

AMH cannot tell us whether an individual oocyte is:

chromosomally normal,

capable of creating a healthy embryo.

Age remains much more informative about the probability of age-related chromosome abnormalities.

ASRM states clearly that ovarian-reserve markers such as:



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AMH,

AFC

are good predictors of:

oocyte yield,

but poor independent predictors of:

reproductive potential.

Age is a much stronger predictor of reproductive success.

Does Low AMH Mean Natural Pregnancy Is Impossible?

No.

This is one of the most important points I explain to women.

A low AMH may indicate:

fewer remaining recruitable follicles,

possibly fewer eggs obtained during IVF stimulation.

It does **not** mean:

“You have no eggs.”

It does **not** automatically mean:

“You cannot conceive naturally.”

ACOG states that a single AMH value in a woman without established infertility does not reliably predict:

time to natural pregnancy.

Therefore:

low AMH deserves interpretation—not panic.

Does Normal or High AMH Mean Fertility Is Excellent?

No.

A woman can have:

normal AMH



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at age 40 and still experience age-related decline in:

oocyte quality.

Likewise, a woman with PCOS may have relatively high AMH because she has many small follicles, while ovulation remains irregular.

Therefore:

AMH should never replace age, clinical history, ovulation assessment and couple-based evaluation.

Can Any Blood Test Measure Egg Quality?

Not directly.

There is currently no routine blood test that can tell us:

“These eggs are genetically normal.”

Age is used as an indirect predictor because:

embryo aneuploidy increases with oocyte age.

This is one reason fertility counselling after 35 must remain realistic even when:

AMH looks reassuring,

periods are regular.

What About Antral Follicle Count?

Antral follicle count—or:

AFC

is measured by transvaginal ultrasound.

The clinician counts the small visible follicles in the ovaries.

Like AMH, AFC can help estimate:

ovarian response.

It does not directly test:

egg quality.

AMH and AFC are among the most useful ovarian-reserve markers, but neither can convert chronological reproductive age into a younger egg age.



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Should Every Woman Over 35 Get AMH?

Not necessarily.

ACOG cautions against using AMH as a general fertility-screening test in women who have not demonstrated infertility because it does not accurately predict short-term natural conception.

However, AMH may be useful after 35 when the result will help with:

fertility-treatment planning,

IVF counselling,

expected response,

consideration of fertility preservation.

The question should be:

“Will this result change management?”

rather than:

“Can we order one more test?”

Assessing the Fallopian Tubes

A woman can:

ovulate regularly,

have reasonable ovarian reserve,

and still experience infertility because of:

tubal disease.

Tubal damage may follow:

PID,

genital infection,

ectopic pregnancy,

pelvic surgery,

endometriosis.

WHO recommends:



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HSG,

HyCoSy

as appropriate methods for assessing tubal patency when tubal disease is suspected in infertility.

After age 35, detecting tubal disease early is especially important because:

repeated months of well-timed intercourse cannot overcome bilateral tubal obstruction.

Age 35 Changes Some Tubal-Factor Decisions

WHO's 2025 guideline makes a particularly important age-specific recommendation.

For women:

younger than 35

with mild-to-moderate tubal disease, tubal surgery may sometimes be considered before IVF.

But for women:

aged 35 or older with tubal-factor infertility,

WHO suggests:

IVF rather than tubal reconstructive surgery,

because the additional time required for surgery and subsequent natural attempts may allow further age-related fertility decline.

This is an excellent example of how:

age changes treatment strategy even when the disease itself is the same.

What About Hydrosalpinx?

Hydrosalpinx means a damaged, fluid-filled fallopian tube.

It can reduce IVF success because inflammatory tubal fluid may enter the uterus and adversely affect implantation.

WHO recommends treating hydrosalpinx before IVF with:

salpingectomy,



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tubal occlusion

where appropriate.

Therefore:

IVF does not mean every structural problem can simply be ignored.

Preparation still matters.

Natural Conception After 35

Natural conception remains possible.

A woman does not need to stop trying naturally simply because she reached 35.

If she is:

35–37,

ovulating regularly,

has no known tubal disease,

partner's semen is reasonable,

has only recently begun trying,

continued natural attempts may be completely appropriate.

The difference is:

we shorten the period before evaluation if pregnancy does not occur.

This allows us to preserve valuable time.

How Should Intercourse Be Timed?

The fertile window is approximately:

the five days before ovulation plus the day of ovulation.

The highest chance of conception is generally around:

the one to two days before ovulation.

Couples can have intercourse:

every one to two days during the fertile period.

There is no need to make conception dependent on:



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one exact hour,

one exact app prediction.

Over-scheduling can sometimes create:

performance anxiety,

erectile difficulties,

reduced sexual satisfaction.

At Saira Health Care, I therefore treat:

sexual function as part of fertility care.

Timed Intercourse After 35

Timed intercourse can be useful when:

tubes are open,

sperm is adequate,

ovulation is occurring.

It may be:

natural,

combined with ovulation treatment in selected disorders.

But prolonged cycles of poorly effective empirical treatment should be avoided when:

age is advancing,

infertility duration is already long,

ovarian reserve is reduced,

another significant factor exists.

After 35, I frequently ask:

“How much reproductive time are we spending on this strategy, and what is its realistic chance of success?”

That is more useful than simply repeating treatment month after month.

IUI After Age 35



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IUI—or:

intrauterine insemination

places prepared sperm into the uterus around ovulation.

IUI may be used in selected cases involving:

unexplained infertility,

mild male-factor infertility,

cervical or ejaculation-related difficulties,

ovulation treatment.

However, IUI still depends on:

an available oocyte,

at least one usable fallopian tube,

sufficient sperm.

It cannot bypass:

severe bilateral tubal disease.

Unexplained Infertility: What Does WHO Recommend?

For unexplained infertility, WHO's 2025 guideline recommends a stepwise strategy.

The guideline suggests an initial period of:

expectant management

rather than immediately using ovarian stimulation with timed intercourse or unstimulated IUI.

In the studies informing that recommendation, expectant management commonly lasted about:

3–6 months.

If expectant management is unsuccessful, WHO suggests:

stimulated IUI

using an appropriate oral ovulation-stimulation medicine such as:

clomiphene,

letrozole.



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If stimulated IUI does not succeed:

IVF becomes an appropriate next step.

But after 35:

this pathway must be individualized according to age and ovarian reserve.

A 35-year-old and a 42-year-old should not automatically spend the same amount of time at each step.

IVF After Age 35

IVF means:

in vitro fertilization.

The ovaries are stimulated so that several follicles may grow.

Eggs are retrieved from the ovaries.

Fertilization occurs in the laboratory.

An embryo is then transferred to the uterus.

IVF can bypass several fertility barriers, especially:

significant tubal disease,

selected male factors,

some unexplained infertility.

But IVF cannot make:

older oocytes biologically younger.

IVF Does Not Reverse Ovarian Ageing

This is one of the biggest misunderstandings in fertility treatment.

Patients sometimes think:

“If natural fertility is lower after 40, IVF will restore my pregnancy chances to those of a 28-year-old.”

That is not true when the woman's own current-age oocytes are being used.

IVF can:

retrieve multiple eggs,



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fertilize them in the laboratory,
identify embryos available for transfer.

But the eggs remain:

the biological age at which they were retrieved.

Therefore:

IVF success with a woman's own eggs also decreases with advancing age.

ACOG emphasizes that fertility-treatment success declines with age.

Why Does IVF Become Less Successful With Age?

Several things may occur.

A woman may produce:

fewer oocytes.

A higher proportion of those oocytes may produce embryos with:
chromosome abnormalities.

As a result:

fewer transferable embryos may be available,

miscarriage risk may be higher.

Age therefore affects both:

quantity

and:

biological competence.

What Is ICSI?

ICSI means:

intracytoplasmic sperm injection.

A single sperm is injected directly into an oocyte.

It is particularly valuable in selected cases involving:

significant male-factor infertility,



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previous fertilization problems,

surgically retrieved sperm.

ICSI is not automatically necessary:

simply because the woman is over 35.

WHO recommends conventional IVF rather than routinely adding ICSI for unexplained infertility after stimulated IUI has failed when there is no other indication for ICSI.

This helps prevent unnecessary procedures.

What Is PGT-A?

PGT-A stands for:

preimplantation genetic testing for aneuploidy.

During IVF, cells are obtained from an embryo and tested for chromosomal copy-number abnormalities.

Because embryo aneuploidy becomes more common with increasing oocyte age, PGT-A is often discussed with patients in their later reproductive years.

But:

PGT-A is not automatically beneficial for every older IVF patient.

Does PGT-A Guarantee a Healthy Baby?

No.

It may help identify embryos classified as chromosomally euploid by the test.

But PGT-A:

does not create normal embryos,

does not improve egg quality,

does not guarantee implantation,

does not exclude every genetic disorder.

ASRM's 2024 committee opinion states that PGT-A may have a useful role in selected patients of advanced reproductive age, particularly those with adequate ovarian reserve and enough embryos, but current evidence does not support routine PGT-A for every IVF patient.



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This is another example of:

individualized treatment rather than automatic treatment.

Egg Freezing After 35

Egg freezing—or:

oocyte cryopreservation

may help preserve reproductive options for people who are not ready to conceive.

The eggs are collected now and stored for possible future use.

But an essential principle is:

the age at which the eggs are frozen matters.

ASRM concludes that pregnancy and live-birth outcomes are generally better when oocytes are cryopreserved at a younger age rather than an older age.

Therefore, a woman should not interpret egg freezing as:

a guarantee of future motherhood.

Is It Too Late to Freeze Eggs After 35?

Not necessarily.

Women in their later 30s still freeze eggs.

But counselling should be realistic.

Compared with freezing at a younger age:

ovarian response may be lower,

more stimulation cycles may sometimes be needed,

a smaller proportion of eggs may eventually produce euploid embryos/live births.

Therefore:

egg freezing is a probability-preservation strategy—not fertility insurance.

Should AMH Decide Whether a Woman Freezes Eggs?

AMH can help estimate:



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likely oocyte yield.

But the decision should not be based on AMH alone.

ASRM emphasizes that:

age and reproductive plans

are fundamental when considering planned egg freezing, while ovarian-reserve testing is better at predicting how many oocytes may be obtained than predicting eventual live birth.

Donor Eggs and Age-Related Infertility

When pregnancy with a woman's own oocytes becomes extremely unlikely, one reproductive option is:

donor-oocyte IVF.

A donor egg from a younger woman carries the biological age of:

the donor oocyte,

not the recipient's ovarian age.

This is why donor-oocyte treatment can largely overcome the age-related decline associated with the recipient's own oocytes.

ACOG notes that pregnancy outcomes using younger donor eggs demonstrate that much of the age-related decline in implantation and pregnancy is driven by:

oocyte ageing.

However:

donor eggs do not make the gestational mother younger.

Pregnancy Risks Still Depend on the Age and Health of the Woman Carrying the Pregnancy

Even when a younger donor egg is used, an older pregnant woman may still have higher pregnancy-related risks such as:

hypertension,

preeclampsia,

gestational diabetes,



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operative delivery.

ASRM emphasizes that reproductive age affects not only gamete quality but also health risks associated with pregnancy itself.

Therefore:

donor eggs can overcome much of oocyte-age infertility, but they do not remove maternal medical risk.

What About Pregnancy After 35?

Once pregnancy occurs, most women over 35 can still have:

successful pregnancies.

But certain risks become more frequent with age.

These include:

miscarriage,

chromosomal abnormalities,

gestational diabetes,

hypertension/preeclampsia,

stillbirth,

some fetal-growth complications.

ACOG also makes an important point:

these risks do not all suddenly rise at age 35.

Some increase gradually.

Some become more significant mainly after:

age 40.

This is why the phrase:

“high risk because you are 35”

should not be used in a frightening or simplistic manner.

Risk is individualized.

Miscarriage and Age



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One important biological consequence of reproductive ageing is:

increasing miscarriage risk.

Many early miscarriages result from chromosomal abnormalities in the embryo.

ACOG states that in women over 40, approximately:

one in three pregnancies

may end in early pregnancy loss, with chromosomal abnormalities accounting for many of these losses.

This does not mean every pregnancy after 40 will miscarry.

It means the probability is higher.

Why Does Miscarriage Increase?

A major reason is:

embryo aneuploidy.

Aneuploidy means the embryo has:

too many,

too few

chromosomes.

The risk rises because age-related changes in the oocyte make chromosome separation during meiosis less reliable.

This is also why IVF cannot completely eliminate age-related miscarriage when using:

older autologous eggs.

Pregnancy Loss Is Not Usually Caused by Ordinary Activity

Women who experience miscarriage after 35 frequently blame:

walking,

travel,

intercourse,

stress,

normal work.



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ACOG emphasizes that early miscarriage is usually a random biological event and common daily activities generally do not cause it.

Patients should not carry unnecessary guilt.

What Genetic Testing Is Available During Pregnancy?

Pregnant patients can discuss:

prenatal genetic screening

and:

diagnostic testing.

Modern guidance offers prenatal screening and diagnostic options to pregnant patients regardless of age.

Age 35 is no longer a rule saying:

“Only women over 35 deserve genetic testing.”

Rather:

age modifies risk, but testing choices should be offered broadly.

ACOG emphasizes that patients do not need to reach a particular age to be offered these options.

Fertility Care at Age 35–37

This group often causes unnecessary anxiety.

For a healthy woman aged 35–37 with:

regular ovulation,

no significant reproductive history,

healthy partner,

natural conception remains very realistic.

I generally focus on:

appropriate intercourse timing,

preconception health,

avoiding smoking,



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folic acid,

early evaluation if conception does not occur within about six months.

If infertility is found, treatment can then be selected according to:

diagnosis,

ovarian reserve,

duration.

The goal is:

efficient care—not panic.

Fertility Care at Age 38–39

At this stage:

reproductive time becomes more important.

A woman may still conceive naturally.

But I am less comfortable with prolonged empirical treatment without understanding:

ovarian reserve,

tubes,

semen,

ovulation.

If several low-yield treatment cycles fail, the cost is not only:

money.

It is also:

biological time.

This is why treatment escalation may occur faster than it would in a 27-year-old.

Fertility Care Around Age 40

At approximately age 40:

natural conception remains possible,

but monthly pregnancy probability is lower,



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miscarriage risk is higher,

IVF success with current-age oocytes is lower.

ACOG estimates natural conception at approximately:

1 in 10 per cycle

around age 40 in healthy couples.

At this stage, I generally prefer:

prompt complete evaluation.

I do not advise deliberately waiting another six or twelve months to “prove” infertility.

Fertility Care After 40

After 40, time-sensitive counselling becomes even more important.

The clinician should discuss realistically:

natural conception,

ovarian reserve,

IVF with own eggs,

donor-egg options where relevant.

But:

age alone should not be used to take reproductive choice away from the patient.

Good counselling explains probability and risk, then supports informed decisions.

Is Natural Pregnancy Possible After 45?

It can occur.

But ACOG states that by approximately age 45:

natural pregnancy becomes unlikely for most women.

A recent 2026 review similarly describes spontaneous conception at age 45 and above as uncommon and notes low success with IVF using current-age autologous oocytes.

When discussing this age group:

realistic counselling is essential.



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Can Supplements Make Eggs Younger?

No supplement has been proven to:

reverse chronological oocyte ageing.

Various products are marketed as:

egg-quality boosters,

ovarian rejuvenators,

fertility anti-ageing medicines.

Patients should be very cautious.

Some nutritional supplements may be useful when:

a genuine deficiency exists.

But no vitamin, antioxidant, herbal or Unani formulation has been shown to:

return 40-year-old oocytes to the chromosome profile of 25-year-old oocytes.

What About CoQ10?

Coenzyme Q10 has biological plausibility and has been studied in fertility care.

Some studies suggest possible effects on:

ovarian-response parameters,

laboratory outcomes.

But evidence is not strong enough to tell every woman over 35:

“Take CoQ10 and your egg quality will become young again.”

It does not reverse:

ovarian age.

Supplements should be discussed according to:

medical history,

fertility treatment,

other medicines.



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PRP and “Ovarian Rejuvenation”

Some clinics market injections of platelet-rich plasma—PRP—into the ovaries as:

ovarian rejuvenation.

This remains investigational.

There is not established high-quality evidence that ovarian PRP can:

regenerate the primordial follicle pool,

reliably restore age-related fertility,

reverse chromosomal ageing of oocytes.

Women after 35 should be particularly cautious about spending valuable reproductive time on treatments promoted with:

guaranteed rejuvenation claims.

Stem-Cell Ovarian Rejuvenation

Stem-cell treatments for age-related ovarian decline remain:

experimental.

They should not replace established fertility evaluation and evidence-based treatment.

The most dangerous aspect of unproven rejuvenation treatment is sometimes not only the financial cost.

It is:

the reproductive time that may be lost.

Can Lifestyle Slow Fertility Ageing?

Healthy lifestyle matters.

It can improve:

general health,

pregnancy fitness,

metabolic wellbeing,

sexual function.

Smoking in particular has been associated with adverse reproductive effects.



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But healthy living cannot completely prevent:

normal ovarian ageing.

A 39-year-old athlete does not biologically possess the eggs of a 25-year-old simply because she is extremely fit.

Lifestyle is important.

Age still matters.

Smoking and Fertility After 35

This becomes especially relevant because age and smoking may both adversely affect reproductive health.

ACOG's updated counselling guidance includes tobacco exposure among non-age factors that may adversely affect ovarian function.

Therefore:

stopping tobacco is one of the most sensible modifiable fertility interventions.

Weight and Metabolic Health

Both obesity and significant underweight may affect:

ovulation,

pregnancy health,

treatment.

For women with:

PCOS,

insulin resistance,

metabolic treatment can be particularly valuable.

But weight advice should never be used as a substitute for:

timely infertility evaluation.

Telling a 39-year-old woman to:

“lose weight for two years and then think about fertility”

may be inappropriate.



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Management should consider:

health improvement and reproductive timing together.

PCOS After Age 35

A woman with PCOS may have:

many follicles,

relatively high AMH,

irregular ovulation.

This creates a common misunderstanding:

“My AMH is high, therefore my fertility is excellent.”

Not necessarily.

High follicle number does not prevent:

age-related decline in oocyte quality.

Treatment may therefore need to address:

ovulation,

metabolic health,

reproductive age

simultaneously.

Endometriosis After Age 35

Endometriosis may affect:

ovaries,

ovarian reserve,

pelvic anatomy,

fallopian tubes.

For a younger patient, some conservative strategies may allow more time.

After 35, fertility planning should place greater emphasis on:

time to pregnancy.



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Prolonged repeated surgery—particularly involving ovarian endometriomas—should be considered carefully because surgery itself can sometimes reduce ovarian reserve.

Treatment decisions should be individualized.

Fibroids After Age 35

Fibroids become increasingly common with age.

But:

not every fibroid causes infertility.

The effect depends on:

size,

location,

whether the uterine cavity is distorted.

A small subserosal fibroid may be irrelevant.

A cavity-distorting submucosal fibroid can have much greater significance.

This is why fertility treatment should target:

the actual reproductive problem.

Secondary Infertility After Age 35

A woman may say:

“I conceived my first baby immediately at age 29, so why am I struggling now at 37?”

This is completely possible.

Past fertility does not freeze reproductive age.

A woman can develop:

age-related decline,

tubal disease,

endometriosis,

fibroids.

Male fertility can also change.



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Difficulty conceiving another child after previous pregnancy is:

secondary infertility.

It deserves the same systematic evaluation.

Male Age Also Matters

Female reproductive age has the most immediate influence on oocyte-related fertility decline.

But male age is also relevant.

ASRM's 2025 opinion on advancing paternal and maternal age notes that increasing paternal age is associated with changes such as:

lower semen volume,

reduced motility,

altered morphology,

increased DNA fragmentation,

increasing de novo genetic mutations.

The overall absolute risk to an individual child remains relatively low, but paternal age should not be ignored.

Therefore:

fertility after 35 is still couple-based medicine.

Sexual Dysfunction After 35

Some couples focus entirely on:

AMH,

ultrasound,

IVF,

while overlooking a simpler barrier.

Pregnancy may be delayed because intercourse is affected by:

erectile dysfunction,

performance anxiety,



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delayed ejaculation,
vaginismus,
painful intercourse,
low sexual frequency.

This is especially important in my practice.

Because my clinical focus includes both:

Sexual Disorders & Infertility,

I always ask whether effective intercourse is actually occurring.

Treating sexual dysfunction can sometimes restore:

natural pregnancy opportunity.

Stress and Fertility After 35

The social pressure around age 35 can itself become overwhelming.

Women may hear:

“Your clock is running out.”

“You should have had a baby earlier.”

“You will definitely need IVF.”

This language is often unhelpful.

Reproductive ageing is real.

But the patient needs:

accurate information—not panic.

Stress can also affect:

sleep,

libido,

sexual function,

relationship wellbeing.

I encourage couples to use age information for:

planning,



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not for:

self-blame.

The Unani Perspective on Fertility After 35

In classical Unani medicine, infertility is discussed under concepts such as:

‘Uqr.

Traditional assessment may consider:

Mizaj,

menstrual health,

reproductive-organ health,

nutrition,

digestion,

body weight,

sexual function,

general vitality.

CCRUUM's Standard Unani Treatment Guidelines include ‘Uqr within the Unani clinical framework and describe traditional individualized principles based on constitutional and general-health factors.

These concepts can still provide useful:

whole-person context.

Where Unani Medicine Can Be Useful After 35

In selected patients, individualized Unani care may support:

nutritional wellbeing,

digestive health,

metabolic health,

menstrual health,

sleep,

sexual health,



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general physical wellbeing.

For a woman with:

metabolic disturbance,

poor nutrition,

sexual-health concerns,

selected functional menstrual problems,

supportive treatment may improve overall reproductive health.

For the male partner, individualized treatment may address:

sexual function,

lifestyle,

selected semen-related health issues.

This integrative approach can be particularly valuable when it is used:

alongside accurate diagnosis.

What Unani Medicine Cannot Realistically Do

Responsible Unani fertility care requires clear boundaries.

No Unani medicine has been proven to:

stop physiological ovarian ageing.

It cannot:

recreate the millions of follicles present earlier in life.

It cannot reliably:

reverse age-related oocyte aneuploidy.

It cannot guarantee:

natural conception after 40.

It cannot mechanically reopen:

every scarred fallopian tube.

It cannot repair:

genetic causes of severe male infertility.



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Acknowledging these limitations does not weaken Unani medicine.

It makes integrative medicine:

safer and more credible.

Unani Research in Infertility

Unani institutions continue to provide clinical services and conduct research relating to infertility.

CCRUM's 2024–2025 annual report includes:

‘Uqr — infertility

among conditions treated within its clinical network.

Published Unani literature also includes case reports and small clinical studies exploring fertility treatments.

For example, a published case report described conception in a young woman with unilateral tubal blockage after Unani treatment.

This is scientifically interesting.

But:

one case report cannot prove that Unani treatment reopened a blocked tube.

A woman with unilateral disease may still conceive through:

the patent tube.

Apparent proximal blockage may also occasionally result from:

temporary tubal spasm.

Therefore:

preliminary evidence should be presented as preliminary evidence.

Unani Medicine and Age-Related Egg Quality

This distinction is particularly important after 35.

Traditional treatment may improve:

nutrition,

sleep,



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metabolic condition,

sexual health,

general wellbeing.

But age-related oocyte quality decline is fundamentally related to:

cellular and chromosomal ageing.

Current evidence does not establish that Unani therapy can reverse this process.

Therefore I never want a 39- or 41-year-old patient to lose crucial reproductive time because someone promised:

“Take this medicine for two years and your ovarian age will become young again.”

That is not responsible fertility care.

The Best Integrative Approach After 35

My preferred approach is:

modern fertility diagnosis + time-sensitive reproductive planning + appropriate Unani supportive care.

Modern reproductive medicine helps us understand:

ovulation,

ovarian reserve,

tubes,

semen,

uterine anatomy.

Unani care may support:

the general health of the patient,

metabolic wellbeing,

sexual wellbeing,

selected reproductive symptoms.

The systems do not need to compete.

The treatment should revolve around:

what is safest and most useful for the patient.



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Special Fertility Assessment by Dr. Nizamuddin Qasmi After Age 35

When a woman over 35 consults me, I do not start with:

“You need IVF.”

I ask:

How old are you exactly?

How long have you been trying?

Are cycles regular?

Any previous pregnancy?

Any miscarriage?

Any ectopic pregnancy?

Any PID or STI history?

Any endometriosis?

Any ovarian surgery?

Have AMH and AFC been assessed where appropriate?

Are the tubes open?

Has the male partner had semen analysis?

Is intercourse occurring normally?

These answers determine:

what happens next.

Situation 1: Age 35, Trying for Two Months

Regular cycles.

No fertility risk.

Partner has no known reproductive problem.

I do not automatically diagnose:

infertility.

The couple may continue:



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appropriately timed natural intercourse.

At the same time, I discuss:

preconception care,

folic acid,

avoiding tobacco,

when to return if pregnancy does not occur.

Situation 2: Age 36, Trying for Eight Months

Now the situation has crossed the usual:

six-month evaluation threshold.

I would generally begin a couple-based fertility evaluation.

This may include:

semen analysis,

ovulation assessment,

pelvic ultrasound,

tubal evaluation,

ovarian reserve where clinically useful.

Waiting another six months simply to reach:

one year

is usually unnecessary.

Situation 3: Age 37 With Very Irregular Periods

Do not wait six months.

The patient may have:

ovulatory dysfunction.

We need to investigate why.

Possible causes include:

PCOS,



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thyroid disease,
prolactin disorder,
diminished ovarian function.

The treatment then focuses on:

the diagnosis.

Situation 4: Age 38 With Bilateral Tubal Disease

Timed intercourse is unlikely to overcome:

blocked tubes.

WHO's current guideline specifically favors IVF over reconstructive tubal surgery for women aged:

35 or older

with tubal-factor infertility because additional delay can reduce future reproductive potential.

Here, delaying effective treatment simply to continue herbal medicine or repeated timed intercourse would not be advisable.

Situation 5: Age 39 With Low AMH but Regular Periods

I explain:

low AMH is not the same as zero fertility.

She may still ovulate naturally.

But low AMH suggests:

fewer recruitable follicles

and may predict a lower ovarian response during IVF.

Her age remains more important for estimating:

egg quality.

We use this information for:

realistic planning,

not hopelessness.



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Situation 6: Age 39, Normal AMH

I do not say:

“Everything is perfect because the AMH is normal.”

The eggs are still:

age 39.

AMH primarily reflects quantity.

The age-related effect on oocyte quality remains relevant.

Situation 7: Age 40, Trying to Conceive

I recommend:

prompt evaluation.

I would not deliberately ask this couple to wait:

six months,

twelve months

before basic testing.

We need to understand:

ovarian reserve,

tubal status,

semen,

ovulation

and then discuss realistic natural and assisted options.

Situation 8: Age 42 With Previous IVF Failure

This requires detailed review.

Important questions include:

how many eggs were retrieved?

how many mature?



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fertilization rate?

embryo development?

embryo testing?

uterine factors?

male factors?

Simply repeating identical IVF indefinitely may not be appropriate.

We need to determine:

where treatment is failing.

Situation 9: Woman Over 35 With Severe Erectile Dysfunction in Husband

Do not blame:

ovarian age alone.

If regular intercourse cannot occur, we need to treat:

erectile dysfunction,

performance anxiety,

medical causes.

Sometimes restoring effective intercourse can provide natural pregnancy opportunity.

Situation 10: Woman Over 35 With Several Miscarriages

The problem is not simply:

failure to conceive.

The couple may conceive relatively easily but experience:

pregnancy loss.

Age-related embryo aneuploidy becomes an important possibility, but evaluation after recurrent pregnancy loss should also consider:

uterine factors,

selected genetic factors,

endocrine/medical issues



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according to clinical circumstances.

ACOG defines recurrent pregnancy loss as:

two or more miscarriages

and recommends evaluation after two losses.

Should Women Over 35 Skip Straight to IVF?

No universal rule supports this.

Some women have excellent reasons to begin IVF relatively early.

Others have:

open tubes,

adequate semen,

recent attempts,

reasonable ovarian reserve

and may still have an appropriate chance of natural conception or simpler treatment.

The decision depends on:

age + duration + diagnosis + ovarian reserve + semen + tubal status + treatment goals.

When IVF May Become More Appropriate Earlier

Examples include:

bilateral tubal obstruction,

significant hydrosalpinx after appropriate management,

severe male-factor infertility,

unsuccessful lower-level treatment,

more advanced reproductive age where time is especially critical.

The point is not:

“IVF because you are 35.”

The point is:



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“IVF when it offers a better balance of chance and time for your particular diagnosis.”

When Natural Conception May Still Be Reasonable

Natural attempts can remain reasonable when:

evaluation is reassuring,

intercourse is regular,

duration of trying is still short,

age is in the earlier part of the 35+ range.

Fertility care should not turn every healthy 35-year-old into:

an infertility patient.

When IUI May Be Reasonable

IUI may be appropriate when:

at least one tube is functional,

semen after preparation is adequate,

infertility is unexplained or mild,

age and ovarian reserve allow enough time.

But repeated IUI cycles should not continue indefinitely when:

probability is falling and reproductive time is being lost.

When Donor Eggs May Be Discussed

Donor eggs may become relevant when:

ovarian reserve is extremely poor,

repeated IVF with own eggs fails,

embryo aneuploidy repeatedly prevents usable embryo creation,

reproductive age makes autologous-oocyte success very low.

This is a personal decision.



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Patients deserve:

medical facts,

emotional support,

time for informed consent.

Fertility Preservation for Women Who Are Not Ready for Pregnancy

If a woman is 35 or older and knows that she wants children but:

is not currently ready,

does not have a partner,

must delay pregnancy,

she may benefit from discussing:

oocyte cryopreservation.

ACOG recommends reproductive-life counselling and notes that patients delaying childbearing may consider referral to a reproductive specialist.

But again:

freezing eggs later is less efficient than freezing them earlier.

No one should be told:

“Freeze five eggs and you are guaranteed a future baby.”

Fertility After 35 Is Also About Preconception Health

Before pregnancy, review:

blood pressure,

diabetes risk,

thyroid disease where appropriate,

medicines,

folic acid,

vaccination,

smoking,



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alcohol,

chronic illness.

A pregnancy achieved quickly is not the only goal.

The goal should be:

healthy conception and healthy pregnancy.

Folic Acid

Women planning pregnancy should generally take:

folic acid

before conception.

This reduces the risk of neural-tube defects.

The dose depends on individual risk.

Women with certain medical histories may require higher doses under clinician supervision.

This should be part of fertility care even when:

IVF,

IUI,

natural conception

is planned.

What Should You Avoid After 35?

Avoid losing reproductive time to:

repeatedly changing unproven fertility supplements,

years of empirical treatment without diagnosis,

unnecessary repeated antibiotics,

claims of guaranteed ovarian rejuvenation,

assuming AMH alone predicts pregnancy,

ignoring the male partner,



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continuing many ineffective treatment cycles without reviewing the plan.

The biggest mistake is often not:

choosing the wrong medicine once.

It is:

continuing a low-yield strategy for too long.

Frequently Asked Questions

Is 35 too old to get pregnant?

No.

Many women conceive naturally and have healthy pregnancies after 35.

Fertility is reduced compared with younger ages, but 35 is not a sudden infertility threshold.

Why do doctors talk so much about age 35?

Because fertility evaluation should generally begin sooner after unsuccessful attempts and age-related decline becomes increasingly relevant.

Does fertility suddenly fall on my 35th birthday?

No.

The decline is gradual and generally becomes faster through the mid-to-late 30s.

What is the chance of pregnancy at 40?

ACOG estimates that approximately:

1 in 10 healthy women around age 40

may conceive per menstrual cycle.

This is a population estimate, not a personalized prediction.

Can I conceive naturally at 40?

Yes.



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Natural pregnancy remains possible.

But you should not delay evaluation unnecessarily if pregnancy is desired.

Should I wait six months after age 40?

Usually not.

Prompt evaluation is recommended.

If I am 36, how long should I try?

If no known infertility factor exists:

approximately six months

before evaluation.

What if I have irregular periods?

Seek evaluation earlier.

You do not need to wait six months when an ovulation problem may already be present.

Do regular periods mean my fertility is good?

They make regular ovulation more likely.

But they do not measure:

tubal health,

semen,

egg quality.

What is ovarian reserve?

The remaining quantity of oocytes/follicles available in the ovaries.

What is AMH?

A hormone used mainly as a marker of ovarian reserve and expected ovarian response.



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Does AMH measure egg quality?

No.

Does low AMH mean I cannot become pregnant naturally?

No.

Low AMH does not automatically mean natural conception is impossible.

Can a woman with very low AMH still ovulate?

Yes.

Does high AMH mean my eggs are high quality?

No.

Egg quality is strongly influenced by age.

What is AFC?

Antral follicle count measured by ultrasound.

It estimates ovarian reserve.

Which is more important: age or AMH?

For overall reproductive potential:

age is generally more important.

AMH is particularly useful for predicting:

ovarian response and egg yield.

Should every woman over 35 have IVF?

No.



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Can timed intercourse work after 35?

Yes, when:

ovulation is occurring,

tubes are functional,

semen is suitable.

Can IUI work after 35?

Yes, in selected patients.

Success depends on:

age,

diagnosis,

ovarian reserve,

semen,

tubal status.

Does IVF guarantee pregnancy after 35?

No.

Does IVF make eggs younger?

No.

Why does IVF success decline with age?

Because age affects:

egg number,

oocyte chromosome quality,

embryo development,

miscarriage risk.



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What is ICSI?

A laboratory fertilization technique in which one sperm is injected into an egg.

Does every IVF patient over 35 need ICSI?

No.

ICSI is primarily indicated for specific fertilization or male-factor situations and should not automatically be added only because of age.

Does every woman over 35 need PGT-A?

No.

It may be considered in selected IVF patients, especially where enough embryos are available, but ASRM does not recommend routine PGT-A for everyone.

Does PGT-A improve egg quality?

No.

It tests embryos.

It does not change the chromosomes inside the egg.

Does PGT-A guarantee implantation?

No.

Can I freeze eggs at 36 or 37?

Yes.

But future success is generally better when oocytes are frozen at a younger age.

Does egg freezing guarantee a future baby?

No.

Should I freeze eggs based only on AMH?

No.

The decision depends on:

age,

family-building plans,

likely ovarian response.

Are donor eggs more successful at older maternal ages?

They can substantially overcome age-related oocyte decline because the egg's biological age is determined by the donor's age.

But pregnancy-related maternal risks still depend on the health and age of the person carrying the pregnancy.

Is miscarriage more common after 35?

Yes.

The risk increases with age, partly because embryo chromosomal abnormalities become more common.

What is miscarriage risk after 40?

ACOG states that approximately:

one in three pregnancies

in women over 40 may end in early pregnancy loss.

Does sex cause miscarriage after 35?

Ordinary intercourse does not usually cause miscarriage.

Does exercise cause miscarriage?

Routine appropriate exercise is not generally a cause of early pregnancy loss.

Should I get prenatal genetic testing because I am over 35?



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You should discuss screening and diagnostic options with your obstetric clinician.

Modern guidance offers prenatal genetic screening and diagnostic choices to pregnant patients of all ages.

Can supplements improve egg quality?

Correcting deficiencies can support general health.

No supplement has been proven to reverse chronological ovarian ageing.

Can CoQ10 make my eggs young again?

No.

Can PRP rejuvenate the ovaries?

Ovarian PRP remains investigational and should not be presented as proven age-reversing treatment.

Can stem cells restore fertility after 40?

This remains experimental.

Can Unani medicine improve fertility after 35?

Individualized Unani care can be used supportively for selected areas such as:

nutrition,

metabolic wellbeing,

digestion,

menstrual wellbeing,

sexual health,

general reproductive health.

But treatment should be diagnosis-led.

Can Unani medicine reverse ovarian ageing?

There is currently no high-quality evidence showing that Unani medicine can reverse chronological ovarian ageing.

Can Unani medicine increase ovarian reserve permanently?

No proven treatment can regenerate the primordial follicle pool to the level of a younger woman.

Can Unani medicine reverse egg chromosome abnormalities?

There is no evidence that it can.

Can Unani medicine open every blocked fallopian tube?

No.

Established structural tubal disease may require:

surgery,

IVF.

Can Unani medicine be used with IVF?

Selected supportive treatment may be integrated when the fertility specialist considers it safe and there are no:

medicine interactions,

stimulation/pregnancy concerns.

Every herbal and Unani product should be disclosed to the fertility team.

Can Unani medicine help sexual problems while trying for pregnancy?

Potentially yes.

Individualized treatment may contribute to care involving:

sexual confidence,

erectile problems,

lifestyle,



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general wellbeing,

alongside appropriate modern evaluation.

Should I spend one year trying Unani treatment first if I am 39?

Not without appropriate fertility evaluation.

At 39:

reproductive time matters.

Supportive Unani treatment can be integrated without postponing clinically necessary fertility assessment or ART.

A Message From Dr. Nizamuddin Qasmi to Women Aged 35–37

Please do not panic.

You still have meaningful reproductive potential.

But use time intelligently.

If pregnancy does not occur after approximately:

six months,

seek evaluation.

Do not spend years assuming:

“It will happen eventually.”

At the same time:

do not assume you automatically need IVF.

First identify your reproductive situation.

A Message to Women Aged 38–40

In this age group, I advise a more:

proactive approach.

Natural pregnancy remains possible.

But I prefer early information about:



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ovarian reserve,

tubes,

semen,

ovulation.

The purpose is to preserve:

options.

A Message to Women Over 40

Please do not feel that you must:

try for one year before you are allowed to seek help.

You do not.

Current fertility guidance supports:

prompt evaluation.

We need to discuss realistic options based on:

ovarian reserve,

overall health,

tubes,

partner fertility,

reproductive goals.

A Message to Men

When your wife is over 35, please do not assume:

“Her age is the entire problem.”

Your semen analysis remains important.

Your:

sexual function,

reproductive history,

testosterone/steroid use,



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testicular health

also matter.

Fertility remains:

a couple's responsibility.

A Message to Couples About IVF

IVF is an extraordinary reproductive technology.

But it should not be treated as:

magic.

It cannot guarantee pregnancy.

It cannot make current-age eggs younger.

It can, however, be extremely valuable when:

tubes are severely damaged,

male factor is significant,

lower-level treatment has failed,

time-sensitive age factors favour a faster path.

The decision should be:

individualized.

A Message About Unani Medicine

As a physician trained in Unani medicine, I value its emphasis on:

Mizaj,

nutrition,

digestion,

general wellbeing,

sexual health,

reproductive health.

These aspects can make meaningful contributions to the care of many patients.



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But after age 35:

time becomes an essential medical factor.

Therefore, I do not believe traditional treatment should be used as a reason to postpone:

semen analysis,

tubal testing,

ovarian-reserve assessment,

IVF when clearly indicated.

The best integrative care respects both:

traditional whole-person medicine

and:

modern reproductive biology.

Saira Health Care's Contribution to Fertility Care After Age 35

At **Saira Health Care**, our particular focus lies at the intersection of:

Sexual Disorders & Infertility.

Women after 35 may consult us not only because of:

delayed conception,

but because their fertility journey is complicated by:

male infertility,

erectile dysfunction,

performance anxiety,

ejaculation problems,

recurrent genital infections,

painful intercourse,

irregular ovulation.

Therefore, our approach considers:

both partners.



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Depending on the individual couple, management may involve:

reproductive history,
menstrual/ovulatory assessment,
ovarian-reserve assessment where appropriate,
pelvic ultrasound,
tubal evaluation,
semen analysis,
male reproductive evaluation,
sexual-function assessment,
selected infection assessment,
fertility-treatment counselling.

Individualized Unani support may then be incorporated where clinically appropriate.

Dr. Nizamuddin Qasmi's Specialized Clinical Approach

I am **Dr. Nizamuddin Qasmi**, Founder & Chief Physician of Saira Health Care, with a focused and specialized clinical practice in **Sexual Disorders & Infertility**.

My professional qualifications and 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

When I see a couple after age 35, my objective is not:

“Give fertility medicine.”

I want to determine:

How much reproductive time do we have?

Is ovulation occurring normally?

What is the ovarian reserve?



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Are the tubes functional?

What does the semen analysis show?

Is intercourse occurring effectively?

Is there a treatable sexual disorder?

Can natural conception reasonably continue?

Is IUI worthwhile?

Would IVF provide a better balance of time and probability?

and:

Where can responsible Unani medicine support the patient without delaying essential treatment?

That is what individualized fertility medicine should mean.

Current Medical Understanding — 2026 Update

The most important recent development is WHO's first global infertility guideline, published in:

November 2025.

It establishes an evidence-based framework for:

diagnosis,

ovulatory infertility,

tubal infertility,

male-factor infertility,

unexplained infertility,

assisted reproductive treatment.

Its recommendations strongly reinforce the importance of:

age-sensitive decision-making.

For example, in tubal-factor infertility, WHO differentiates between patients younger than 35 and those 35 or older because the additional time associated with surgery and natural attempts may reduce future pregnancy opportunity in older patients.



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ACOG's updated **November 2025** counselling statement likewise emphasizes that reproductive counselling should begin before patients encounter infertility because ovarian reserve and oocyte quality naturally decline throughout reproductive life.

A crucial modern principle is:

AMH should not be mistaken for an age-reversal test.

WHO now emphasizes age as the most important predictor of ovarian reserve in infertility evaluation, while ASRM continues to emphasize that AMH and AFC predict:

oocyte yield

better than:

natural reproductive potential.

Modern fertility treatment also increasingly emphasizes avoiding unnecessary procedures.

For example, WHO recommends that when couples with unexplained infertility proceed to IVF after unsuccessful stimulated IUI, conventional IVF rather than automatic ICSI should be used unless another indication for ICSI exists.

Likewise, ASRM's current position is that PGT-A may be useful in selected advanced-age IVF patients but is not automatically required for every IVF cycle.

The overall 2026 message is therefore:

age matters greatly—but age alone should not determine every treatment.

The best approach combines:

age + ovarian reserve + infertility diagnosis + semen + tubal status + reproductive goals.

Conclusion

Fertility care after age 35 should be informed, proactive and individualized.

Age 35 is:

not a fertility cliff.

It is a useful point at which doctors become more conscious of:

reproductive time.

Female fertility declines because both:



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oocyte quantity

and:

oocyte quality

change with age.

ACOG notes that fertility begins declining before 35 and decreases more rapidly through the mid-30s and beyond. Around age 40, natural conception probability for healthy couples is approximately one in ten per menstrual cycle, while spontaneous conception becomes uncommon by the mid-40s.

Women aged 35–40 who have not conceived after approximately:

six months

should generally begin fertility evaluation.

Women over:

40

should usually seek evaluation promptly.

Evaluation should involve:

both partners.

For the woman, this may include:

ovulation assessment,

pelvic ultrasound,

ovarian-reserve assessment when appropriate,

tubal testing.

For the man:

semen analysis

is a fundamental early investigation.

AMH should be interpreted carefully.

It mainly reflects:

ovarian reserve / potential ovarian response.

It does not directly measure:

egg quality,



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chromosome normality,

natural pregnancy probability.

Age remains the more powerful reproductive predictor.

Natural conception can remain entirely reasonable after 35 when:

reproductive evaluation is reassuring,

duration of trying remains short.

IUI may be useful in selected couples.

IVF becomes more appropriate when:

tubal disease is significant,

male factor is severe,

simpler treatment has failed,

age makes additional delay undesirable.

But:

IVF cannot make the woman's eggs younger.

Likewise:

egg freezing,

PGT-A,

ICSI

should not be presented as guarantees.

Donor eggs can substantially overcome the age-related decline related to the recipient's own oocytes, but the age and health of the woman carrying the pregnancy still influence:

obstetric risk.

From the **Unani perspective**, individualized care can provide useful support in selected patients through attention to:

Mizaj,

nutrition,

digestion,

metabolic health,



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menstrual health,

sexual wellbeing,

general reproductive health.

CCRUM continues to recognize and provide clinical care for:

‘Uqr — infertility.

But responsible Unani medicine should never make unsupported claims that it can:

reverse ovarian ageing,

permanently restore lost ovarian reserve,

correct age-related chromosome abnormalities,

guarantee pregnancy,

reopen every scarred fallopian tube.

At **Saira Health Care**, my preferred model is:

evaluate early → investigate both partners → understand ovarian reserve without misusing AMH → identify tubal, ovulatory, male and sexual factors → preserve reproductive time → use natural conception, IUI or IVF according to diagnosis → integrate responsible Unani supportive care where it genuinely adds value.

The most important message I want women over 35 to remember is:

Do not panic because of your age—but do not ignore it either.

Fertility care after 35 is not about fear.

It is about:

making well-informed decisions while the widest range of reproductive options is still available.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Qualifications & Professional Training

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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 with a **specialized clinical focus on Sexual Disorders & Infertility**.

His work at **Saira Health Care** includes evaluation and management planning for:

age-related fertility concerns,

diminished ovarian reserve,

ovulation disorders,

male infertility,

abnormal semen analysis,

tubal-factor infertility,

erectile dysfunction,

ejaculatory disorders,

performance anxiety,

sexual problems interfering with conception.

His clinical philosophy emphasizes:

time-sensitive diagnosis rather than prolonged empirical treatment.

Depending upon the individual couple, assessment may include:

menstrual and ovulatory history,

ovarian-reserve assessment,

pelvic ultrasound,

fallopian-tube evaluation,

semen analysis,

male reproductive assessment,

sexual-function assessment,

review of previous IUI or IVF treatment.



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Where medically appropriate, individualized Unani principles may be used supportively for:

general physical health,
nutritional wellbeing,
digestion,
metabolic health,
menstrual wellbeing,
sexual health,
reproductive wellbeing.

At **Saira Health Care**, the objective is not simply:

“Treat fertility after age 35.”

The objective is to determine:

What is this woman's realistic reproductive potential?

What is the male partner's fertility status?

Is natural conception still reasonable?

How much time can safely be used for simpler treatment?

When should IUI or IVF be considered?

Is donor-oocyte treatment relevant?

and:

How can responsible Unani supportive care be integrated without losing valuable reproductive time?

Medical Disclaimer

This article is intended for professional education and general public awareness. It does not replace individualized consultation with an appropriately qualified physician, gynecologist, reproductive-medicine specialist, male reproductive specialist or obstetrician.

Age 35 should not be interpreted as a sudden biological cut-off between fertility and infertility.



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Women aged 35 or older who have not conceived after approximately six months of regular unprotected intercourse should generally seek fertility evaluation; women over 40 should usually seek more prompt assessment. Earlier evaluation is appropriate at any age when a known fertility risk exists.

AMH and AFC estimate ovarian reserve and expected ovarian response but should not be interpreted as direct measures of egg quality or guarantees of natural conception.

Very low AMH does not automatically mean pregnancy is impossible, while normal or high AMH does not remove age-related oocyte-quality decline.

IVF, ICSI, PGT-A and egg freezing can expand reproductive options but none can guarantee pregnancy or live birth.

PGT-A should be individualized and is not automatically required solely because a woman is over 35.

Pregnancy after age 35 carries gradually increasing risks of miscarriage, chromosomal abnormalities and some obstetric complications, but most risks do not suddenly increase on the 35th birthday.

Unani medicine may be integrated as supportive care in selected patients but should not be used to delay evidence-based evaluation or medically indicated fertility treatment in women with significant age-related time constraints, severe tubal disease, markedly reduced ovarian response or serious male-factor infertility.

Claims that any herbal, Unani, supplement, PRP or stem-cell treatment can reliably restore ovarian age, regenerate a depleted primordial follicle pool or guarantee pregnancy are not supported by current high-quality evidence.



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