

Intrauterine Adhesions (Asherman Syndrome)

Understanding Uterine Scar Tissue, Reduced Periods, Infertility, Recurrent Miscarriage, Hysteroscopic Treatment and an Integrative Unani Approach

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When a woman comes to me for infertility and tells me:

“Doctor, my periods became very light after a miscarriage procedure,”

or:

“My periods almost stopped after a D&C,”

or:

“I was becoming pregnant before, but after a uterine procedure I have been unable to conceive,”

one condition that deserves consideration is:

Intrauterine Adhesions

When intrauterine adhesions cause symptoms such as menstrual disturbance, pelvic pain, infertility or pregnancy complications, the condition is commonly referred to as:

Asherman Syndrome

In simple terms, **scar tissue develops inside the uterine cavity and causes parts of the inner uterine walls to stick together.**

The adhesions may be very thin and delicate in a mild case.

In severe disease, dense fibrous scar tissue may partly or almost completely close the uterine cavity.

This can affect:

- menstruation,
- implantation of an embryo,
- fertility,
- pregnancy maintenance,
- placental development.



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Modern guidelines distinguish between simply finding an intrauterine adhesion and having true symptomatic Asherman syndrome. An asymptomatic adhesion seen incidentally is not necessarily equivalent to clinically significant Asherman syndrome.

My first message to patients is:

Asherman syndrome is not simply “irregular periods,” and it is not simply “weakness of the uterus.” It is usually a structural problem involving scar tissue inside the uterine cavity.

Therefore, treatment begins by understanding the anatomy.

Unani medicine may have a supportive role in improving the woman's general reproductive health, nutrition, menstrual wellbeing and associated problems, but **established scar tissue that is physically distorting the uterine cavity generally requires hysteroscopic evaluation and, when clinically significant, hysteroscopic adhesiolysis.**

That distinction is essential for safe and effective treatment.

What Are Intrauterine Adhesions?

The inside of the uterus is lined by a specialized tissue called the:

Endometrium

During a normal menstrual cycle, part of this lining grows under the influence of reproductive hormones.

If pregnancy does not occur, much of the functional layer sheds during menstruation.

Beneath it lies a deeper regenerative layer from which the endometrium rebuilds.

When this deeper layer is significantly injured, normal healing may be disrupted.

Instead of restoring a healthy endometrial surface, fibrous scar tissue may form.

Scarred surfaces on opposite sides of the uterus can then attach to one another.

These bands of scar tissue are called:

**intrauterine adhesions,
uterine synechiae,
or IUAs.**

If these adhesions produce symptoms or fertility problems, the condition is usually called **Asherman syndrome.**



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Why Is the Endometrium So Important for Fertility?

For pregnancy to develop normally, several events need to occur.

An egg must be released.

Sperm must reach and fertilize the egg.

The embryo must then reach the uterus.

Finally, it needs to implant into a sufficiently healthy and receptive endometrium.

The uterus is therefore not merely a hollow container.

Its internal lining is a biologically active tissue.

If substantial areas of healthy endometrium have been replaced by scar tissue, several problems may occur:

- the uterine cavity may become smaller,
- implantation surface may be reduced,
- blood supply may be impaired,
- access to the fallopian tubes may become obstructed,
- normal menstrual flow may be restricted.

This explains why Asherman syndrome can affect fertility even when:

- ovulation is normal,
- sperm parameters are satisfactory,
- hormone tests appear normal.

Asherman Syndrome Is Usually Acquired

Most women are **not born** with Asherman syndrome.

It usually develops after damage to the inner uterine lining.

One of the most important settings is trauma to the uterus associated with pregnancy.

Current reviews identify instrumentation of a recently pregnant uterus as one of the classic causes of symptomatic Asherman syndrome.

Dilation and Curettage — D&C

A common historical risk factor is:



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Dilation and Curettage

During a D&C, the cervix is dilated and tissue is removed from inside the uterine cavity.

D&C may be performed in circumstances such as:

- miscarriage,
- retained pregnancy tissue,
- retained placenta after delivery,
- abnormal uterine bleeding.

Most D&C procedures do **not** lead to Asherman syndrome.

However, when the deeper endometrial layer is damaged—particularly in a recently pregnant uterus—the risk of adhesion formation increases.

Repeated curettage may increase the risk further.

Older and contemporary reviews consistently identify curettage following pregnancy-related events as one of the major precursors of intrauterine adhesions.

Miscarriage and Retained Products of Conception

A common clinical history is:

pregnancy → miscarriage → surgical evacuation → periods become very light.

Not every woman with lighter periods after miscarriage has Asherman syndrome.

Hormonal changes can also temporarily affect menstruation.

However, if a marked reduction in menstrual flow persists after uterine evacuation—especially when accompanied by infertility or cyclic pelvic pain—adhesions deserve investigation.

Repeated procedures for retained products of conception increase concern.

Postpartum Curettage and Retained Placenta

The postpartum uterus may be particularly vulnerable to adhesion formation if significant endometrial trauma occurs.

Sometimes placental tissue remains after delivery and requires removal.

If the procedure damages the basal endometrium, intrauterine scar tissue can develop.



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Recent research also suggests that adhesions arising in the postpartum or puerperal setting may be particularly difficult to manage.

A 2025 matched-cohort study found substantially greater adhesion reformation after hysteroscopic surgery among women whose Asherman syndrome developed in the puerperal period compared with those whose adhesions arose outside that period.

This is one reason prevention of unnecessary uterine trauma around pregnancy is so important.

Cesarean Section

A cesarean section does not automatically cause Asherman syndrome.

Most women undergoing cesarean delivery will never develop intrauterine adhesions.

However, scar formation can occur in selected circumstances, especially when additional intrauterine procedures, infection or retained placental tissue are present.

The complete obstetric history therefore matters.

Hysteroscopic Surgery

Ironically, procedures performed inside the uterus to treat other abnormalities can themselves occasionally create adhesions.

Risk varies with the procedure.

Examples include:

- hysteroscopic myomectomy,
- removal of multiple submucosal fibroids,
- uterine septum surgery,
- other procedures damaging opposing endometrial surfaces.

AAGL/ESGE guidance notes that adhesion risk is influenced by the type and depth of hysteroscopic surgery, with procedures extending into the myometrium generally carrying greater risk than superficial procedures such as simple polypectomy.

Myomectomy

Fibroids that project into the uterine cavity can require hysteroscopic removal.

If a large area of endometrium is disrupted, particularly on opposing walls, adhesions can occasionally develop during healing.

This does not mean hysteroscopic myomectomy should be avoided when medically indicated.

It means postoperative adhesion risk should be considered in fertility-oriented surgery.

Infection

Severe uterine infection can sometimes damage the endometrium and promote fibrosis.

This is much less common than pregnancy-related instrumentation in many populations, but infection becomes particularly important in certain geographical regions.

Genital Tuberculosis and Asherman Syndrome

For patients in India and other regions where tuberculosis remains clinically relevant, **female genital tuberculosis deserves particular attention.**

Genital tuberculosis can involve:

- endometrium,
- fallopian tubes,
- ovaries,
- surrounding pelvic structures.

Chronic endometrial inflammation can result in:

- fibrosis,
- intrauterine adhesions,
- blocked tubes,
- infertility.

Indian studies have documented genital tuberculosis as an important cause of severe intrauterine adhesions and Asherman syndrome in selected infertile women.

This is especially important when a patient has:

- primary infertility,



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- significant intrauterine adhesions,
- tubal disease,
- menstrual reduction,
- past tuberculosis exposure,
- other clinical suspicion.

However, tuberculosis should not be diagnosed simply because an infertile woman has adhesions.

Appropriate investigations are required.

Asherman Syndrome Does Not Always Produce the Same Symptoms

The symptoms depend upon:

- amount of uterine cavity involved,
- density of the scar tissue,
- location of the adhesions,
- amount of healthy endometrium remaining,
- whether menstrual outflow is blocked.

A woman with mild adhesions may continue having apparently normal periods.

Another woman with severe disease may have almost no menstruation.

Hypomenorrhea — Very Light Periods

A classic symptom is:

Hypomenorrhea

meaning menstrual bleeding becomes significantly lighter than before.

For example, a woman may say:

“Before my miscarriage I bled for five days. After the procedure I barely bleed for one day.”

This does not automatically prove Asherman syndrome.

But when the change begins after uterine surgery, miscarriage treatment or postpartum intervention, it is an important clue.



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Amenorrhea — Periods Stop Completely

If adhesions are severe enough, menstruation may stop.

This is called:

Amenorrhea

The woman may still have functioning ovaries and normal hormonal cycling.

The problem may be:

- insufficient functioning endometrium,
- severe uterine-cavity obliteration,
- blockage preventing menstrual blood from escaping.

This is why amenorrhea after a uterine procedure deserves proper evaluation rather than automatically being treated with hormones.

Normal Periods Do Not Completely Exclude Adhesions

Some women with mild or localized intrauterine adhesions continue to menstruate.

The adhesion may instead present through:

- difficulty conceiving,
- recurrent miscarriage,
- unsuccessful embryo implantation.

Therefore, normal menstrual flow does not completely rule out IUA.

Cyclic Pelvic Pain

Some patients continue to undergo hormonal menstrual cycles but scar tissue obstructs the normal escape of blood.

They may therefore experience:

- monthly cramping,
- pelvic pressure,
- severe cyclic pain

with little or no visible menstrual bleeding.



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Pain associated with reduced menstruation after uterine surgery deserves evaluation.

Hematometra

If menstrual blood becomes trapped inside the uterus because of severe obstruction, it can accumulate.

This is called:

Hematometra

The patient may develop:

- pelvic pain,
- pressure,
- cyclic symptoms.

This situation requires gynecological assessment.

Infertility

Intrauterine adhesions can reduce fertility through several mechanisms.

They may:

- reduce healthy implantation surface,
- prevent embryo implantation,
- distort the uterine cavity,
- obstruct access to tubal openings,
- impair endometrial blood supply.

Therefore, Asherman syndrome may contribute to:

primary infertility or **secondary infertility**.

Secondary infertility is particularly suggestive when the woman previously conceived normally but begins having difficulty after:

- miscarriage treatment,
 - childbirth,
 - intrauterine surgery.
-

Recurrent Pregnancy Loss

Some women with intrauterine adhesions can conceive but experience repeated miscarriage.

Possible mechanisms include:

- inadequate implantation area,
- abnormal endometrial vascularity,
- abnormal placental attachment,
- reduced cavity volume.

Current clinical literature recognizes recurrent pregnancy loss as one of the important reproductive presentations of symptomatic intrauterine adhesions.

Implantation Failure During IVF

A patient may have:

- good embryos,
- apparently normal ovaries,
- repeated embryo-transfer failure.

When there is a history suggesting endometrial injury, evaluation of the uterine cavity becomes important.

IVF cannot bypass a severely scarred endometrium.

IVF can overcome:

- tubal blockage,
- some ovulation problems,
- severe male infertility.

But an embryo still needs to implant into the uterus.

Therefore, uterine cavity health remains important even when IVF is used.

Asherman Syndrome Does Not Mean Pregnancy Is Impossible

Many women achieve pregnancy following successful treatment.

The prognosis depends heavily upon:



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- severity of adhesions,
- amount of healthy endometrium remaining,
- age,
- ovarian reserve,
- fallopian-tube status,
- male fertility,
- recurrence after surgery.

Mild adhesions usually have a better prognosis than very dense, extensive fibrosis.

Therefore, one diagnosis should not automatically create hopelessness.

How Is Asherman Syndrome Diagnosed?

Diagnosis should combine:

- clinical history,
- menstrual changes,
- fertility history,
- uterine-cavity assessment.

The strongest diagnostic test is:

Hysteroscopy

Hysteroscopy — The Diagnostic Gold Standard

Hysteroscopy involves passing a narrow telescope through the cervix so that the uterine cavity can be viewed directly.

Current AAGL/ESGE guidance identifies hysteroscopy as the **most accurate method and investigation of choice when available**.

The physician can directly see:

- where adhesions are located,
- whether they are thin or dense,
- how much of the cavity is affected,
- whether the tubal openings are visible,



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- what the remaining endometrium looks like.

Hysteroscopy also has another major advantage:

diagnosis and treatment can sometimes occur during the same procedure.

Saline Infusion Sonography

Saline infusion sonography—also called:

- SIS,
- sonohysterography,
- SHG

involves introducing sterile fluid into the uterine cavity during ultrasound.

The fluid helps outline the cavity.

Adhesions may appear as:

- irregular bridges,
- areas where the cavity fails to open,
- filling defects.

A modern review describes saline sonohysterography as a sensitive screening investigation, but hysteroscopy remains the criterion standard for final diagnosis.

Hysterosalpingography — HSG

During HSG, contrast material is placed through the cervix and X-ray images are taken.

HSG can show:

- irregular filling defects,
- partial cavity obliteration,
- failure of the cavity to fill,
- tubal patency.

However, it cannot directly characterize scar tissue.

AAGL/ESGE guidance considers HSG and saline sonography reasonable alternatives when hysteroscopy is unavailable but identifies hysteroscopy as more accurate.



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Ordinary Ultrasound May Be Normal

A routine transvaginal ultrasound can sometimes miss intrauterine adhesions.

This is important.

A patient may say:

“My ultrasound was normal, so how can I have Asherman syndrome?”

Routine ultrasound is excellent for many gynecological disorders but may not clearly demonstrate thin intrauterine adhesions.

Therefore, when clinical suspicion is strong, further cavity assessment may still be necessary.

MRI

MRI is not usually the first-line diagnostic investigation for intrauterine adhesions.

AAGL/ESGE guidance does not recommend routine MRI for IUA diagnosis outside research or selected complex clinical situations.

Classification of Asherman Syndrome

Several classification systems exist.

One commonly used system is the **American Fertility Society—AFS classification**, which considers:

- amount of the uterine cavity involved,
- type or density of adhesions,
- menstrual pattern.

The condition may broadly be described as:

- mild,
- moderate,
- severe.

There is no universally perfect classification system.

AAGL/ESGE guidance recommends classifying adhesions because prognosis correlates with disease severity, while acknowledging that no single classification system has proven clearly superior.



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Mild Intrauterine Adhesions

Mild adhesions may be:

- thin,
- filmy,
- limited to a relatively small part of the cavity.

They may sometimes separate easily during hysteroscopy.

Healthy endometrium may remain over most of the uterine surface.

Fertility prognosis is generally more favourable.

Moderate Adhesions

Moderate disease involves more substantial areas of the uterine cavity.

Adhesions may be:

- thicker,
- more numerous,
- partially obstructive.

Tubal openings may be difficult to visualize.

Treatment and prevention of recurrence become more important.

Severe Asherman Syndrome

Severe disease may involve:

- dense fibrous adhesions,
- extensive cavity obliteration,
- very limited normal endometrium,
- cervical obstruction,
- amenorrhea.

Treatment can be technically difficult.



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AAGL/ESGE specifically recommends that extensive dense adhesions be treated by clinicians experienced in advanced hysteroscopic adhesiolysis.

This is important because aggressive treatment performed without adequate expertise can cause:

- uterine perforation,
- additional endometrial damage,
- false passage formation.

Treatment of Asherman Syndrome

The main established treatment for symptomatic Asherman syndrome is:

Hysteroscopic Adhesiolysis

This means separating or cutting the adhesions under direct hysteroscopic vision.

The purpose is to:

- restore normal uterine-cavity shape,
- expose healthy endometrium,
- reopen access toward the tubal openings,
- improve menstrual flow,
- improve conditions for implantation.

AAGL/ESGE recommends hysteroscopic adhesiolysis under direct vision as the surgical treatment of choice for symptomatic intrauterine adhesions.

Why Blind D&C Should Not Be Used to Treat Asherman Syndrome

Historically, blind dilation and curettage was sometimes used in an attempt to disrupt adhesions.

Modern guidance advises against this.

Why?

Because the surgeon cannot directly see:

- where scar tissue ends,
- where healthy uterine wall begins.



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Blind curettage may:

- fail to remove the correct scar,
- damage healthy endometrium,
- increase perforation risk,
- worsen future adhesions.

AAGL/ESGE states that there is **no evidence supporting blind D&C as treatment for IUAs** and specifically recommends hysteroscopic treatment instead.

How Are Adhesions Divided?

During hysteroscopy, adhesions may be divided with techniques such as:

- hysteroscopic scissors,
- mechanical dissection,
- selected electrosurgical instruments.

Thin adhesions may sometimes separate with gentle hysteroscopic manipulation.

Dense scars require more careful dissection.

There is no strong evidence that one instrument is superior in every patient.

The overriding principle is:

restore the cavity while causing as little new endometrial trauma as possible.

Severe Cases May Require Image Guidance

In very difficult cases, additional guidance may be used.

Options include:

- transabdominal ultrasound guidance,
- occasionally laparoscopy,
- specialized imaging techniques in selected centres.

The objective is to help determine the correct uterine anatomy and reduce the consequences of a possible false passage or perforation.

These methods are not routinely necessary for mild disease.



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Can One Operation Completely Treat Asherman Syndrome?

Sometimes.

But not always.

Mild adhesions may be restored after a single hysteroscopy.

Moderate or severe disease may require:

- more than one hysteroscopic procedure,
- postoperative treatment,
- repeat cavity assessment.

Large surgical series demonstrate that uterine anatomy can frequently be restored, but recurrence is an important problem—particularly in severe disease.

Adhesion Recurrence Is One of the Biggest Challenges

After scar tissue has been divided, the opposite uterine walls are again injured surfaces.

During healing, they can adhere to one another again.

This produces:

Recurrent Intrauterine Adhesions

A 2025 review estimated postoperative recurrence in contemporary series at approximately **3–25% overall**, although rates vary substantially according to disease severity, definitions and preventive methods.

Individual studies of severe disease report much higher recurrence.

Therefore, a successful first operation is sometimes only the beginning of treatment.

Disease Severity Strongly Influences Recurrence

A woman with a few thin adhesions and extensive healthy endometrium has a very different prognosis from a woman whose uterine cavity is almost completely replaced by dense fibrosis.

A 2024 clinical series found recurrence approaching approximately half of patients initially classified with severe disease.

These numbers should not be applied to every patient, but they demonstrate why severe Asherman syndrome often requires:



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- expert surgery,
- recurrence-prevention strategies,
- follow-up hysteroscopy.

Preventing Adhesions From Returning

Several strategies are used after hysteroscopic adhesiolysis.

These may include:

- intrauterine balloon catheters,
- selected intrauterine devices,
- anti-adhesion gels such as hyaluronic acid,
- postoperative estrogen in selected patients,
- second-look hysteroscopy,
- newer regenerative strategies in research settings.

The most important point is:

there is still no single universally accepted postoperative combination that is clearly best for every woman.

Treatment is therefore individualized according to adhesion severity and specialist preference.

Intrauterine Balloon

A balloon catheter can be placed inside the uterus after surgery.

The concept is simple:

keep the freshly separated uterine walls apart while the endometrium begins healing.

A 2025 randomized trial involving women with severe intrauterine adhesions reported substantially less adhesion reformation when balloon-stent use was extended to eight weeks compared with a shorter protocol—17.4% versus 43.3% at third-look hysteroscopy in that particular study.

This is promising evidence, but it should not be interpreted as meaning every patient requires an eight-week balloon.



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Treatment needs to account for:

- severity,
 - infection risk,
 - tolerance,
 - specialist protocol.
-

Intrauterine Devices

Selected intrauterine devices have historically been used to help keep the uterine walls apart after adhesiolysis.

However, the ideal device and duration remain debated.

Not every ordinary contraceptive IUD is appropriate as an adhesion-prevention device.

This should be managed by an experienced gynecologist rather than attempted as routine contraception.

Hyaluronic Acid Gel

Hyaluronic acid-based anti-adhesion gels are increasingly studied.

A 2024 systematic review and meta-analysis of **16 randomized trials involving 2,359 women** found that hyaluronic acid reduced the incidence of postoperative intrauterine adhesions overall. The analysis suggested a possible improvement in pregnancy rates, although evidence for some reproductive outcomes—including live birth—remained less certain.

This is useful evidence, but again:

hyaluronic acid does not replace adhesiolysis when established scar tissue is already significantly distorting the cavity.

Its main role is in prevention of new or recurrent adhesion formation.

Estrogen After Adhesiolysis

Estrogen is frequently prescribed after surgery with the goal of encouraging endometrial proliferation.

The concept is biologically reasonable:



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help remaining healthy endometrium grow rapidly so that damaged surfaces become covered.

However, the evidence is not uniform.

Older AAGL/ESGE evidence found inconsistent benefit of postoperative estrogen in preventing new adhesions after some types of hysteroscopic surgery.

Therefore:

estrogen is commonly used in selected Asherman protocols, but it should not be described as a universally proven standalone treatment.

The prescription should be individualized according to:

- remaining endometrium,
- surgical findings,
- contraindications,
- treating specialist's protocol.

Progesterone

When estrogen is prescribed for a woman who has a uterus, progesterone or a progestogen may later be added to create an organized withdrawal bleed and protect the endometrium from prolonged unopposed estrogen exposure.

The exact regimen varies.

Patients should not self-prescribe hormonal treatment from internet protocols.

Second-Look Hysteroscopy

After surgery, some specialists perform a repeat hysteroscopy.

This may be called:

Second-Look Hysteroscopy

Its purpose is to:

- assess whether the cavity has remained open,
- identify early recurrent adhesions,
- separate new thin adhesions before they become dense.



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Given that recurrence is particularly common in moderate-to-severe disease, second-look hysteroscopy can be an important component of treatment.

Platelet-Rich Plasma — PRP

PRP has received considerable attention.

It contains concentrated platelets and biologically active growth factors.

Researchers are investigating whether intrauterine PRP can:

- improve endometrial regeneration,
- reduce adhesion recurrence,
- improve fertility outcomes.

A 2024 network meta-analysis examining several postoperative strategies found promising results for some combinations involving PRP and balloon treatment, but pregnancy-rate differences were not consistently established and comparisons were limited by variation among trials.

Therefore, PRP should currently be described as:

promising but not yet a universally established standard treatment for Asherman syndrome.

Patients should be cautious about guarantees.

Stem-Cell Therapy

One of the most scientifically interesting areas in severe Asherman syndrome is:

Endometrial Regeneration Using Stem Cells

Researchers are exploring whether stem or progenitor cells can help regenerate endometrium in women with extensive basal-layer damage.

A 2025 systematic review and meta-analysis of clinical studies found encouraging signals for clinical pregnancy and live birth in selected women treated with stem-cell approaches, particularly in some autologous cell-and-scaffold protocols. However, the available studies were heterogeneous and the authors emphasized the need for better controlled trials and standardized treatment protocols.

Therefore:



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stem-cell therapy remains an emerging regenerative strategy rather than routine established treatment.

It should preferably be undertaken within specialized research or highly experienced centres with transparent counselling.

Can the Endometrium Regrow After Severe Asherman Syndrome?

Sometimes.

The potential depends upon how much functioning basal endometrium remains.

If substantial healthy basal endometrium survives, the lining may regenerate after the adhesions are removed.

If most of the basal layer has been replaced by dense fibrosis, regeneration becomes much more difficult.

This is why two women with similar-looking infertility histories can have very different treatment outcomes.

Menstrual Improvement After Treatment

Many women experience:

- increased menstrual flow,
- return of previously absent periods,
- reduction of cyclic pain.

However, menstrual improvement does not automatically guarantee normal fertility.

Likewise, a woman can sometimes conceive without completely normal menstrual volume.

The goals of treatment are broader:

- restore cavity anatomy,
 - improve endometrial function,
 - improve reproductive potential.
-

Pregnancy After Hysteroscopic Adhesiolysis

Pregnancy is possible after successful treatment.



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However, pregnancy following significant intrauterine adhesions should generally be regarded with greater obstetric awareness.

A 2025 systematic review comparing pregnancies after hysteroscopic treatment of IUAs with controls found increased risks of several complications, including:

- placenta previa,
- placental abruption,
- placenta accreta spectrum,
- miscarriage,
- preterm birth,
- postpartum hemorrhage.

The evidence was based largely on retrospective studies and is therefore not perfect, but the pattern supports closer obstetric surveillance.

Placenta Accreta Spectrum

One particularly important complication is:

Placenta Accreta Spectrum — PAS

Normally, the placenta attaches to the endometrium and separates after delivery.

When the endometrium and underlying uterine tissue have been significantly scarred, the placenta may attach abnormally deeply.

This can create serious bleeding during delivery.

Previous Asherman syndrome and uterine procedures can therefore become relevant information for the obstetrician during pregnancy.

Placenta Previa

Placenta previa means the placenta lies unusually low and covers or approaches the cervix.

Recent meta-analysis indicates that placenta previa occurs more frequently in pregnancies following treatment for intrauterine adhesions than in comparison pregnancies.

Women should therefore tell their obstetric team about their Asherman history even if the fertility treatment occurred years earlier.



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Preterm Birth

Pregnancy after significant uterine scar disease may also carry a greater risk of premature delivery.

This does not mean premature birth will occur.

It means the pregnancy deserves appropriate antenatal surveillance.

Postpartum Hemorrhage

Abnormal placental attachment can increase the risk of heavy bleeding after delivery.

Again, the purpose of informing the patient is not to cause fear.

It is to ensure:

proper pregnancy planning and obstetric monitoring.

Does Hysteroscopic Treatment Restore Normal Pregnancy Risk Completely?

Not necessarily.

The uterus may look much more normal after successful adhesiolysis, but previous injury to the basal endometrium and placental implantation environment may persist.

This explains why:

- fertility can improve,
- yet obstetric risk may remain higher than in women who never had the condition.

The 2025 systematic review found that ART pregnancy and live-birth rates could be similar in some comparison groups after treatment, while certain obstetric complications remained increased.

When Can Pregnancy Be Attempted After Surgery?

There is no single timetable suitable for every woman.

Before attempting conception, the physician generally wants to know:

- has the uterine cavity healed?
- have adhesions recurred?



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- is adequate endometrium developing?
- was a second-look hysteroscopy needed?
- are additional fertility problems present?

In moderate-to-severe disease, confirming cavity restoration before pregnancy treatment may be particularly valuable.

The treating gynecologist or reproductive specialist should determine timing.

Does Every Woman Need IVF After Asherman Syndrome?

No.

If:

- the cavity is successfully restored,
- fallopian tubes are open,
- ovulation is normal,
- sperm parameters are favourable,
- age and ovarian reserve are appropriate,

natural conception may still be possible.

IVF may be considered when:

- tubal disease coexists,
- maternal age makes time important,
- male-factor infertility is significant,
- other infertility factors exist,
- previous treatment has failed.

Asherman syndrome alone does not automatically equal IVF.

IVF Cannot Replace Treatment of Severe Adhesions

This is an important misunderstanding.

Patients sometimes think:

“If I do IVF, the uterus doesn't matter.”



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But IVF bypasses fertilization problems—not implantation.

An embryo still requires a receptive uterine environment.

Therefore, clinically significant adhesions usually need to be addressed before embryo transfer.

Why Female Age Still Matters

Suppose two women have the same moderate Asherman syndrome.

One is 26.

The other is 41.

Both may benefit from cavity restoration.

But their broader fertility plans cannot be identical because ovarian reserve and egg quality decline with reproductive age.

Therefore, at Saira Health Care I believe infertility treatment should always consider:

the uterus + ovaries + fallopian tubes + male partner + age + reproductive history.

Treating only one abnormality is not enough.

Can Asherman Syndrome Return During Future Pregnancies?

The original scar tissue does not automatically regrow simply because a woman becomes pregnant.

However, future uterine procedures associated with miscarriage, retained placenta or postpartum complications can create new injury.

Therefore, when possible, unnecessary blind uterine instrumentation should be minimized and pregnancy-related uterine procedures should be performed according to appropriate modern obstetric practice.

Prevention Is Extremely Important

The ideal treatment is to prevent avoidable intrauterine injury.

Modern hysteroscopic techniques can sometimes reduce unnecessary blind curettage by allowing pathology to be removed under direct vision.

Older evidence suggests hysteroscopic removal of retained pregnancy tissue may produce fewer adhesions than blind curettage in some settings, although decisions depend upon:

- bleeding,
- clinical stability,
- available expertise,
- exact obstetric situation.

Patient safety always comes first.

The Unani Perspective on Asherman Syndrome and Female Infertility

As a physician trained in Unani medicine and focused clinically on sexual disorders and infertility, I consider reproductive health in the context of the whole patient.

Traditional Unani medicine gives importance to:

- uterine health,
- menstrual pattern,
- constitutional temperament or **Mizaj**,
- nutrition,
- digestion,
- sleep,
- physical activity,
- psychological wellbeing,
- overall reproductive function.

These principles can be useful when supporting a woman experiencing:

- infertility,
- menstrual disturbance,
- weakness after pregnancy loss,
- nutritional deficiencies,
- associated sexual-health concerns.

However, in Asherman syndrome we must make an extremely important distinction.



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Established intrauterine scar tissue is a structural problem.

A dense fibrous band connecting two walls of the uterus cannot responsibly be assumed to dissolve simply because an oral herbal medicine is given.

Unani Medicine Should Not Replace Hysteroscopy

When the uterine cavity is significantly scarred and distorted, the established treatment is hysteroscopic restoration of the cavity.

I do **not** consider it appropriate to delay necessary hysteroscopy for months while repeatedly changing herbal infertility medicines.

This is especially important when:

- the patient is older,
- ovarian reserve is declining,
- adhesions are severe,
- IVF is planned,
- menstrual obstruction is causing pain.

The structural problem should be corrected first.

Where Unani Medicine May Be Useful

The responsible role is usually **supportive and integrative**.

Depending upon the individual woman, Unani management may focus on areas such as:

- optimizing general nutrition,
- correcting unhealthy lifestyle patterns,
- supporting digestive health,
- improving sleep,
- treating coexisting menstrual complaints where appropriate,
- supporting physical recovery following pregnancy loss or surgery,
- addressing sexual and emotional wellbeing.



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These factors matter to reproductive health even though they do not physically remove dense scar tissue.

Unani Medicine and Female Infertility Research

There is published Unani literature involving selected forms of female infertility.

For example, a National Institute of Unani Medicine case report described conception in a woman with unilateral tubal blockage following a traditional Unani fertility regimen. However, this was a **single case report**, not evidence for treatment of Asherman syndrome.

This distinction is important.

A woman with:

- ovulatory infertility,
- unexplained infertility,
- unilateral tubal disease

is biologically different from a woman whose uterine cavity is partly obliterated by dense fibrous scar tissue.

At present, there is **insufficient high-quality clinical evidence showing that Unani medicines alone can remove established intrauterine adhesions or replace hysteroscopic adhesiolysis.**

Why Scientific Honesty Strengthens Integrative Medicine

I believe an integrative approach becomes stronger—not weaker—when we clearly distinguish what each system can realistically contribute.

Modern hysteroscopy is extremely effective at:

- visualizing the uterine cavity,
- cutting adhesions,
- reopening scarred areas.

Unani medicine can contribute more naturally to:

- whole-person recovery,
- nutrition,



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- lifestyle,
- associated reproductive and sexual wellbeing.

Using each approach according to its strength is more rational than claiming that one method can do everything.

Genital Tuberculosis Requires Specific Treatment

This point is especially important in India.

If Asherman syndrome is associated with confirmed female genital tuberculosis, the patient requires appropriate **anti-tuberculosis treatment under qualified medical supervision.**

Unani medicine should not be used as a substitute for eradication of active tuberculosis.

Furthermore, even after infection has been treated, established intrauterine scar tissue may remain and require separate fertility management.

Herbal Medicines Around Surgery

Patients should tell their gynecologist about all:

- herbal medicines,
- Unani preparations,
- supplements

before hysteroscopy.

Some products can influence:

- bleeding,
- anesthesia,
- drug metabolism.

A medically coordinated approach is safer than using separate treatments without informing each clinician.

Special Treatment Planning by Dr. Nizamuddin Qasmi



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At **Saira Health Care**, my approach to a woman with suspected Asherman syndrome begins with identifying whether a structural uterine problem is actually present.

I ask:

Did the periods change after miscarriage, delivery or uterine surgery?

Are periods now very light or absent?

Is there cyclic pain?

Has she previously conceived?

Has she experienced recurrent miscarriage?

Was D&C performed once or repeatedly?

Was retained placenta treated after childbirth?

Is there any clinical reason to consider genital tuberculosis?

Has hysteroscopy, HSG or saline sonography been performed?

What is the age and ovarian reserve?

Are the fallopian tubes normal?

Has the male partner been evaluated?

These questions help determine whether Asherman syndrome is truly the central fertility problem.

What “Special Treatment” Means at Saira Health Care

I do not use the phrase “special treatment” to mean that one proprietary medicine can cure all intrauterine adhesions.

For me, specialized infertility care means:

correct diagnosis + severity assessment + individualized treatment + appropriate referral + whole-patient support.

Consider four women.

Patient One

A 25-year-old woman with a single thin adhesion and otherwise normal fertility.

Her treatment may be relatively straightforward.

Patient Two

A 31-year-old woman with secondary amenorrhea after repeated miscarriage curettage and extensive adhesions.

She needs experienced hysteroscopic treatment and careful recurrence prevention.

Patient Three

A woman with severe adhesions, bilateral tubal damage and evidence of genital tuberculosis.

Her treatment must address:

- infection,
- uterine cavity,
- tubal-factor infertility.

Patient Four

A 40-year-old woman with Asherman syndrome and low ovarian reserve.

For her, spending a year repeatedly trying empirical therapy may significantly reduce fertility potential.

Treatment needs to be timely and coordinated with reproductive medicine.

These four women should not receive identical treatment.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At **Saira Health Care**, reproductive problems are approached as a complete fertility picture.

A woman with Asherman syndrome may simultaneously experience:

- infertility,
- recurrent miscarriage,
- menstrual reduction,
- pelvic pain,
- painful intercourse,
- anxiety after pregnancy loss,
- relationship stress.

Some of these problems arise directly from adhesions.



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Others may be separate.

Our objective is to identify those differences and guide appropriate treatment.

Where hysteroscopic surgery is required, management should involve an experienced gynecologic hysteroscopist or reproductive surgeon.

Where additional reproductive technology is needed, collaboration with an appropriate IVF/reproductive-medicine service may be required.

Unani supportive care can be incorporated where clinically appropriate without replacing structural treatment.

Psychological Impact of Asherman Syndrome

The emotional burden can be considerable.

Many women developed the condition after a difficult reproductive event such as:

- miscarriage,
- pregnancy termination,
- complicated delivery,
- retained placenta.

The patient may already be grieving pregnancy loss when she later discovers that treatment of that pregnancy may have been followed by uterine scar formation.

She may feel:

- guilt,
- anger,
- fear,
- distrust,
- anxiety about another pregnancy.

These feelings deserve compassionate care.

The woman should not blame herself.

The focus should be on understanding the current anatomy and planning the most appropriate next step.



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Asherman Syndrome Is Not a Woman's Fault

Adhesions are a biological healing response after endometrial injury.

Some women develop them despite appropriate treatment.

Others undergo similar procedures and never develop significant adhesions.

Individual susceptibility appears to differ.

The diagnosis should therefore never be framed as a personal failure.

When Should Asherman Syndrome Be Suspected?

I particularly consider the condition when a woman develops:

- very light periods after pregnancy-related uterine surgery,
- amenorrhea after D&C,
- cyclic pain with little menstrual bleeding,
- unexplained secondary infertility after a miscarriage procedure,
- recurrent pregnancy loss after uterine instrumentation,
- repeated embryo implantation failure with a suggestive uterine history.

The history is extremely important.

When Is More Urgent Medical Assessment Needed?

Seek prompt medical care for symptoms such as:

- severe pelvic pain,
- fever,
- foul-smelling vaginal discharge,
- heavy bleeding,
- pregnancy with significant pain or bleeding,
- symptoms following recent uterine surgery suggesting infection or another complication.

These symptoms are not simply “Asherman symptoms” and may indicate an urgent gynecologic condition.



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Frequently Asked Questions

What is Asherman syndrome?

Asherman syndrome is a clinical condition in which intrauterine adhesions or scar tissue inside the uterus are associated with symptoms such as:

- reduced menstruation,
- pelvic pain,
- infertility,
- recurrent pregnancy loss.

Simply finding an asymptomatic adhesion is not always equivalent to Asherman syndrome.

What are intrauterine adhesions?

They are bands of scar tissue connecting parts of the inner walls of the uterus.

They may be:

- thin and filmy,
 - thick and fibrotic,
 - localized,
 - extensive.
-

What causes Asherman syndrome?

The most common causes involve injury to the endometrium, especially after pregnancy-related uterine procedures such as:

- D&C after miscarriage,
- treatment of retained pregnancy tissue,
- postpartum treatment of retained placenta.

It can also follow:

- hysteroscopic surgery,
- fibroid surgery,
- severe uterine infection,



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- genital tuberculosis in selected populations.
-

Can one D&C cause Asherman syndrome?

Yes, it is possible.

Most women having a single D&C do not develop clinically important adhesions.

Risk depends upon:

- pregnancy status,
- amount of endometrial injury,
- retained placental tissue,
- infection,
- individual healing.

Repeated curettage generally creates greater concern.

Can Asherman syndrome occur after miscarriage?

Yes.

A common setting is uterine instrumentation after:

- missed miscarriage,
 - incomplete miscarriage,
 - retained products of conception.
-

Can Asherman syndrome occur after childbirth?

Yes.

It may occur after treatment for:

- retained placenta,
- postpartum uterine complications.

Recent evidence suggests puerperal Asherman syndrome may have a particularly high recurrence tendency after treatment in some severe cohorts.



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Can tuberculosis cause Asherman syndrome?

Yes.

Female genital tuberculosis can cause chronic inflammation, endometrial fibrosis and intrauterine adhesions.

This is particularly relevant in India and other tuberculosis-endemic populations.

Does Asherman syndrome stop periods?

It can.

Severe adhesions may cause:

- amenorrhea,
- very light menstruation.

Milder adhesions may occur with relatively normal periods.

Why are my periods lighter after a D&C?

There are several possible explanations.

However, persistent major reduction in flow following intrauterine surgery should prompt consideration of intrauterine adhesions, particularly when infertility or cyclic pain is also present.

Can I have Asherman syndrome and still get periods?

Yes.

Localized or mild adhesions may not prevent menstruation completely.

Can Asherman syndrome cause pelvic pain?

Yes.

Pain may occur, particularly when adhesions interfere with normal menstrual drainage.

Can Asherman syndrome cause infertility?

Yes.



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Adhesions can impair:

- implantation,
- cavity shape,
- access to tubal openings,
- healthy endometrial surface.

It is an established cause of female infertility.

Can it cause miscarriage?

Yes.

Asherman syndrome is associated with:

- recurrent pregnancy loss,
 - abnormal placentation,
 - other pregnancy complications.
-

Can it cause repeated IVF failure?

It can contribute to implantation failure when clinically significant adhesions affect the endometrial cavity.

However, IVF failure has many causes and should not automatically be attributed to Asherman syndrome.

What is the best test for Asherman syndrome?

Hysteroscopy is the most accurate diagnostic method and remains the criterion standard.

Can ultrasound diagnose it?

Routine ultrasound can miss adhesions.

Saline infusion sonography is more useful for evaluating the cavity.

Hysteroscopy provides direct visualization.



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Is HSG useful?

Yes, particularly as a screening test.

It can show uterine filling defects and also assess fallopian-tube patency.

But hysteroscopy is more accurate for confirming and characterizing adhesions.

Is MRI required?

Usually not.

MRI is not routinely recommended as the primary diagnostic test for intrauterine adhesions.

What is the best treatment?

For symptomatic clinically significant intrauterine adhesions:

hysteroscopic adhesiolysis under direct vision is the established treatment.

Can D&C treat Asherman syndrome?

Blind D&C is not recommended as treatment because it can damage healthy endometrium and cannot accurately identify scar tissue.

Modern management uses hysteroscopic visualization.

Can adhesions return after surgery?

Yes.

Recurrence is one of the major challenges, especially in severe disease.

Current literature reports highly variable rates depending on severity and preventive strategy.

Why are severe adhesions more likely to return?

Because:

- a larger area of endometrium has been injured,
- opposing raw surfaces contact one another,



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- less normal basal endometrium may remain.

What can prevent recurrence?

Depending upon the case, specialists may use:

- intrauterine balloon,
- selected intrauterine device,
- hyaluronic acid barrier,
- postoperative hormonal therapy,
- early repeat hysteroscopy.

There is no single universally established best protocol for every patient.

Does hyaluronic acid help?

A 2024 meta-analysis of 16 randomized trials found reduced postoperative adhesion formation with hyaluronic acid and suggested possible fertility benefits, although some reproductive outcomes remain uncertain.

Does a balloon prevent recurrence?

It can help in selected patients.

A 2025 randomized trial in severe IUAs found lower recurrence with prolonged balloon-stent treatment, but the exact duration should be individualized.

Does estrogen cure Asherman syndrome?

No.

Estrogen does not physically cut established scar tissue.

It is sometimes used after adhesiolysis to support endometrial proliferation, but evidence regarding the ideal regimen remains incomplete.

Is PRP proven?



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PRP is promising, but it is not yet a universally established standard therapy for Asherman syndrome.

Current comparative research continues to evaluate it.

Is stem-cell therapy available?

Stem-cell-based endometrial regeneration is an exciting research area.

A 2025 meta-analysis reported encouraging pregnancy and live-birth signals, but available trials remain heterogeneous and more high-quality evidence is needed.

It should therefore still be considered an emerging treatment rather than routine first-line care.

Can Asherman syndrome be completely cured?

Many women can have substantial restoration of the uterine cavity and menstruation.

However, prognosis depends upon severity.

Severe endometrial fibrosis may not be completely reversible, and recurrence can occur.

Can I become pregnant after treatment?

Yes.

Many women conceive after successful hysteroscopic treatment.

The chance depends upon:

- disease severity,
 - age,
 - remaining endometrium,
 - tubes,
 - ovarian reserve,
 - male fertility,
 - recurrence.
-



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Is natural pregnancy possible?

Yes, in appropriate cases.

IVF is not automatically required simply because Asherman syndrome was diagnosed.

Do I need IVF?

Not necessarily.

IVF becomes more relevant when:

- other infertility factors exist,
 - tubal damage is present,
 - age or ovarian reserve makes time important,
 - natural conception does not occur.
-

Is pregnancy after Asherman treatment high risk?

Some risks remain increased.

A 2025 systematic review found higher rates of:

- placenta previa,
- placental abruption,
- placenta accreta spectrum,
- miscarriage,
- preterm birth,
- postpartum hemorrhage

in women with a history of hysteroscopic treatment for intrauterine adhesions compared with controls.

Therefore, the obstetric team should know about the history.

Can Asherman syndrome cause placenta accreta?

A history of severe endometrial injury and intrauterine adhesions is associated with increased risk of abnormal placental attachment.

This does not mean every pregnancy will develop placenta accreta.

Appropriate antenatal surveillance is important.

Can Unani medicine dissolve intrauterine adhesions?

There is currently insufficient high-quality evidence that an oral Unani medicine can dissolve established dense fibrous adhesions inside the uterine cavity.

When adhesions significantly distort the cavity, hysteroscopic treatment remains the established approach.

Is Unani medicine useless in Asherman syndrome?

No.

Its role is better understood as **supportive and integrative** rather than as a substitute for structural treatment.

Individualized Unani care may support:

- nutrition,
- digestion,
- lifestyle,
- menstrual health,
- general reproductive wellbeing,
- associated sexual-health concerns.

But established scar tissue should be evaluated anatomically.

Can Unani medicine improve fertility after surgery?

It may potentially be used as supportive care in appropriately selected patients, but direct high-quality evidence specifically proving improved pregnancy or live-birth outcomes after Asherman adhesiolysis is currently insufficient.

Therefore, objective follow-up should remain based upon:

- uterine-cavity assessment,
- endometrial response,
- fertility evaluation.



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Should I take herbs before hysteroscopy?

Tell your gynecologist about every:

- Unani medicine,
- herb,
- supplement

before a surgical procedure because some products can interact with anesthesia or affect bleeding.

A Message From Dr. Nizamuddin Qasmi

When a woman tells me:

“My periods almost disappeared after my miscarriage procedure,”

I do not simply prescribe medicine to bring the period back.

I want to know:

Why did the bleeding decrease?

Is it hormonal?

Is the cervix blocked?

Is there scar tissue inside the uterus?

How much endometrium remains?

Has the uterine cavity become smaller?

Are the fallopian tubes also affected?

Is genital tuberculosis relevant?

Is the woman trying for pregnancy?

These questions are much more useful than treating amenorrhea blindly.

What I Tell Patients About Infertility

I explain:

Pregnancy requires more than ovulation.



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The embryo also needs a healthy place to implant.

If the uterine cavity is significantly scarred, simply increasing ovulation or prescribing fertility tablets does not correct the structural problem.

The uterine environment must be assessed.

Once the cavity is restored as much as possible, we can then evaluate the other fertility factors.

What I Tell Patients About Severe Disease

When adhesions are severe, I avoid making unrealistic promises.

Sometimes the cavity can be restored very effectively.

Sometimes repeated surgery is necessary.

Sometimes the cavity opens but the endometrium remains thin because the regenerative basal layer has been seriously damaged.

These patients deserve:

realistic hope—not guaranteed pregnancy claims.

Modern research into:

- PRP,
- stem cells,
- tissue-engineered scaffolds

is encouraging, but these approaches have not yet eliminated the difficulties of severe Asherman syndrome.

Current Medical Understanding

Several important points now define modern Asherman syndrome care.

1. Asherman syndrome and asymptomatic adhesions are not identical

The syndrome involves symptoms such as:

- menstrual disturbance,
- pain,
- impaired fertility



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associated with IUAs.

2. Pregnancy-related uterine trauma remains an important cause

Particularly:

- D&C after miscarriage,
- retained placental tissue,
- postpartum instrumentation.

3. Genital tuberculosis remains clinically important in India

It can produce:

- endometrial fibrosis,
- adhesions,
- tubal damage,
- infertility.

4. Hysteroscopy remains the diagnostic gold standard

It directly shows the:

- location,
- density,
- extent

of adhesions.

5. Hysteroscopic adhesiolysis remains the cornerstone treatment

Blind D&C should not be used to treat established intrauterine adhesions.

6. Recurrence prevention remains an active area of research

Balloon barriers, hyaluronic acid, selected IUDs, hormonal treatment and second-look hysteroscopy may be incorporated depending on the case.

7. Regenerative treatment is advancing

PRP and particularly stem-cell strategies are producing encouraging research findings, but they are not yet replacements for established first-line treatment.

8. Pregnancy following treatment deserves careful surveillance

Even after cavity restoration, placental and obstetric risks can remain elevated.



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Conclusion

Intrauterine Adhesions are bands of scar tissue that develop inside the uterine cavity. When these adhesions cause menstrual disturbance, pelvic pain, infertility or pregnancy problems, the condition is commonly called Asherman Syndrome.

The condition frequently develops after injury to the endometrium, especially following pregnancy-related uterine procedures such as:

- D&C after miscarriage,
- evacuation of retained pregnancy tissue,
- treatment of retained placenta after childbirth.

Other causes include:

- hysteroscopic surgery,
- myomectomy,
- severe intrauterine infection,
- female genital tuberculosis.

In India, genital tuberculosis deserves particular consideration in selected women because it can produce severe endometrial fibrosis, tubal disease and infertility.

Symptoms may include:

- reduced menstrual bleeding,
- complete absence of periods,
- cyclic pelvic pain,
- infertility,
- recurrent miscarriage,
- repeated implantation failure.

The diagnosis should not be based solely upon symptoms.

Hysteroscopy remains the most accurate diagnostic test.

It allows direct visualization of:

- scar location,
- severity,
- remaining endometrium,



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- uterine-cavity anatomy.

For symptomatic disease, the established treatment is:

Hysteroscopic Adhesiolysis

The adhesions are separated under direct vision while attempting to preserve as much healthy endometrium as possible.

Recurrence remains a major challenge, particularly after treatment of severe disease.

Depending upon the patient, postoperative strategies may involve:

- intrauterine balloon,
- selected mechanical barriers,
- hyaluronic acid gel,
- hormonal treatment,
- second-look hysteroscopy.

Recent randomized and meta-analytic evidence has improved our understanding of these interventions, although there is still no universally accepted single postoperative protocol suitable for every woman.

Emerging treatments such as:

- platelet-rich plasma,
- stem cells,
- tissue-engineered regenerative therapies

are scientifically promising.

A 2025 meta-analysis reported encouraging fertility outcomes from stem-cell interventions, but evidence remains heterogeneous and these approaches should still be regarded as emerging rather than routine standard treatment.

Pregnancy after successful treatment is possible.

However, women with previous significant Asherman syndrome should receive appropriate obstetric surveillance because recent evidence demonstrates increased risks of:

- miscarriage,
- placenta previa,
- placenta accreta spectrum,



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- placental abruption,
- preterm delivery,
- postpartum hemorrhage.

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

- Mizaj,
- nutrition,
- digestion,
- physical health,
- sleep,
- menstrual wellbeing,
- emotional health,
- sexual wellbeing.

These factors can form an important part of individualized integrative fertility care.

However:

established intrauterine scar tissue is a structural disorder.

There is currently insufficient scientific evidence to claim that an oral Unani formulation can reliably remove dense intrauterine adhesions or replace hysteroscopic adhesiolysis.

At **Saira Health Care**, my approach is therefore integrative but firmly diagnosis-led:

identify the cause, determine adhesion severity, assess the uterine cavity properly, investigate associated infertility factors, refer for expert hysteroscopic adhesiolysis when indicated, prevent recurrence as effectively as possible, treat specific underlying diseases such as genital tuberculosis appropriately, and use individualized Unani supportive care to strengthen the patient's broader reproductive and general health.

My most important message to patients is:

If your periods became dramatically lighter after a miscarriage, delivery or uterine procedure—especially if you are now having difficulty conceiving—do not simply treat the period. Evaluate the uterine cavity.



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Early recognition of intrauterine adhesions can prevent years of unexplained infertility and allow a much more rational treatment plan.

About the Author

Dr. Nizamuddin Qasmi

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

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

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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's clinical work at **Saira Health Care** focuses on sexual disorders, reproductive health and infertility.

His approach to infertility emphasizes identifying the actual reproductive mechanism rather than treating every patient empirically.

In women with suspected intrauterine adhesions, this means understanding the menstrual and obstetric history, recognizing possible structural uterine disease, identifying other fertility factors and coordinating appropriate hysteroscopic or reproductive-medicine care when required.

Where clinically appropriate, individualized principles of Unani medicine may be incorporated as supportive care for general reproductive, nutritional, menstrual and sexual wellbeing without replacing established structural treatment.

Medical Disclaimer

This article is intended for health education and public awareness. It does not establish an individual diagnosis and does not replace consultation with an appropriately qualified gynecologist, reproductive surgeon, fertility specialist or other healthcare professional.

Persistent reduction or absence of menstruation after D&C, miscarriage treatment, childbirth or uterine surgery deserves appropriate medical assessment.



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Hysteroscopy is the established diagnostic standard for suspected intrauterine adhesions and hysteroscopic adhesiolysis is the principal treatment for clinically significant symptomatic disease.

Patients should not delay appropriate hysteroscopic evaluation while relying solely on hormonal, herbal or Unani treatment for suspected structural uterine adhesions.

Women with possible genital tuberculosis require appropriate specialist investigation and evidence-based anti-tuberculosis treatment when infection is confirmed.

Women who become pregnant after treatment for significant Asherman syndrome should inform their obstetric team because previous intrauterine adhesions may increase the risk of placental and other pregnancy complications.

PRP, stem-cell therapies and other regenerative techniques should not be interpreted as guaranteed fertility treatments; several remain investigational or incompletely standardized.

All medications—including herbal, Unani and nutritional products—should be disclosed before hysteroscopic surgery, fertility treatment and pregnancy.



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