

Azoospermia: Causes, Diagnosis, Treatment, Fertility Options and the Role of Unani Medicine

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Introduction: “Doctor, My Semen Report Shows Zero Sperm. Can I Ever Become a Father?”

Among all the reports that a man can receive during an infertility evaluation, the words:

“Sperm count: Nil”

or

“No spermatozoa seen”

can be extremely frightening.

Many patients come to me believing that a zero sperm count means:

“My fertility is permanently finished.”

Some believe it means:

“My testes are not functioning at all.”

Others assume that:

“If sperm are absent in semen, there can never be sperm anywhere in my body.”

These conclusions are not always correct.

The medical term for complete absence of sperm from the ejaculate is **azoospermia**.

Azoospermia is one of the most severe forms of male-factor infertility, but it is **not one single disease**. It is a laboratory finding that can result from very different conditions.



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In one man, the testes may be producing sperm normally, but a blockage prevents sperm from entering the semen.

In another man, sperm production inside the testes may be severely impaired.

In another, the testes may be capable of producing sperm but are not receiving the correct hormonal signals from the brain.

These three patients may all have a semen report showing:

“Zero sperm.”

Yet their treatment, prognosis and chances of biological fatherhood may be completely different.

This is why my first principle when treating azoospermia at **Saira Health Care** is:

Do not start treatment merely because the report says zero. First find out why the sperm count is zero.

Current international guidelines follow exactly this cause-based approach. Azoospermia affects approximately **1% of men of reproductive age and around 10% of men evaluated for infertility**, making it an important cause of male infertility.

Modern reproductive medicine has also changed the outlook for many men with azoospermia. Depending on the cause, treatment may involve:

- correction of hormonal deficiency,
- microsurgical reconstruction of an obstruction,
- treatment of an ejaculatory disorder,
- sperm retrieval from the epididymis or testis,
- microdissection testicular sperm extraction or **micro-TESE**,
- IVF with intracytoplasmic sperm injection or **ICSI**,
- or, in selected patients, treatment of reversible medical and lifestyle factors.

The Unani system of medicine can also contribute to an individualized programme, particularly through attention to nutrition, metabolic health, lifestyle, general reproductive health and appropriately selected traditional pharmacotherapy.

However, I want to make one point very clear:

Azoospermia should never be treated blindly with a fertility supplement for months without identifying whether the problem is obstruction, hormonal failure, genetic disease or severe testicular failure.



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The diagnosis comes first.

What Is Azoospermia?

Azoospermia means that **no spermatozoa are identified in the ejaculate after an appropriately performed semen analysis**, including careful examination of the concentrated or centrifuged specimen.

Current male-infertility guidelines emphasize that azoospermia is a description of what is found in the semen—not a diagnosis of why it has happened.

This distinction is essential.

A semen report can tell us:

“No sperm are present in this ejaculate.”

It cannot by itself tell us:

- whether the testes are producing sperm,
- whether sperm production is reduced,
- whether there is a blockage,
- whether there is a hormonal problem,
- whether there is a genetic problem,
- or whether sperm may still be found inside the testes.

Further evaluation is necessary.

Azoospermia Is Different From Aspermia

Patients sometimes confuse these terms.

Azoospermia

Semen is ejaculated, but sperm are absent from it.

Aspermia

There is little or no ejaculate produced during orgasm.

These are not the same condition.

Aspermia can result from:

- failure of emission,



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- retrograde ejaculation,
- neurological problems,
- certain operations,
- or other ejaculatory disorders.

Current AUA/ASRM guidance treats these problems differently from true azoospermia.

Azoospermia Is Different From Oligospermia

Another important distinction is between:

Oligozoospermia

Sperm are present, but the concentration is below the expected reference range.

Severe oligozoospermia

Very few sperm are present.

Cryptozoospermia

No sperm may be visible in an ordinary examination, but rare sperm can be detected after concentration and careful examination of the semen pellet.

Azoospermia

No sperm are found even after the appropriately processed specimen is carefully examined.

This is why a single casual semen examination should not be used to label a man permanently azoospermic.

Should Azoospermia Be Confirmed?

Yes.

A diagnosis with such major reproductive implications should be confirmed properly.

The current European Association of Urology guideline recommends confirming **non-obstructive azoospermia on two consecutive semen analyses when no sperm are found after centrifugation.**

Why is this important?

Because occasionally a man initially labelled azoospermic may actually have an extremely small and intermittent number of sperm in the ejaculate.

Finding even rare viable sperm can influence:

- diagnosis,
- fertility counselling,
- cryopreservation,
- and treatment planning.

Therefore, when a patient brings me one report showing:

“Sperm count – NIL,”

I do not immediately declare permanent infertility.

I first verify that the diagnosis has been established correctly.

Does Azoospermia Mean a Man Is Impotent?

No.

Azoospermia is a fertility disorder.

It is not the same as erectile dysfunction.

A man with azoospermia may have completely normal:

- sexual desire,
- erections,
- intercourse,
- orgasm,
- ejaculation,
- testosterone,
- and outward sexual appearance.

The problem may become apparent only when the couple is investigated because pregnancy has not occurred.

This is an important distinction because many patients unnecessarily associate:

“zero sperm”

with:

“sexual weakness.”



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They are different medical issues.

Can a Man With Azoospermia Ejaculate Normally?

Yes.

Most of the volume of semen does not come from sperm.

Seminal fluid is produced mainly by glands such as the:

- seminal vesicles,
- prostate,
- and other accessory reproductive glands.

Sperm contribute only a small portion of total semen volume.

Therefore, a man can have:

- normal-looking semen,
- normal ejaculatory volume,
- normal orgasm,

and still have azoospermia.

You cannot diagnose azoospermia by looking at semen with the naked eye.

A laboratory semen analysis is necessary.

Main Classification of Azoospermia

The most useful modern classification divides azoospermia into:

1. Obstructive Azoospermia – OA

Sperm production is generally present, but a blockage prevents sperm from entering the ejaculate.

2. Non-Obstructive Azoospermia – NOA

Sperm production within the testes is severely impaired.

There is also a useful physiological classification into:

Pre-testicular causes

The hormonal signals required for sperm production are deficient.



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Testicular causes

The main problem lies within the testes.

Post-testicular causes

Sperm are produced but cannot reach the ejaculate because of obstruction or ejaculatory dysfunction.

These two classification systems overlap.

The central question remains:

Are sperm not being produced properly, or are sperm being produced but prevented from entering the semen?

Obstructive Azoospermia

In obstructive azoospermia, sperm production may be relatively normal.

The problem is similar to a factory producing a product normally while the delivery road is blocked.

The testes may continue producing sperm, but sperm cannot pass through the reproductive ducts into the ejaculate.

The blockage may occur in the:

- epididymis,
- vas deferens,
- ejaculatory ducts,
- or another part of the reproductive tract.

Men with obstructive azoospermia often have:

- normal-sized testes,
- relatively normal hormone levels,
- and sometimes normal semen volume.

Current AUA/ASRM guidance recommends using physical examination, semen characteristics and FSH to help distinguish obstruction from impaired sperm production.

Causes of Obstructive Azoospermia



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Congenital Absence of the Vas Deferens

Some men are born without one or both vas deferens.

This is particularly important because congenital bilateral absence of the vas deferens can be associated with **CFTR gene variants**, which are also associated with cystic fibrosis.

Current AUA/ASRM guidance recommends **CFTR mutation carrier testing, including assessment of the 5T allele, in men with vasal agenesis or idiopathic obstructive azoospermia.**

If a man carries a clinically relevant CFTR variant, testing of the female partner and genetic counselling may be advised because of potential implications for children.

This is a good example of why azoospermia treatment cannot be reduced to fertility medicine alone.

Sometimes the semen report reveals an important genetic issue.

Previous Vasectomy

Vasectomy intentionally interrupts the vas deferens.

If a man later wishes to have children, options may include:

- microsurgical vasectomy reversal,
- surgical sperm retrieval with IVF/ICSI,
- or reconstruction combined with sperm retrieval and cryopreservation.

Current AUA/ASRM guidance considers both reconstruction and surgical sperm retrieval valid options, depending on the couple's circumstances and preferences.

Infection or Inflammation

Previous infection may occasionally damage or scar the:

- epididymis,
- vas deferens,
- or ejaculatory ducts.

This can create obstruction.

A detailed history is important, including:

- genital infections,



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- sexually transmitted infections,
 - previous epididymitis,
 - genital tuberculosis where clinically relevant,
 - and previous surgery.
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Previous Surgery

Operations involving the:

- groin,
- scrotum,
- prostate,
- bladder,
- pelvis,
- or hernia

can occasionally damage or obstruct reproductive ducts.

This is why previous surgical history is important in every azoospermia evaluation.

Ejaculatory Duct Obstruction

The ejaculatory ducts carry seminal fluid into the urethra.

Obstruction may result from:

- congenital abnormalities,
- cysts,
- inflammation,
- or scarring.

One clue can be:

very low semen volume combined with azoospermia.

Current guidelines recognize transrectal ultrasound or pelvic imaging as useful in selected men when distal obstruction is suspected, particularly with low-volume semen and suggestive semen characteristics.



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Non-Obstructive Azoospermia

Non-obstructive azoospermia is different.

Here the major problem is **severely impaired sperm production within the testes**.

The testes may produce:

- no mature sperm,
- extremely few areas of sperm production,
- or sperm development may stop before complete maturation.

NOA is therefore generally more challenging than straightforward obstruction.

However:

NOA does not always mean absolutely no sperm exist anywhere inside the testes.

Sperm production can sometimes be patchy.

A small region of testicular tissue may contain sperm even when none are present in the ejaculate.

This principle is the basis of **micro-TESE**.

Causes of Non-Obstructive Azoospermia

Genetic Disorders

Genetic causes are particularly important in severe sperm-production failure.

Important examples include:

- Klinefelter syndrome,
- Y-chromosome microdeletions,
- and other chromosomal or gene abnormalities.

Klinefelter Syndrome

Klinefelter syndrome most commonly involves the chromosome pattern:

47,XXY

instead of the usual male pattern:

46,XY.



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Affected men may have varying features, including:

- small testes,
- reduced testosterone,
- infertility,
- azoospermia,
- or other hormonal findings.

However, a diagnosis of Klinefelter syndrome does not automatically mean that biological fatherhood is impossible.

The AUA/ASRM 2024 guideline notes that small areas of sperm production may be found using micro-TESE in approximately **50–60% of appropriately selected non-mosaic 47,XXY men.**

That does not mean pregnancy is guaranteed.

Finding sperm is only one step; fertilization, embryo development, implantation and pregnancy depend on additional factors.

Y-Chromosome Microdeletions

Certain regions on the Y chromosome are important for sperm production.

They are known as the **AZF regions**:

- AZFa,
- AZFb,
- AZFc.

This information can directly affect treatment decisions.

According to the amended 2024 AUA/ASRM guideline, Y-chromosome microdeletion testing is recommended in men with primary infertility and azoospermia, or sperm concentration **≤1 million/mL**, when there is evidence of impaired sperm production such as elevated FSH or testicular atrophy.

The exact deletion matters.

Complete AZFa or AZFb deletion

Current evidence indicates that sperm retrieval is essentially unsuccessful, so micro-TESE should not routinely be performed merely in hope of finding sperm.



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AZFc deletion

The prognosis is different.

Sperm may sometimes be found, including through micro-TESE.

However, a male child conceived using such sperm can inherit the Y-chromosome deletion and therefore may also experience infertility.

Genetic counselling is important.

Undescended Testes

A history of one or both testes failing to descend normally into the scrotum can impair later sperm production.

The risk is greater when:

- both testes were affected,
- treatment was delayed,
- or significant testicular damage occurred.

This history should always be discussed during evaluation.

Mumps Orchitis

Mumps infection after puberty can occasionally cause severe inflammation of the testes.

If both testes are significantly affected, sperm production may be impaired.

Not every man who has had mumps develops infertility, but it is a relevant history in azoospermia evaluation.

Testicular Trauma or Torsion

Severe injury to the testes or testicular torsion can damage sperm-producing tissue.

Bilateral severe injury creates a greater risk than injury affecting only one testis.

Chemotherapy and Radiation

Some cancer treatments can damage rapidly dividing sperm-producing cells.

The risk depends on:



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- the drug used,
- total dose,
- treatment duration,
- radiation field,
- age,
- and underlying disease.

Some men eventually recover sperm production.

Others develop prolonged or permanent azoospermia.

This is why sperm cryopreservation **before gonadotoxic cancer treatment** is so important whenever feasible.

Varicocele and Azoospermia

Varicocele is an enlargement of veins around the testis and is associated with impaired fertility in some men.

However, its role in **non-obstructive azoospermia** needs careful explanation.

Some uncontrolled studies have reported sperm appearing in the ejaculate after varicocele repair in selected men with NOA.

But current AUA/ASRM guidance specifically states that couples with clinical varicocele and NOA should be told that **definitive evidence supporting varicocele repair before assisted reproductive treatment is lacking**.

Therefore, I do not believe every azoospermic man with an ultrasound-detected varicocele should automatically undergo surgery.

The complete clinical picture matters.

Hypogonadotropic Hypogonadism: A Particularly Important Treatable Cause

Some of the most rewarding azoospermia cases are those in which the testes are not receiving adequate hormonal stimulation.

Normal sperm production depends on signals from the:

hypothalamus → pituitary gland → testes.

The two important pituitary hormones are:



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- FSH,
- LH.

If these signals are deficient, testosterone inside the testes and sperm production may fall dramatically.

Possible causes include:

- congenital hypogonadotropic hypogonadism,
- Kallmann syndrome,
- pituitary disease,
- severe hyperprolactinemia,
- certain medications,
- anabolic steroid exposure,
- or other hypothalamic-pituitary disorders.

In an appropriately diagnosed man, fertility can sometimes be restored with **gonadotropin-based therapy**, such as hCG with or without FSH, rather than sperm retrieval surgery.

Current European guidance confirms that in men with secondary hypogonadism who desire fertility, gonadotropin treatment can restore sperm production.

This is why hormone testing is so important in azoospermia.

Testosterone Injections Can Actually Cause Azoospermia

This is one of the most important warnings in male fertility medicine.

A young man may take:

- testosterone injections,
- testosterone gels,
- anabolic steroids,
- bodybuilding hormones,

believing they will improve masculinity and fertility.

They can do the opposite.

External testosterone suppresses the brain's release of LH and FSH.

This can reduce the very high concentration of testosterone required **inside the testes** for sperm production.

As a result, sperm count may fall severely and can sometimes reach zero.

Current AUA/ASRM guidance clearly states that **testosterone monotherapy should not be prescribed to a man interested in current or future fertility.**

Therefore:

Low blood testosterone + desire for children does not automatically mean “give testosterone injections.”

Fertility-preserving hormonal management is different.

Symptoms of Azoospermia

Azoospermia itself usually causes **no specific symptoms** apart from infertility.

Many patients have:

- normal erections,
- normal orgasm,
- normal ejaculation,
- normal libido,
- and normal external genital appearance.

The first sign may simply be:

The couple has been trying for pregnancy without success.

However, symptoms of the underlying condition may sometimes be present.

These can include:

- small testes,
- decreased libido,
- erectile problems,
- reduced facial or body hair,
- breast enlargement,
- low energy,
- history of undescended testes,



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- previous genital surgery,
 - very low semen volume,
 - difficulty ejaculating,
 - pelvic or scrotal surgery,
 - or other endocrine symptoms.
-

How I Evaluate an Azoospermia Patient

At Saira Health Care, I consider the evaluation more important than immediately prescribing medicine.

My approach begins with:

Confirm → classify → identify cause → assess reversibility → discuss fertility options.

Step 1: Confirm the Semen Report

The first question is:

Is this really azoospermia?

I review:

- number of semen analyses,
- laboratory quality,
- abstinence period,
- collection method,
- whether the complete ejaculate was collected,
- semen volume,
- pH where relevant,
- and whether the centrifuged pellet was carefully examined.

Current European guidance recommends confirming NOA using **two consecutive semen analyses**.

A rushed diagnosis from one inadequate sample can cause enormous unnecessary distress.

Step 2: Take a Detailed Fertility History



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I ask about:

- duration of infertility,
- previous pregnancies with any partner,
- frequency and timing of intercourse,
- sexual function,
- childhood testicular problems,
- undescended testes,
- mumps,
- genital infection,
- testicular injury,
- surgery,
- hernia repair,
- vasectomy,
- chemotherapy,
- radiation,
- diabetes,
- medications,
- testosterone or anabolic steroid use,
- occupational exposures,
- family history,
- and genetic disorders.

Every detail may provide an important clue.

Step 3: Examine the Reproductive System

When clinically appropriate, examination may assess:

- testicular size and consistency,
- epididymis,
- presence of the vas deferens,



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- varicocele,
- secondary sexual characteristics,
- and other signs of endocrine disease.

The combination of:

testicular size + FSH + semen volume

can often help distinguish obstruction from sperm-production failure.

Current AUA/ASRM guidance uses these factors in the initial differentiation of obstructive and non-obstructive azoospermia.

Step 4: Hormonal Evaluation

For men with azoospermia, hormonal evaluation is important.

Typical tests include:

FSH

Provides information about the relationship between the pituitary gland and sperm-producing tissue.

A markedly elevated FSH may suggest severe impairment of spermatogenesis.

Testosterone

Helps assess androgen status.

LH

Particularly useful when testosterone is low.

Prolactin

May be indicated in men with:

- low testosterone,
- low or low-normal LH,
- reduced libido,
- or suspected pituitary disease.

Other endocrine tests may be selected according to the clinical picture.

No hormone value should be interpreted in isolation.



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What Can FSH Tell Us?

A simplified explanation is:

High FSH

May mean the pituitary gland is sending a strong signal but the testes are not responding adequately.

This favors impaired sperm production.

Normal FSH

Can be seen in obstruction and in some men with NOA.

Therefore, normal FSH does **not guarantee normal spermatogenesis**.

Low FSH and low LH

May suggest a hypothalamic or pituitary problem.

This category deserves particular attention because some causes are medically treatable.

Step 5: Genetic Testing

Genetic testing is one of the most important parts of modern azoospermia care.

Karyotype

The 2024 AUA/ASRM guideline recommends karyotype testing for men with primary infertility and azoospermia, or sperm concentration below 5 million/mL, when accompanied by evidence of impaired sperm production such as elevated FSH or testicular atrophy.

This can identify conditions such as:

Klinefelter syndrome.

Y-Chromosome Microdeletion Testing

Current 2024 AUA/ASRM guidance recommends Y-chromosome microdeletion testing in appropriately selected men with azoospermia or sperm concentration **≤1 million/mL** where impaired sperm production is suspected.

This is a significant update from older thresholds sometimes still quoted online.



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CFTR Testing

CFTR testing should be considered particularly when:

- the vas deferens is absent,
- or idiopathic obstructive azoospermia is present.

If a significant CFTR variant is found, partner testing and genetic counselling may become important.

Step 6: Ultrasound and Imaging

Ultrasound is not used merely because every azoospermic man needs a scan.

It is selected according to the suspected cause.

Scrotal ultrasound

May help assess:

- testicular structure,
- masses,
- varicocele,
- epididymal abnormalities,
- or other scrotal findings.

Transrectal ultrasound or pelvic imaging

May be useful when distal reproductive-tract obstruction is suspected, particularly in a patient with:

- azoospermia,
- very low semen volume,
- abnormal semen pH,
- and suggestive reproductive anatomy.

Current AUA and European guidance recognizes this selective use of imaging.

Is a Diagnostic Testicular Biopsy Always Necessary?

No.



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Current AUA/ASRM guidance specifically states that a **diagnostic testicular biopsy should not routinely be performed simply to distinguish obstructive from non-obstructive azoospermia.**

In many cases, clinical examination, semen findings, hormones, genetics and imaging provide enough information to guide treatment.

If surgical sperm retrieval is planned, testicular tissue may be evaluated as part of that procedure when appropriate.

Treatment of Azoospermia: The Cause Determines the Treatment

There is no universal azoospermia medicine.

I divide treatment broadly into:

1. correcting reversible causes,
2. treating hormonal deficiency,
3. correcting obstruction,
4. retrieving sperm when necessary,
5. assisted reproduction,
6. supportive treatment and health optimization.

Treatment of Hormonal Azoospermia

When the problem is hypogonadotropic hypogonadism, the testes may still possess the biological capacity to produce sperm.

They are simply not receiving adequate hormonal stimulation.

Depending on the diagnosis, treatment may involve:

- hCG,
- FSH or related gonadotropins,
- treatment of hyperprolactinemia,
- treatment of pituitary disease,
- stopping fertility-suppressing anabolic steroids,
- or other endocrine treatment.



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These patients should not automatically be placed directly into micro-TESE.

Some can develop sperm in the ejaculate after appropriate endocrine treatment.

The treatment takes time because human spermatogenesis itself takes many weeks.

Treatment of Obstructive Azoospermia

When sperm production is normal but there is a blockage, two major strategies are available.

Microsurgical Reconstruction

Depending on the location and cause of obstruction, procedures may reconnect the reproductive tract.

Examples include:

- vasovasostomy,
- vasoepididymostomy,
- or appropriate treatment of ejaculatory duct obstruction.

Current AUA/ASRM guidance states that microsurgical reconstruction can successfully return sperm to the ejaculate in selected men with vasal or epididymal obstruction.

When successful, reconstruction may allow natural conception.

Surgical Sperm Retrieval in Obstructive Azoospermia

If reconstruction is not appropriate, sperm can often be obtained from:

- the epididymis,
- or the testis.

Techniques may include different forms of sperm aspiration or extraction depending on the clinical situation.

The retrieved sperm can then be used with **ICSI**.

Current guidelines recognize both epididymal and testicular retrieval in obstructive azoospermia.

Ejaculatory Duct Obstruction

Selected men with confirmed ejaculatory duct obstruction may be candidates for:

transurethral resection of the ejaculatory ducts – TURED

or sperm retrieval with assisted reproduction.

In some appropriately selected men, relieving the obstruction may allow sperm to return to the ejaculate and potentially restore the possibility of natural conception.

Treatment of Non-Obstructive Azoospermia

NOA is more complex because the main problem is reduced sperm production.

Treatment depends on:

- cause,
- genetics,
- hormonal status,
- previous therapy,
- testicular function,
- reproductive goals,
- and female-partner factors.

When reversible hormonal causes have been excluded or treated and sperm retrieval is appropriate, the preferred technique is generally:

Microdissection Testicular Sperm Extraction – Micro-TESE

During micro-TESE, the surgeon examines testicular tissue under magnification and searches for seminiferous tubules more likely to contain areas of sperm production.

Current AUA/ASRM guidance recommends **micro-TESE for men with NOA undergoing surgical sperm retrieval**.

Current EAU guidance also identifies microdissection TESE as the preferred sperm-retrieval technique for NOA.

What Happens If Sperm Are Found With Micro-TESE?

If viable sperm are retrieved, they may be:

- used fresh,



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- or frozen when appropriate,

and subsequently used with **ICSI**.

In ICSI, an embryologist injects an individual sperm directly into an egg.

This has made biological fatherhood possible for some men who would previously have been considered permanently infertile.

However, sperm retrieval is **not the same as pregnancy**.

After sperm are found, success still depends on:

- sperm viability,
- egg quality,
- female age,
- ovarian reserve,
- fertilization,
- embryo development,
- implantation,
- and other fertility factors.

Therefore, responsible counselling should never present micro-TESE as a guaranteed route to pregnancy.

Can Medicines Improve the Chance of Micro-TESE in NOA?

Various medicines have been tried before sperm retrieval, including:

- hCG,
- FSH,
- aromatase inhibitors,
- and selective estrogen receptor modulators.

However, current AUA/ASRM guidance states that the evidence supporting routine pharmacological manipulation before surgical sperm retrieval in NOA is **limited and low quality**.

This is an extremely important point for patients.

A man should not be kept on months or years of expensive medication simply because:



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“Maybe the sperm will come.”

Treatment should be based on his hormonal pattern and actual diagnosis.

Does Varicocele Surgery Cure NOA?

Not reliably.

As discussed earlier, current guidelines consider the evidence insufficient to promise that varicocele repair will restore sperm in men with NOA.

Some selected patients may benefit, but counselling must be realistic.

Can Lifestyle Changes Cure Azoospermia?

Lifestyle improvement is valuable for reproductive and general health.

I commonly advise patients to:

- stop smoking,
- avoid recreational drugs,
- avoid anabolic steroids,
- maintain healthy body weight,
- control diabetes,
- sleep adequately,
- exercise regularly,
- improve diet,
- minimize unnecessary heat exposure,
- and avoid unverified hormone products.

However:

Lifestyle change cannot reopen a congenitally absent vas deferens.

It cannot correct a complete AZFa deletion.

It cannot reverse every case of severe testicular failure.

Lifestyle measures should therefore be presented as:

supportive health optimization



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rather than a guaranteed cure for azoospermia.

Why the Female Partner Must Also Be Evaluated

Infertility belongs to the couple, not only to the semen report.

Current AUA/ASRM guidance recommends parallel evaluation of both partners because treatment decisions depend on factors affecting both individuals.

For example, suppose a man has reconstructable obstructive azoospermia.

If his wife:

- is young,
- ovulates normally,
- and has good reproductive potential,

microsurgical reconstruction may be attractive.

But if the female partner has:

- markedly reduced ovarian reserve,
- advanced reproductive age,
- blocked tubes,
- or already requires IVF,

sperm retrieval with ICSI may offer a more practical route.

Therefore, azoospermia treatment should not be planned without understanding the couple's complete fertility situation.

Azoospermia in the Unani System of Medicine

As a physician trained in Unani medicine, I approach male reproductive health not only through the semen report but through the patient's complete physical and constitutional state.

Classical Unani medicine describes health using concepts including:

- **Mizaj** – temperament,
- **Akhlat** – traditional humoral theory,
- organ function,



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- nutrition,
- digestion,
- physical activity,
- sleep,
- psychological state,
- and environmental factors.

The four classical humors are described as:

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

These are part of the historical explanatory model of Unani medicine.

It is important to make a scientific distinction:

Traditional Unani humoral terminology should not be confused with modern endocrinology, genetics or testicular histology.

Modern medicine explains azoospermia through mechanisms such as:

- gonadotropin deficiency,
- genetic abnormalities,
- impaired spermatogenesis,
- testicular injury,
- congenital absence of reproductive ducts,
- and physical obstruction.

My approach is to respect traditional Unani principles while also using modern semen analysis, hormones, genetics and imaging to determine the actual clinical diagnosis.

Classical Unani Concepts Related to Reduced Male Fertility

Standard Unani literature discusses conditions related to reduced seminal production and male reproductive weakness.



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For example, CCRUM's Standard Unani Treatment Guidelines describe **Qillat-i-Mani**, or reduced seminal production, within traditional Unani terminology and discuss factors such as:

- general weakness,
- inadequate nutrition,
- abnormalities of temperament affecting reproductive organs,
- digestive health,
- and lifestyle.

However, I want to emphasize an important distinction:

Qillat-i-Mani or oligospermia is not automatically the same condition as modern laboratory-confirmed azoospermia.

A man with 5 million sperm/mL and a man with confirmed zero sperm after centrifugation require different diagnostic thinking.

Therefore, classical terminology must be integrated carefully with modern semen analysis.

Asbab-e-Sitta Zarooriya and Male Fertility

One of the most useful preventive-health concepts in Unani medicine is **Asbab-e-Sitta Zarooriya**, the six essential factors.

These broadly involve:

1. air and environment,
2. food and drink,
3. physical activity and rest,
4. psychological activity and rest,
5. sleep and wakefulness,
6. retention and elimination.

Official AYUSH literature continues to describe these principles as fundamental to Unani health maintenance.

These principles remain relevant in male reproductive health.

For example:

Nutrition

Severe malnutrition or inappropriate dietary patterns can affect endocrine and reproductive health.

Physical activity

Regular appropriate exercise supports:

- metabolic health,
- cardiovascular function,
- healthy body weight,
- and psychological well-being.

Sleep

Chronic sleep disturbance can affect general health and hormonal physiology.

Psychological health

Infertility itself can cause:

- anxiety,
- depression,
- sexual performance problems,
- relationship stress,
- and loss of confidence.

Metabolic health

Obesity and metabolic disease can negatively influence reproductive hormones and overall fertility.

This is where the Unani whole-person approach can add meaningful value.

The Four Modes of Unani Treatment

Official AYUSH sources describe four broad therapeutic approaches in Unani medicine:

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bil-Tadbir

Regimenal therapy

Ilaj-bil-Dawa



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Pharmacotherapy

Ilaj-bil-Yad

Surgical treatment

In azoospermia, these principles need to be applied according to the modern diagnosis.

A man with nutritional deficiency does not require the same intervention as a man with complete vasal obstruction.

Ilaj-bil-Ghiza: Dietary Management in Azoospermia

Diet cannot correct every cause of azoospermia.

However, adequate nutrition is important for maintaining:

- general health,
- endocrine function,
- testicular health,
- antioxidant defence,
- healthy body weight,
- and metabolic stability.

My dietary assessment may therefore focus on:

- protein adequacy,
- healthy fats,
- fruits and vegetables,
- whole foods,
- micronutrient deficiencies,
- diabetes control,
- obesity,
- excessive processed food,
- smoking,
- alcohol,



- and overall nutritional status.

I do not believe a responsible physician should say:

“Eat this one food and your zero sperm count will become normal.”

Male reproductive biology is much more complex.

Ilaj-bil-Tadbir: Regimenal and Lifestyle Management

Lifestyle management can include:

- appropriate physical activity,
- healthy sleep,
- reduction of chronic stress,
- weight management,
- avoidance of tobacco,
- avoidance of recreational drugs,
- avoiding anabolic steroids,
- and improvement of overall metabolic health.

These measures are especially important when a man has:

- obesity,
- diabetes,
- chronic stress,
- unhealthy lifestyle,
- nutritional deficiency,
- or exposure to factors that may worsen reproductive health.

However, lifestyle management should complement—not replace—investigation of severe male infertility.

Ilaj-bil-Dawa: Individualized Unani Pharmacotherapy

Unani medicine traditionally uses various single drugs and compound formulations according to:

- Mizaj,



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- underlying condition,
- general health,
- digestive status,
- reproductive symptoms,
- and associated disease.

In my practice, I do not support:

one fertility medicine for every azoospermia patient.

A man with:

hypogonadotropic hypogonadism

requires a different approach from a man with:

Klinefelter syndrome.

A man with:

obstruction

requires a different strategy from a man with:

severe testicular failure.

Therefore, when Unani pharmacotherapy is incorporated, I use it as part of an individualized programme after establishing the clinical diagnosis.

What Does Scientific Research Say About Unani Treatment for Male Infertility?

There is some clinical research within Unani medicine on **oligospermia**, meaning low sperm count.

For example, a CCRUM-published comparative analysis reviewed Unani formulations used in men with idiopathic oligospermia and reported changes in semen parameters across treatment groups.

CCRUM literature has also described clinical investigation of traditional formulations for **Qillat-i-Mani or oligospermia**.

This research is relevant and encourages further investigation of Unani reproductive medicine.

However, scientifically we must make an important distinction:



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Evidence showing improvement in men who already have sperm in their semen cannot automatically be applied to men with confirmed azoospermia.

Azoospermia is a much more heterogeneous and severe condition.

If sperm production is blocked because the vas deferens is absent, an herbal medicine cannot create a new vas deferens.

If a complete AZFa deletion prevents spermatogenesis, a supplement cannot replace the missing genetic region.

If azoospermia is caused by gonadotropin deficiency, targeted endocrine therapy may be required.

Therefore, traditional treatment should be applied according to the diagnosis rather than making universal claims.

Spermogenic and Azoospermia: An Evidence-Based Clarification

Patients of Saira Health Care may be familiar with **Spermogenic**, a traditional herbal formulation used within the clinic's male reproductive-health practice.

The formulation described by Saira Health Care contains ingredients such as:

- Asgand,
- Kaunch,
- Musli,
- Satawar,
- Kholanjan,
- Darchini,
- and other traditional ingredients.

From an Unani and traditional herbal perspective, such ingredients may be selected to support:

- general reproductive health,
- nutrition,
- vitality,
- and semen parameters in appropriately selected patients.

However, I want to make an important professional distinction regarding **azoospermia**.



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Current AUA/ASRM guidelines state that the clinical usefulness of fertility supplements, including antioxidants and vitamins, remains uncertain and that available evidence is insufficient to recommend specific supplement agents for male infertility.

I therefore do **not** believe it is appropriate to state that:

“Spermogenic is scientifically proven to cure azoospermia in 75% of patients”

unless such a figure is supported by an identifiable peer-reviewed clinical trial conducted specifically in properly confirmed azoospermic men.

The available literature I reviewed for this article did **not identify a peer-reviewed controlled clinical study validating that specific 75% claim for the branded Spermogenic formulation in azoospermia.**

Therefore, the medically responsible way I use or discuss such a formulation is:

It may form part of individualized supportive Unani management in selected patients.

But:

It should not replace investigation for obstruction, hormonal disease or genetic azoospermia.

It should not be presented as a guaranteed way to generate sperm in every case of NOA.

And it should not delay micro-TESE, reconstructive treatment or endocrine treatment when these are medically indicated.

I believe this honesty ultimately strengthens patient confidence in Unani medicine.

Can Herbal Medicine Turn Zero Sperm Into Normal Sperm?

Sometimes patients ask me this very directly.

My answer is:

It depends completely on why the sperm count is zero.

If the patient has a reversible general-health or hormonal factor contributing to severely impaired sperm production, improvement may sometimes occur when the underlying problem is appropriately treated.

But if the patient has:

- complete reproductive-tract obstruction,
- congenital absence of the vas deferens,
- complete AZFa/AZFb deletion,



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- severe irreversible testicular destruction,
- or another major structural or genetic cause,

herbal medicine alone should not be expected to correct that pathology.

Therefore, the clinically meaningful question is not:

“Which herb increases sperm?”

It is:

“Why does this man have azoospermia?”

Antioxidants and Fertility Supplements

Oxidative stress is an important topic in male reproductive medicine.

Many supplements contain:

- vitamins,
- minerals,
- antioxidants,
- amino acids,
- or herbal extracts.

Some studies show improvement in selected semen parameters.

Others do not show meaningful improvement in pregnancy or live-birth outcomes.

Current AUA/ASRM guidance describes the clinical utility of such supplements as **questionable** and states that existing evidence is insufficient to recommend specific agents.

Therefore, supplements should be considered supportive rather than curative.

Dr. Nizamuddin Qasmi's Individualized Approach to Azoospermia

At Saira Health Care, my approach to azoospermia is not simply:

“Zero sperm = give sperm-increasing medicine.”

I prefer a structured pathway.

Step 1: Verify That Azoospermia Is Genuine



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I review the semen report and, when necessary, advise repeat analysis from an appropriate laboratory.

I want to distinguish:

- genuine azoospermia,
 - cryptozoospermia,
 - incomplete semen collection,
 - retrograde ejaculation,
 - and laboratory error.
-

Step 2: Determine Whether It Is Obstructive or Non-Obstructive

I evaluate:

- semen volume,
- medical history,
- testicular size,
- reproductive ducts,
- FSH,
- testosterone,
- LH,
- and other relevant findings.

This classification changes everything about treatment.

Step 3: Search for Treatable Hormonal Causes

When hormones suggest hypothalamic or pituitary dysfunction, I investigate the cause.

Selected men may benefit from:

- gonadotropin treatment,
- management of prolactin disorders,
- withdrawal of fertility-suppressing testosterone or steroids,
- or endocrine specialist care.



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Step 4: Assess Genetic Causes

When indicated, I advise:

- karyotype,
- Y-chromosome microdeletion testing,
- CFTR testing,
- and genetic counselling.

Genetic information is particularly important before attempting sperm retrieval or assisted reproduction.

Step 5: Look for Obstruction

When clinical findings suggest obstructive azoospermia, I assess whether:

- microsurgical reconstruction,
- treatment of ejaculatory duct obstruction,
- or surgical sperm retrieval

may be appropriate.

Step 6: Assess Reversible General-Health Factors

I evaluate:

- obesity,
- diabetes,
- smoking,
- substance use,
- anabolic steroids,
- nutritional problems,
- sleep,
- stress,
- and lifestyle.



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These factors may not explain every case of azoospermia, but correcting them improves overall reproductive and general health.

Step 7: Integrate Unani Treatment Where Appropriate

Where clinically suitable, I may integrate:

Ilaj-bil-Ghiza

Individualized dietary and nutritional correction.

Ilaj-bil-Tadbir

Appropriate lifestyle and regimenal care.

Ilaj-bil-Dawa

Carefully selected Unani pharmacotherapy according to the patient's complete clinical picture.

My objective is to improve the patient's health and potentially support reproductive function where biologically possible.

I do not use Unani treatment to create false hope when modern evaluation shows that a structural or genetic barrier requires another solution.

Step 8: Discuss Micro-TESE When Appropriate

If a man has confirmed NOA and is a suitable candidate, I believe patients should be informed about micro-TESE rather than being kept indefinitely on unproven medicine.

Current international guidelines support micro-TESE as the preferred sperm-retrieval approach for NOA.

Where this procedure is required, referral to an appropriately experienced reproductive urologist and IVF/ICSI centre is part of responsible care.

Step 9: Evaluate the Female Partner

The woman's:

- age,
- ovarian reserve,
- tubal health,



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- menstrual status,
- and other fertility factors

can change the most appropriate treatment plan.

Male and female fertility should therefore be evaluated together.

Step 10: Provide Realistic Counselling

One of my most important responsibilities is explaining what treatment can realistically achieve.

Some forms of azoospermia are highly treatable.

Others can be bypassed through sperm retrieval.

Some have an uncertain prognosis.

And unfortunately, there are situations in which current medicine cannot retrieve sperm.

A responsible physician must be able to say all of these things honestly.

Can a Man With Azoospermia Become a Biological Father?

In many cases, **yes—but not in every case.**

The pathway depends on the cause.

Obstruction

Sperm production may be normal.

Reconstruction may restore sperm to the semen, or sperm may be retrieved directly for ICSI.

Hypogonadotropic hypogonadism

Appropriate hormonal therapy can sometimes restart sperm production.

Non-obstructive azoospermia

Micro-TESE may identify small areas of sperm production in selected men.

AZFc deletion

Sperm may sometimes be retrieved, although genetic counselling is important.

Klinefelter syndrome

Micro-TESE can retrieve sperm in a meaningful proportion of selected men.



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Complete AZFa or AZFb deletion

Current evidence indicates that sperm retrieval is essentially unsuccessful, and surgery is therefore generally not recommended.

The words:

“zero sperm in semen”

therefore do not provide enough information to answer:

“Can I become a biological father?”

The cause provides the answer.

What Does Successful Azoospermia Treatment Mean?

Success is not identical for every patient.

For one man, success may mean:

Hormonal treatment restores sperm to the ejaculate.

For another:

Microsurgical reconstruction returns sperm to semen and natural conception becomes possible.

For another:

Micro-TESE retrieves viable sperm that can be used in ICSI.

For another:

A genetic diagnosis prevents unnecessary surgery and gives the couple realistic counselling.

For another:

Stopping testosterone or anabolic steroids allows the hormonal system and spermatogenesis to recover.

And for another:

Treatment reveals that biological sperm retrieval is not realistically possible, allowing the couple to consider other family-building options without wasting years on false promises.

All of these can represent good medical care.



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Why I Avoid Invented Azoospermia “Success Stories”

A fertility patient is emotionally vulnerable.

Statements such as:

“100% cure for zero sperm”

or

“75% of azoospermia patients become normal with one product”

can create unrealistic expectations.

A genuine success story should be supported by:

- documented azoospermia before treatment,
- appropriately repeated semen analysis,
- established diagnosis,
- treatment records,
- follow-up laboratory results,
- and patient consent before publication.

I believe Saira Health Care's contribution to infertility medicine should be based on **transparent clinical care**, not exaggerated statistics.

Common Myths About Azoospermia

Myth 1: Zero sperm means zero semen.

Fact: A man can ejaculate a normal amount of semen while having no sperm in it.

Myth 2: Azoospermia means impotence.

Fact: Azoospermia is primarily a fertility problem. Erections and sexual desire may be completely normal.

Myth 3: Every azoospermia patient has permanent testicular failure.

Fact: Some men have obstruction or hormonal deficiencies while sperm-producing capacity remains present.



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Myth 4: One semen analysis is enough to permanently diagnose zero sperm.

Fact: Azoospermia should be properly confirmed, and contemporary EAU guidance recommends two consecutive analyses for NOA.

Myth 5: High FSH means there can never be sperm inside the testes.

Fact: High FSH suggests impaired spermatogenesis but does not perfectly predict whether small areas of sperm production remain.

Myth 6: Normal FSH means sperm production must be normal.

Fact: Some men with NOA have FSH values that are not dramatically elevated.

Myth 7: Testosterone injection increases sperm count.

Fact: External testosterone can suppress FSH and LH and can reduce or even stop sperm production. Testosterone monotherapy should not be used in men seeking fertility.

Myth 8: Varicocele surgery always restores sperm in azoospermia.

Fact: Evidence in NOA is uncertain, and current AUA/ASRM guidance specifically advises counselling couples about the lack of definitive evidence.

Myth 9: No sperm in semen means there cannot be sperm inside the testes.

Fact: In NOA, sperm production can sometimes occur in small isolated areas, which is why micro-TESE can retrieve sperm in selected patients.

Myth 10: Herbs can cure every type of azoospermia.

Fact: Azoospermia has hormonal, obstructive, genetic, testicular and other causes. No single herbal medicine can logically correct all of them.

Myth 11: IVF is always necessary.

Fact: Some hormonal causes can respond to medical therapy and some obstructive conditions can be surgically reconstructed.



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Myth 12: Azoospermia always comes from masturbation or frequent sex.

Fact: Normal masturbation or sexual intercourse does not cause permanent azoospermia.

Frequently Asked Questions

What does “sperm count NIL” mean?

It means sperm were not identified in that semen sample.

The result should be appropriately confirmed before definitive treatment decisions are made.

Can azoospermia be cured?

Some causes can be corrected.

Others cannot currently be reversed but may still allow biological fatherhood through sperm retrieval and ICSI.

Therefore, the word “**cure**” depends on the cause.

Which type is easier to treat?

Obstructive azoospermia generally has a more favorable biological situation because sperm production is often preserved.

Treatment may involve reconstruction or sperm retrieval.

NOA is more challenging because sperm production itself is impaired.

Can hormone treatment cure azoospermia?

It can be highly useful in specific hormonal conditions, particularly hypogonadotropic hypogonadism.

It is not appropriate for every patient.

Can I take testosterone if my testosterone level is low?

Not without discussing fertility goals with a qualified physician.



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External testosterone can suppress sperm production and is contraindicated as fertility treatment in men trying to conceive.

Can azoospermia happen after testosterone or bodybuilding steroids?

Yes.

These substances can suppress the pituitary hormones needed for sperm production and may cause severe oligospermia or azoospermia.

Recovery varies and can take time.

Can varicocele cause azoospermia?

Varicocele may coexist with severely impaired spermatogenesis, but not every azoospermic man with varicocele will recover sperm after surgery.

Evidence supporting varicocele repair specifically in NOA remains uncertain.

Can sperm be found inside the testis even when the semen report is zero?

Yes, in selected men.

This is particularly relevant in NOA, where sperm production may occur in small focal areas.

Micro-TESE is used to search for these areas.

Is micro-TESE guaranteed to find sperm?

No.

Micro-TESE improves the ability to search for focal sperm production but cannot guarantee retrieval.

The chance depends on the underlying diagnosis and testicular biology.

Is micro-TESE the preferred operation for NOA?

Yes.

Both current AUA/ASRM and EAU guidance identify micro-TESE as the preferred sperm-retrieval technique for appropriately selected men with NOA.



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Do I need genetic tests?

Many men with suspected impaired sperm production do.

Current guidelines recommend karyotype and appropriately selected Y-chromosome testing in severe male infertility, with CFTR testing for vasal agenesis or idiopathic obstructive azoospermia.

Does azoospermia affect sexual performance?

Not necessarily.

Many azoospermic men have normal:

- libido,
 - erections,
 - intercourse,
 - ejaculation,
 - and orgasm.
-

Can Unani medicine help?

Unani medicine can contribute to an individualized programme by addressing:

- general reproductive health,
- nutrition,
- lifestyle,
- metabolic health,
- sleep,
- stress,
- and selected reversible conditions.

Traditional pharmacotherapy may also be considered according to the patient's clinical situation.

However, Unani treatment should be used after establishing the type and cause of azoospermia and should not delay:

- genetic evaluation,
- hormonal therapy,
- reconstruction,
- micro-TESE,
- or ART

when these are required.

Is Spermogenic proven to cure azoospermia?

I have not found sufficient peer-reviewed controlled evidence to support a universal claim that the branded product cures azoospermia or produces a 75% response rate.

It may be used as a traditional supportive formulation in appropriately selected patients under professional supervision, but it should not be presented as a replacement for cause-specific azoospermia treatment.

When Should a Man Seek Specialist Evaluation?

A man should obtain proper male-fertility evaluation when:

- semen analysis shows zero sperm,
- repeated reports show extremely low sperm counts,
- the testes are unusually small,
- puberty was abnormal,
- there is a history of undescended testes,
- there was significant testicular injury,
- mumps affected the testes,
- genital surgery was performed,
- vasectomy was performed,
- chemotherapy or radiation was received,
- testosterone or anabolic steroids have been used,
- semen volume is consistently very low,
- ejaculation is absent or abnormal,



- or the couple has been unable to conceive.

Azoospermia warrants detailed assessment rather than treatment by trial and error.

Dr. Nizamuddin Qasmi and Saira Health Care

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

My professional education and additional training listed for this clinical work 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**

My focused work in male infertility is particularly relevant to azoospermia because this condition requires more than reading one semen-analysis number.

It requires understanding:

- semen analysis,
- hormonal physiology,
- testicular function,
- reproductive anatomy,
- genetics,
- sexual health,
- lifestyle,
- the female partner's fertility,
- and assisted-reproductive options.

At Saira Health Care, my aim is to combine this diagnostic perspective with the individualized principles of Unani medicine wherever they can be used appropriately.



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Saira Health Care's Contribution to Sexual Disorders and Infertility

A major challenge in infertility care is misinformation.

Men with azoospermia are often told:

“You can never become a father.”

Others are told the opposite:

“Take this medicine and the sperm will definitely come.”

Neither statement is scientifically responsible without knowing the cause.

At **Saira Health Care**, our broader approach in sexual disorders and infertility is based on:

- confidential patient consultation,
- detailed reproductive history,
- review of semen analysis,
- appropriate hormonal evaluation,
- interpretation of fertility reports,
- identification of potentially reversible causes,
- lifestyle and nutritional assessment,
- individualized Unani treatment when appropriate,
- modern medical investigation,
- couple-based fertility evaluation,
- and referral for surgical sperm retrieval or assisted reproductive treatment when required.

I consider patient education one of the most important parts of this work.

A man should understand **why** his sperm count is zero before deciding **how** it should be treated.

Saira Health Care's Integrative Philosophy

My approach is not:

“Unani medicine versus modern medicine.”

Instead:

If the patient has nutritional and metabolic problems



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I use appropriate dietary and lifestyle management.

If the patient has a reversible endocrine disorder

He requires correct hormonal diagnosis and treatment.

If testosterone or steroids have suppressed spermatogenesis

Those agents must be managed appropriately rather than adding random fertility supplements.

If there is obstruction

Reproductive microsurgery or sperm retrieval may be needed.

If there is a clinically significant genetic cause

Genetic counselling becomes essential.

If the patient has NOA and wishes to pursue biological fatherhood

Micro-TESE and ICSI may need to be discussed.

If Unani pharmacotherapy may support general reproductive health

It can be incorporated responsibly.

This is the type of individualized treatment I believe gives patients the most realistic and medically appropriate opportunity.

Latest Scientific Perspective: 2024–2026

Modern azoospermia management has become increasingly precise.

The **AUA/ASRM Male Infertility Guideline, amended in 2024**, updated genetic-testing recommendations and now recommends Y-chromosome microdeletion testing particularly in men with azoospermia or sperm concentration ≤ 1 million/mL when impaired sperm production is suspected.

Current AUA/ASRM guidance recommends:

- hormonal evaluation in azoospermia,
- differentiation between obstruction and impaired sperm production,
- appropriate karyotype testing,
- Y-chromosome microdeletion testing,
- CFTR evaluation for appropriate obstructive cases,



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- avoiding routine diagnostic testicular biopsy,
- avoiding testosterone monotherapy when fertility is desired,
- micro-TESE for surgical sperm retrieval in NOA,
- and reconstructive or sperm-retrieval options for obstructive disease.

The **2025 European Association of Urology male infertility update** similarly emphasizes cause-specific diagnostic evaluation, genetics and evidence-based sperm-retrieval strategies.

These guidelines reinforce one message that I consider fundamental:

Do not treat azoospermia as a number. Treat its cause.

My Final Message to Patients With Zero Sperm Count

If your semen report says:

“Zero sperm”

please do not immediately lose hope.

But also do not begin months of medicines without finding out why the result is zero.

Ask the following questions:

Was the semen test properly performed and repeated?

Was the centrifuged pellet examined?

Is my semen volume normal?

Are my testes producing sperm?

Could there be an obstruction?

What are my FSH, LH and testosterone levels?

Have I used testosterone or anabolic steroids?

Do I need karyotype or Y-chromosome testing?

Could CFTR testing be relevant?

Do I have a treatable hormonal disorder?

Am I a candidate for reconstruction?

Could sperm be retrieved through micro-TESE?

These questions are much more useful than simply asking:



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“Which medicine increases sperm count?”

At Saira Health Care, I believe the patient deserves both:

hope and honesty.

Hope—because many men with azoospermia still have meaningful treatment or biological-fatherhood options.

Honesty—because not every form of azoospermia can be cured by medicine, herbs, surgery or even micro-TESE.

A responsible infertility physician must explain both.

Conclusion

Azoospermia is defined as the absence of sperm from the ejaculate after appropriate laboratory examination.

It affects approximately **1% of men of reproductive age and around 10% of infertile men.**

It should not be considered one disease.

The two major categories are:

Obstructive azoospermia

Sperm production is present, but a blockage prevents sperm from reaching the ejaculate.

Non-obstructive azoospermia

Sperm production itself is severely impaired.

A third clinically important pattern involves **pre-testicular hormonal disorders**, particularly hypogonadotropic hypogonadism, in which the testes receive inadequate hormonal stimulation.

Possible causes include:

- genetic abnormalities,
- Klinefelter syndrome,
- Y-chromosome microdeletions,
- congenital absence of the vas deferens,
- obstruction,
- previous infection or surgery,



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- undescended testes,
- testicular trauma,
- mumps orchitis,
- chemotherapy,
- radiation,
- hormonal disorders,
- testosterone or anabolic steroid exposure,
- and severe unexplained impairment of spermatogenesis.

Accurate diagnosis requires:

- properly performed semen analysis,
- confirmation when appropriate,
- detailed medical and reproductive history,
- physical examination,
- hormonal assessment,
- genetic testing in selected men,
- and appropriate imaging.

Treatment is determined by the cause.

Hypogonadotropic azoospermia may respond to appropriate hormonal therapy.

Obstructive azoospermia may be treated through microsurgical reconstruction or sperm retrieval.

Selected men with NOA may undergo **micro-TESE**, followed by **ICSI** if viable sperm are retrieved.

Current international guidelines support micro-TESE as the preferred surgical sperm-retrieval strategy for NOA.

The **Unani system of medicine** can contribute through:

- Ilaj-bil-Ghiza,
- Ilaj-bil-Tadbir,
- individualized Ilaj-bil-Dawa,
- lifestyle optimization,



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- nutrition,
- metabolic health,
- stress management,
- sleep,
- and general reproductive-health support.

Research within Unani medicine has reported encouraging findings in some men with **oligospermia**, but this evidence should not automatically be extended to every case of confirmed azoospermia.

Likewise, fertility supplements and herbal formulations—including products used within Saira Health Care's reproductive practice—should be considered adjunctive and individualized rather than advertised as guaranteed cures for zero sperm count. Current AUA/ASRM guidance states that the clinical utility of supplements and antioxidants in male infertility remains uncertain.

My treatment philosophy at **Saira Health Care** can therefore be summarized as:

Confirm azoospermia first.

Identify whether the problem is hormonal, testicular or obstructive.

Investigate genetic causes when indicated.

Correct reversible factors.

Protect fertility by avoiding inappropriate testosterone treatment.

Use Unani medicine rationally and individually.

Use reproductive microsurgery and modern assisted-reproductive techniques when appropriate.

Evaluate both partners—not just the semen report.

And never replace an accurate diagnosis with an unsupported promise.

For a man receiving a zero-sperm report, the most important message is:

Azoospermia is a diagnosis that requires investigation—not a final verdict on fatherhood.

About the Author

Dr. Nizamuddin Qasmi

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

Professional Education & Training

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

Dr. Nizamuddin Qasmi's focused work at Saira Health Care involves the assessment and management of sexual disorders and infertility, including complex male-fertility problems such as severe oligospermia, azoospermia, sexual dysfunction and couple-based fertility concerns.

His approach combines professional training in Unani medicine with additional education in infertility, urology, male infertility and sexual and reproductive health, while incorporating modern fertility investigations and appropriate specialist referral into patient care.

Medical Disclaimer

This article is intended for patient education and general health information. It is not a substitute for an individual consultation, diagnosis or treatment plan.

Azoospermia is a complex condition that may result from genetic, hormonal, obstructive, testicular, medication-related and other causes.

Do not begin testosterone injections, anabolic steroids, hormones, fertility medicines, herbal formulations or supplements solely on the basis of a single semen report without appropriate medical assessment.

Men interested in current or future fertility should specifically inform their physician before using testosterone therapy because external testosterone can suppress sperm production.

Unani medicines should also be used under qualified professional supervision.

Spermogenic or any other nutritional or herbal formulation should not be interpreted as a guaranteed treatment for azoospermia. Evidence for specific supplements in severe male infertility remains limited, and therapy should be matched to the underlying diagnosis.



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Patients with suspected genetic azoospermia may require appropriate genetic counselling before assisted reproduction.

Where a patient needs reproductive urology, endocrinology, genetic counselling, micro-TESE, IVF/ICSI or another specialist service, referral should be part of responsible care.



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