

Primary and Secondary Male Infertility

Understanding Why Some Men Have Never Achieved a Pregnancy and Why Fertility Can Decline After a Previous Pregnancy

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Male infertility is not one single disease.

Some men come to me because they have been married for several years and a pregnancy has never occurred.

Others say:

“Doctor, we already have one child. Why are we unable to conceive again?”

Another patient may have fathered a pregnancy in a previous relationship but is now unable to achieve pregnancy with his present partner.

These situations are commonly described as **primary and secondary infertility**.

The distinction is useful, but it is very important to understand what it means.

According to the World Health Organization, infertility is a disease of the male or female reproductive system defined by failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**. WHO describes **primary infertility** as a situation in which a pregnancy has never been achieved, while **secondary infertility** means that at least one pregnancy has occurred previously.

Therefore:

Primary male infertility generally describes a man who has never previously contributed to a pregnancy and is currently part of a couple experiencing infertility.

Secondary male infertility describes a man who has contributed to a pregnancy previously but is now experiencing difficulty achieving another pregnancy.

A previous pregnancy does **not** guarantee that male fertility will remain unchanged throughout life.

This is one of the most important messages I give my patients.

A man may have had completely adequate fertility five or ten years ago and later develop:

- varicocele,
- hormonal abnormalities,



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- reduced sperm production,
- infection,
- testicular disease,
- medication-related infertility,
- anabolic-steroid suppression,
- sexual dysfunction,
- metabolic disease,
- consequences of surgery,
- cancer-treatment-related testicular damage.

At **Saira Health Care**, I therefore do not assume that the male partner is fertile simply because he has fathered a pregnancy in the past.

Both primary and secondary infertility deserve proper evaluation.

Infertility Is a Couple's Condition

Infertility should never automatically be blamed on the woman.

WHO's latest infertility guidance emphasizes that infertility may result from male factors, female factors, a combination of both, or remain unexplained despite evaluation. WHO estimates that approximately **one in six people of reproductive age worldwide experience infertility during their lifetime.**

The current European Association of Urology guidance states that a male-associated factor can be identified in approximately half of infertile couples, with a purely male factor accounting for roughly one-fifth.

This is why I prefer the following approach:

Do not investigate the woman for years before looking at the man.

The male and female partners should ideally be evaluated **in parallel.**

What Is Primary Male Infertility?

Primary male infertility means that a pregnancy has never previously been achieved with that man's reproductive contribution.

For example:



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A couple has been having regular unprotected intercourse for two years and no pregnancy has ever occurred.

If evaluation identifies a male fertility factor, this would represent primary male infertility.

Possible abnormalities may include:

- very low sperm count,
- azoospermia,
- poor sperm movement,
- severe sperm morphology abnormalities,
- undescended testes,
- genetic abnormalities,
- hormonal deficiency,
- congenital obstruction,
- varicocele,
- sexual or ejaculatory dysfunction.

Some causes have existed since childhood or puberty.

Others may have developed during adulthood before the man ever attempted conception.

What Is Secondary Male Infertility?

Secondary infertility occurs after at least one previous pregnancy has been achieved.

The previous pregnancy does not necessarily have to have resulted in a living child for the WHO definition of secondary infertility to apply; the important point is that a pregnancy occurred previously.

In practical male-fertility assessment, I also ask:

- Was the pregnancy with the current partner?
- Was it with a previous partner?
- How many years ago?
- Did conception occur naturally?



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- Was fertility treatment required?
- Has anything changed medically since then?

These questions are important because previous fertility tells us about the man's reproductive function **at that earlier time**, not necessarily today.

“I Already Have a Child, So How Can I Be Infertile?”

This is probably the most common misunderstanding regarding secondary infertility.

Fertility is not a permanent certificate issued after the birth of one child.

Male reproductive health changes with:

- age,
- disease,
- medications,
- weight,
- metabolic health,
- testicular injury,
- surgery,
- infections,
- environmental exposures,
- hormonal status.

One example is **varicocele**.

Current EAU guidance reports varicocele in approximately 35–44% of men presenting with primary infertility and historical estimates as high as 45–81% among men presenting with secondary infertility. Varicocele can sometimes be associated with progressive deterioration of testicular function.

Therefore, when a man says:

“I fathered a child ten years ago, so the problem cannot be mine,”

I explain that fertility needs to be assessed **now**.

Primary Versus Secondary Infertility Does Not Tell Us the Cause



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These words classify reproductive history.

They do not give the diagnosis.

A man with primary infertility may have a varicocele.

A man with secondary infertility may also have a varicocele.

Both may have low sperm count.

Both may have hormonal abnormalities.

Both may have sexual dysfunction.

Both may have unexplained infertility.

The value of the distinction is that secondary infertility makes me particularly interested in **what changed between the previous pregnancy and the present infertility**.

How Does Pregnancy Normally Occur?

To understand male infertility, it helps to understand what a man needs for normal reproductive function.

He must generally be able to:

1. produce adequate sperm inside the testes,
2. mature and transport sperm through the epididymis,
3. transport them through the vas deferens,
4. produce normal seminal fluid,
5. achieve an erection sufficient for intercourse,
6. ejaculate semen into the vagina,
7. produce sperm capable of reaching and fertilizing the egg.

A problem at any one of these stages can contribute to infertility.

Main Causes of Male Infertility

WHO identifies important male causes including problems with semen ejaculation, absence or low concentration of sperm, and abnormalities of sperm motility or morphology.

In clinical practice, I divide male infertility into several broad categories:



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- impaired sperm production,
 - obstruction to sperm transport,
 - hormonal disorders,
 - genetic disorders,
 - varicocele,
 - infection and inflammation,
 - sexual or ejaculatory dysfunction,
 - medication or toxin-related infertility,
 - lifestyle and metabolic contributors,
 - unexplained infertility.
-

Low Sperm Count — Oligozoospermia

One of the common abnormalities is a low sperm concentration.

The WHO sixth-edition semen-analysis framework uses approximately **16 million sperm/mL** as the lower fifth-centile reference for sperm concentration in men whose partners conceived naturally within twelve months.

However, this is not a dividing line where:

above 16 million = fertile

below 16 million = infertile.

Current European guidelines specifically emphasize that semen-reference values do not distinguish fertility from infertility by themselves.

The complete semen picture and the couple's reproductive circumstances matter.

Severe Oligospermia

When sperm concentration becomes very low—particularly below approximately **5 million/mL**—more serious disorders of sperm production, genetics or the reproductive tract become increasingly important.

These men deserve detailed andrological assessment.

Severe oligospermia should not simply be treated with vitamins for several months without looking for the cause.



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Azoospermia

Azoospermia means that sperm are not detected in the ejaculate after appropriate laboratory assessment.

It has two major types.

Obstructive azoospermia

Sperm production may be relatively preserved, but sperm cannot reach the ejaculate because of blockage or absence of the reproductive ducts.

Non-obstructive azoospermia

The principal problem lies in sperm production within the testes.

Distinguishing these two situations is extremely important because treatment is completely different.

Poor Sperm Motility

Sperm must move effectively toward the egg.

Poor progressive movement is called **asthenozoospermia**.

A man can have an apparently reasonable sperm concentration but still have significantly reduced fertility because too few sperm move forward effectively.

Abnormal Sperm Morphology

Sperm shape is assessed under strict laboratory criteria.

Severely abnormal morphology can contribute to male-factor infertility, although morphology should never be interpreted completely independently from concentration, movement and the couple's overall reproductive situation.

Oligoasthenoteratozoospermia — OAT

When sperm concentration, movement and morphology are all abnormal, the pattern is called:

Oligo-Astheno-Teratozoospermia, commonly abbreviated as **OAT**.



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This is a common pattern in male infertility and may occur in both primary and secondary cases.

The greater the number and severity of simultaneous semen abnormalities, the more important a detailed male-fertility evaluation becomes.

Varicocele

Varicocele is an abnormal enlargement of veins surrounding the testicle.

It is among the most common potentially correctable conditions identified in infertile men.

Current EAU guidance estimates varicocele in approximately:

- 15% of the general male population,
- 25% of men with abnormal semen analyses,
- 35–40% of men presenting with infertility.

Possible mechanisms include:

- increased scrotal temperature,
- oxidative stress,
- impaired testicular blood flow,
- accumulation of metabolic substances,
- progressive testicular injury.

Varicocele is especially interesting in **secondary infertility** because sperm production may have been adequate years earlier and deteriorated gradually.

Does Every Varicocele Need Treatment?

No.

A very small varicocele seen only on ultrasound does not automatically require surgery.

Current AUA/ASRM and EAU guidance generally supports considering repair when a man has:

- infertility,
- a **clinically palpable varicocele**,



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- abnormal semen parameters,

and treatment makes sense in the context of the couple's fertility situation.

Subclinical ultrasound-only varicoceles are generally not treated solely to improve fertility.

Undescended Testes

Testicles normally descend into the scrotum before or around birth.

When one or both remain undescended—a condition known as **cryptorchidism**—future sperm production can be impaired.

Bilateral cryptorchidism carries a particularly important fertility risk.

A man may have undergone corrective surgery as a child and forgotten about it until infertility is investigated decades later.

That childhood history can be extremely important in primary infertility.

Testicular Torsion

Testicular torsion occurs when a testicle twists and its blood supply is compromised.

If treatment is delayed, testicular tissue may suffer permanent damage.

Men with a history of torsion should therefore mention it during fertility assessment, even if the event occurred during adolescence.

Testicular Trauma

Major trauma can damage:

- sperm-producing tissue,
- blood supply,
- reproductive ducts.

A history of sports injury, accident or surgery may therefore provide important clues.

Genital and Urinary Infections

Some infections can impair male fertility.



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Examples include:

- epididymitis,
- orchitis,
- sexually transmitted infections,
- selected urinary/genital infections,
- genitourinary tuberculosis in relevant settings.

Possible consequences include:

- inflammation,
- testicular injury,
- epididymal obstruction,
- damage to sperm function.

Current EAU guidance includes genitourinary infections and STIs among important elements of an infertility history.

Mumps Orchitis

Mumps infection involving the testes after puberty can occasionally damage sperm-producing tissue.

Not every man who had mumps becomes infertile.

The fertility impact depends upon whether orchitis occurred and how severely the testes were affected.

Hormonal Causes of Male Infertility

Normal sperm production depends upon a hormonal communication system involving:

- hypothalamus,
- pituitary gland,
- testes.

Important hormones include:

- GnRH,
- FSH,



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- LH,
- testosterone.

Abnormalities can produce either primary or secondary infertility.

FSH and Sperm Production

FSH plays a major role in stimulating the sperm-producing environment within the testes.

When testicular sperm production is severely impaired, FSH is often elevated because the pituitary gland is trying harder to stimulate the testes.

Therefore:

high FSH + small testes + very low sperm concentration

raises concern for significant primary testicular dysfunction.

However, normal FSH does not completely exclude abnormal sperm production.

LH and Testosterone

LH stimulates the testicular Leydig cells to produce testosterone.

When both LH and testosterone are low or inappropriately normal, we may consider a hypothalamic or pituitary cause.

This distinction matters because certain hormonal causes are particularly treatable.

Hypogonadotropic Hypogonadism

In this condition, the brain or pituitary gland does not provide adequate hormonal stimulation to the testes.

The testes may have the ability to produce sperm but are not receiving adequate FSH and LH signals.

Current EAU and AUA/ASRM guidance recognizes treatment with gonadotropins—such as hCG and FSH—as capable of initiating spermatogenesis in many appropriately selected men.

This is a very different condition from irreversible primary testicular failure.



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Hyperprolactinemia

Excessive prolactin can suppress normal reproductive hormone signalling.

A man may develop:

- low libido,
- erectile difficulty,
- low testosterone,
- impaired sperm production.

When hyperprolactinemia is confirmed, the underlying cause should be identified and treated.

Current guidelines recommend investigating the cause rather than simply treating the semen report.

Testosterone Treatment Can Cause Male Infertility

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

Many men believe:

“Testosterone is a male hormone, so it must improve sperm.”

Unfortunately, external testosterone can do the opposite.

Testosterone injections, gels and anabolic hormones suppress pituitary LH and FSH.

This reduces testosterone concentration **inside the testes**, which is essential for normal sperm production.

The result can be:

- severe oligospermia,
- azoospermia,
- testicular shrinkage.

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

Anabolic Steroids and Gym Hormones

Bodybuilding anabolic steroids can produce the same reproductive suppression.



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Some men who previously fathered a child develop secondary infertility after beginning:

- testosterone injections,
- anabolic steroids,
- unregulated bodybuilding hormones.

This history is particularly important because the man may not consider gym injections to be “medicine” and may forget to tell the fertility doctor.

Current EAU guidance recommends stopping anabolic steroids and allowing time for reproductive recovery before considering further hormonal stimulation in appropriate patients.

Genetic Causes

Genetic abnormalities are particularly important in men with:

- azoospermia,
- severe oligospermia,
- small testes,
- markedly elevated FSH,
- evidence of severe sperm-production failure.

Examples include:

- Klinefelter syndrome,
- Y-chromosome microdeletions,
- structural chromosomal abnormalities,
- CFTR-related reproductive-tract abnormalities.

Genetic causes are more often identified in severe primary infertility, but reproductive history alone cannot completely rule genetics in or out.

Klinefelter Syndrome

Klinefelter syndrome most commonly involves an extra X chromosome:

47,XXY

It can be associated with:



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- small testes,
- very low sperm production,
- high FSH,
- reduced testosterone,
- gynecomastia,
- infertility.

Current AUA/ASRM guidance recognizes Klinefelter syndrome among the most important chromosomal causes of severe male infertility.

Y-Chromosome Microdeletion

The Y chromosome contains important regions involved in sperm production.

Certain deletions can produce severe oligospermia or azoospermia.

The **2024 AUA/ASRM guideline update** recommends Y-chromosome microdeletion analysis particularly in men with primary infertility and azoospermia or sperm concentrations ≤ 1 million/mL when findings suggest impaired sperm production.

European guidance also supports genetic testing in appropriately selected men with severe sperm-production abnormalities.

CFTR Abnormalities and Obstruction

Some men are born without one or both vas deferens, the tubes transporting sperm from the testes.

Congenital bilateral absence of the vas deferens is strongly associated with **CFTR gene variants**.

AUA/ASRM recommends CFTR testing in men with vasal agenesis or idiopathic obstructive azoospermia and partner testing when a CFTR mutation is identified.

This is important because reproductive genetic counselling may be necessary before ICSI.

Ejaculatory-Duct Obstruction

A man may produce sperm but be unable to transport them normally into the semen.



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Possible clues include:

- low ejaculate volume,
- very low sperm count or azoospermia,
- abnormal seminal-vesicle findings.

Transrectal ultrasound may be considered when ejaculatory-duct obstruction is clinically suspected.

Some obstructive causes can be treated surgically.

Vasectomy and Secondary Male Infertility

A man who previously fathered children and later underwent vasectomy may present years afterward wanting another pregnancy.

Technically, his reproductive history represents secondary infertility after an intentionally created obstruction.

Options can include:

- microsurgical vasectomy reversal,
- surgical sperm retrieval combined with IVF/ICSI.

The best approach depends upon several factors, including:

- time since vasectomy,
- female partner's age,
- ovarian reserve,
- couple preference,
- reproductive goals.

Previous Pelvic or Groin Surgery

Secondary infertility can occasionally result from injury or obstruction after:

- hernia surgery,
- scrotal surgery,
- pelvic surgery,
- prostate surgery,



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- bladder surgery.

A complete surgical history is therefore essential.

Cancer Treatment

Chemotherapy and radiation therapy can damage sperm-producing cells.

Men who previously had normal fertility may develop secondary infertility after cancer treatment.

The degree of reproductive damage depends upon:

- chemotherapy agent,
- cumulative dose,
- radiation field,
- pretreatment testicular function.

Sperm banking before gonadotoxic cancer therapy is therefore important when circumstances allow.

Diabetes and Male Reproductive Health

Diabetes may influence fertility through several mechanisms.

It can contribute to:

- erectile dysfunction,
- ejaculatory dysfunction,
- metabolic abnormalities,
- hormonal problems,
- neuropathy.

Some men with diabetes develop **retrograde ejaculation**, in which semen enters the bladder rather than exiting normally.

A man may have previously fathered children but later develop secondary infertility because of progressive diabetic complications.

Obesity and Metabolic Syndrome



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Obesity can influence the reproductive hormonal environment.

Potential mechanisms include:

- increased conversion of testosterone to estrogen,
- lower testosterone,
- metabolic inflammation,
- altered scrotal temperature,
- accompanying diabetes.

Current European guidance identifies obesity, low physical activity, smoking and heavy alcohol intake as lifestyle factors associated with poorer sperm quality and recommends addressing these factors.

Smoking

Smoking has been associated with reductions in several semen parameters and increased sperm DNA damage.

ASRM's 2024 committee review found evidence for lower sperm density, motility and potentially morphology in smokers, with effects increasing according to exposure.

Smoking cessation is therefore a reasonable part of male fertility treatment.

It is supportive—not a guaranteed cure.

Alcohol

Heavy chronic alcohol consumption can affect reproductive hormone levels and semen quality.

Moderate use appears less clearly harmful than heavy intake, but men with significant infertility should avoid excessive drinking.

Heat and Occupational Exposures

Repeated substantial heat exposure and certain environmental toxins may adversely affect sperm production in susceptible men.

During history-taking I therefore ask about:

- occupational heat,



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- pesticides,
- industrial chemicals,
- heavy metals,
- radiation exposure.

This is particularly important when no obvious medical cause has been identified.

Male Age

Men do not experience the same abrupt reproductive decline as women, but male reproductive biology still changes with age.

Increasing paternal age has been associated with:

- declining semen parameters,
- increasing sperm DNA fragmentation,
- increasing de novo genetic mutations.

ASRM notes that semen parameters begin showing measurable age-related changes relatively early, although major effects on overall male fertility generally become more relevant later in life.

For secondary infertility, the age difference between the previous conception and the present attempt can therefore matter.

Sexual Dysfunction and Male Infertility

Infertility is not always a sperm-production disorder.

Pregnancy also requires sperm to reach the female reproductive tract.

Important sexual causes include:

- erectile dysfunction,
- markedly reduced libido,
- premature loss of erection,
- anejaculation,
- retrograde ejaculation,
- severely infrequent intercourse.



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ASRM emphasizes that sexual dysfunction should be assessed during infertility care and that erectile and ejaculatory disorders can be treatable contributors.

Erectile Dysfunction

A man may have completely normal sperm but still struggle to achieve pregnancy because he cannot reliably complete vaginal intercourse.

Common contributors include:

- diabetes,
- vascular disease,
- medications,
- hormonal problems,
- performance anxiety,
- infertility-related psychological pressure.

Sexual function should therefore be discussed openly.

Retrograde Ejaculation

Normally, the bladder neck closes during ejaculation.

In retrograde ejaculation, semen flows backward into the bladder.

The man may experience orgasm but produce little or no semen.

Possible causes include:

- diabetes-related neuropathy,
- pelvic surgery,
- prostate surgery,
- certain medications.

AUA/ASRM notes that retrograde ejaculation may be treated medically in some patients or sperm may be recovered from post-ejaculatory urine for fertility treatment.

Psychological Stress

Infertility can create substantial psychological pressure.



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A couple may start timing every sexual encounter around ovulation.

Sex becomes a task.

The male partner may think:

“This is the only important day. I must perform.”

That pressure can produce:

- erectile difficulty,
- delayed ejaculation,
- loss of desire.

This does not mean the infertility is “psychological.”

It means an existing fertility problem has begun to affect sexual function as well.

Primary Infertility: Causes I Particularly Consider

Although almost any male factor can occur in either group, primary infertility makes me particularly alert to conditions that may have been present for many years, such as:

- congenital reproductive-tract abnormalities,
- undescended testes,
- genetic disorders,
- severe primary testicular dysfunction,
- congenital hormonal deficiency,
- lifelong sexual dysfunction.

A man who has never attempted conception before may have had one of these conditions without knowing it.

Secondary Infertility: Causes I Particularly Consider

In secondary infertility, my key question is:

What changed since the previous pregnancy?

I particularly review:

- newly developed varicocele,
- age,



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- weight gain,
- diabetes or metabolic disease,
- new medications,
- testosterone or anabolic-steroid use,
- genital infection,
- testicular trauma,
- surgery,
- cancer treatment,
- erectile or ejaculatory dysfunction,
- changes in lifestyle.

However, secondary infertility should still trigger **evaluation of both partners**.

The female partner's age and fertility may also have changed since the previous pregnancy.

The Previous Child May Have Been With a Different Partner

This situation needs careful interpretation.

If a man fathered children with a previous partner, his fertility was proven at that time.

It does not prove:

- his fertility is still normal today,
- his present partner has infertility,
- the current infertility is necessarily female-factor.

Similarly, if the female partner previously conceived with someone else, that does not guarantee her fertility is currently normal.

The correct approach is simultaneous evaluation of the current couple.

When Should a Couple Seek Fertility Evaluation?

The traditional WHO definition uses **12 months of regular unprotected intercourse** without pregnancy.

However, evaluation should sometimes begin earlier.



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ASRM recommends evaluation after approximately **six months** when the female partner is aged 35 or older and more immediate assessment when she is over 40 or when a known fertility problem exists.

Evaluation should also not be delayed when the man already has:

- undescended-testis history,
- testicular injury,
- chemotherapy,
- known azoospermia,
- severe oligospermia,
- major sexual dysfunction.

How I Evaluate Primary and Secondary Male Infertility

Modern guidelines recommend a structured male evaluation including:

- medical history,
- reproductive history,
- family history,
- lifestyle assessment,
- physical examination,
- semen analysis,
- hormonal evaluation,

with genetic and imaging investigations added when indicated.

At Saira Health Care, I apply this principle while also evaluating the sexual and reproductive-health concerns that brought the patient to consultation.

Step 1: Detailed Fertility History

I ask:

- How long has the couple been trying?
- Has any pregnancy ever occurred?
- With which partner?



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- How long ago?
- Was fertility treatment used?
- Was the previous pregnancy natural?
- Was it a miscarriage, ectopic pregnancy, stillbirth or live birth?
- Have there been repeated miscarriages?

This establishes whether infertility is primary or secondary and may suggest further testing.

Step 2: Sexual History

I assess:

- intercourse frequency,
- erection quality,
- libido,
- ejaculation,
- painful intercourse,
- timing of intercourse.

Some couples have completely normal fertility investigations but intercourse is too infrequent to maximize pregnancy chances.

ASRM notes that intercourse every one to two days during the fertile window maximizes the opportunity for natural conception.

Step 3: Medical History

I ask about:

- diabetes,
- thyroid disease,
- obesity,
- chronic systemic illness,
- childhood illnesses,
- testicular diseases.



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Male infertility can sometimes reveal an important health problem that has never previously been diagnosed.

Step 4: Surgical History

Important surgery includes:

- orchidopexy,
 - hernia surgery,
 - testicular surgery,
 - varicocele surgery,
 - pelvic operations,
 - vasectomy,
 - prostate surgery.
-

Step 5: Medication and Supplement History

I ask specifically about:

- testosterone,
- bodybuilding steroids,
- fertility supplements,
- herbal medicines,
- psychiatric medicines,
- chemotherapy,
- other long-term medications.

Patients sometimes omit supplements because they do not consider them medicines.

For fertility assessment, everything matters.

Step 6: Physical Examination

Current guidelines recommend examination of:

- secondary sexual characteristics,



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- testes,
- epididymis,
- vas deferens,
- spermatic cord,
- varicocele.

Testicular size and consistency can be particularly informative.

A very small testis can suggest impaired sperm production.

An absent vas deferens suggests a completely different diagnosis.

Semen Analysis — The Foundation of Male Fertility Testing

Semen analysis remains the basic laboratory investigation.

The WHO's sixth edition standardized modern semen laboratory procedures to improve reliability and comparison between laboratories.

A semen analysis evaluates:

- volume,
- sperm concentration,
- total sperm number,
- motility,
- morphology,
- sometimes vitality and additional parameters.

Importantly:

semen analysis alone cannot definitively classify a man as fertile or infertile.

Current EAU guidance specifically emphasizes this limitation.

Repeat Semen Testing

Semen parameters vary naturally.

Therefore, if an initial analysis is abnormal, EAU guidance recommends **at least two consecutive semen analyses** before drawing definitive conclusions.

This is particularly important when:



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- sperm concentration is unexpectedly low,
 - motility is poor,
 - one sample was incomplete,
 - the patient recently had fever.
-

Hormonal Evaluation

Depending upon the semen result and clinical picture, testing may include:

- total testosterone,
- FSH,
- LH,
- prolactin in selected patients.

The objective is not simply to identify “low testosterone.”

We want to determine **where the hormonal abnormality originates.**

Genetic Testing

Genetic investigation becomes particularly relevant in men with:

- azoospermia,
- severe oligospermia,
- small testes,
- elevated FSH,
- congenital absence of the vas deferens.

The **2024 AUA/ASRM amendment** recommends karyotype analysis in primary infertility with azoospermia or sperm concentration under 5 million/mL when there is evidence of impaired sperm production, and Y-chromosome testing particularly at sperm concentrations ≤ 1 million/mL in the appropriate clinical setting.

Genetic testing is not automatically required in every case of infertility.

Scrotal Ultrasound

Ultrasound is useful when there is a specific clinical indication.



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It may evaluate:

- testicular lesions,
- uncertain varicocele,
- epididymal abnormalities,
- other scrotal pathology.

AUA/ASRM does **not** recommend routine scrotal ultrasound for every infertile man simply as part of a standard package.

Sperm DNA Fragmentation

Sperm DNA fragmentation is heavily advertised, but it is not generally a routine first test for every infertile man.

AUA/ASRM does not recommend it as part of the initial evaluation of every couple.

It becomes more relevant in selected circumstances such as:

- recurrent pregnancy loss,
- repeated ART failure,
- unexplained infertility.

Current EAU guidance similarly recommends selective rather than universal use.

Treatment Depends on the Cause

The most important principle is:

There is no one medicine for male infertility.

The correct treatment for varicocele is different from the treatment for hormonal deficiency.

The treatment for obstruction is different from treatment for poor sperm production.

The management of erectile dysfunction is different from treatment of azoospermia.

Treating Varicocele

When an infertile man has:

- a clinical palpable varicocele,



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- abnormal semen parameters,
- otherwise suitable circumstances,

varicocele repair may improve semen parameters and pregnancy prospects.

Both AUA/ASRM and EAU guidance support treatment in appropriately selected men.

However, the female partner's reproductive age and ovarian reserve need consideration because improvement takes time.

Treating Hormonal Infertility

Hormonal treatment should be diagnosis-specific.

Men with hypogonadotropic hypogonadism may respond very well to:

- hCG,
- FSH-containing therapy,
- selected endocrine treatment.

Men with hyperprolactinemia may benefit from treatment of the prolactin disorder.

Men using anabolic steroids may need to stop them and allow the hormonal axis to recover.

The same treatment does not apply to everyone.

Testosterone Is Not Fertility Treatment

I repeat this because it is so important.

External testosterone should not be used as ordinary fertility treatment in men trying to conceive.

AUA/ASRM explicitly advises against testosterone monotherapy in men interested in present or future fertility.

A man with low testosterone who wants children needs a fertility-preserving endocrine strategy.

Treating Obstruction

Certain obstructive conditions may be treated through:



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- microsurgical reconstruction,
- treatment of ejaculatory-duct obstruction,
- sperm retrieval followed by IVF/ICSI.

AUA/ASRM guidance recognizes reconstructive surgery as a useful option for selected obstructive infertility, particularly when the female partner has good reproductive potential.

Treating Erectile and Ejaculatory Disorders

When infertility is partly due to difficulty completing intercourse, treatment of sexual dysfunction can sometimes restore the possibility of natural conception.

This may include management of:

- erectile dysfunction,
- retrograde ejaculation,
- anejaculation,
- hormonal deficiency.

The aim is not simply to improve sexual performance but to restore effective sperm deposition when possible.

Antibiotics Should Not Be Given Simply Because a Man Is Infertile

Not every sperm abnormality means infection.

Antibiotics should be directed toward a documented or clinically meaningful infection.

Repeatedly taking antibiotics for poor sperm count without evidence of infection may:

- fail to improve fertility,
- cause side effects,
- promote antimicrobial resistance.

Antioxidants and Fertility Supplements

The fertility market contains hundreds of supplements advertised as sperm boosters.

Some individual studies report improvements in semen parameters.



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However, the overall evidence is inconsistent.

Current EAU guidance states that evidence remains inconclusive for routine antioxidant treatment in idiopathic infertility, while AUA/ASRM advises that the clinical benefits of supplements and antioxidants are of questionable value and insufficient to recommend specific products universally.

This does not mean nutrition is unimportant.

It means:

supplements should not substitute for finding the cause of infertility.

Lifestyle Improvement

Lifestyle matters most when a genuine adverse factor is present.

I advise infertile men to address:

- smoking,
- obesity,
- physical inactivity,
- heavy alcohol use,
- anabolic steroid exposure,
- significant occupational toxins.

Current European guidance supports improving these factors because they are associated with reduced sperm quality.

Natural Conception

Many men with abnormal semen parameters can still contribute to natural pregnancy.

The probability depends upon:

- total sperm number,
- motility,
- morphology,
- sexual timing,
- duration of infertility,



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- female partner's age,
- ovarian reserve,
- tubal health.

Therefore, one abnormal laboratory number should not be interpreted in isolation.

Intrauterine Insemination — IUI

IUI involves preparing sperm in the laboratory and introducing concentrated motile sperm into the uterus around ovulation.

It can be useful in selected couples.

However, success falls when the available total motile sperm count is very low.

AUA/ASRM notes that IUI success becomes limited when fewer than roughly **5 million motile sperm remain after laboratory processing**, and IVF/ICSI may be considered.

IVF

In vitro fertilization involves fertilizing eggs in the laboratory.

It may be used when:

- male infertility is significant,
 - female factors coexist,
 - simpler treatments have failed.
-

ICSI

Intracytoplasmic sperm injection, or ICSI, has transformed treatment of severe male-factor infertility.

In this technique, an embryologist selects one sperm and injects it directly into a mature egg.

AUA/ASRM guidance notes that ICSI can overcome much of the adverse effect of poor sperm concentration, motility and morphology as long as viable sperm are available for injection.

This allows some men with extremely poor semen parameters to achieve biological fatherhood.



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Surgical Sperm Retrieval

If sperm are absent from the ejaculate, they may sometimes still be obtained surgically.

Depending upon the diagnosis, sperm can be retrieved from:

- epididymis,
- testis.

For men with non-obstructive azoospermia undergoing sperm retrieval, AUA/ASRM recommends **microdissection testicular sperm extraction—micro-TESE**.

These sperm can potentially be used for ICSI.

Primary Infertility Does Not Mean Treatment Will Be More Difficult

Some patients assume:

“If I have never caused a pregnancy, my condition must be worse.”

Not necessarily.

A man with primary infertility may have a very treatable hormonal disorder.

Another may have a correctable varicocele.

Meanwhile, a man with secondary infertility may have severe progressive testicular failure.

Primary versus secondary infertility describes history—not severity.

Secondary Infertility Does Not Mean Treatment Will Be Easy

Likewise:

“We conceived once before, so it will happen again.”

Unfortunately, this cannot be guaranteed.

Both partners may have aged.

A new medical disorder may have developed.

Sperm quality may have changed.

The female partner's ovarian reserve may be lower.

Treatment must reflect present circumstances.



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Importance of Female Age

Even when the male factor is clearly identified, the female partner's age profoundly influences fertility planning.

ASRM identifies female age as one of the strongest predictors of reproductive success and recommends earlier evaluation when the female partner is aged 35 or above.

For example:

A man with varicocele and mildly abnormal semen whose partner is 25 may reasonably have time for treatment and reassessment.

The same man with a 40-year-old partner may require a much faster fertility plan.

Recurrent Pregnancy Loss and the Male Partner

Male evaluation is also relevant when pregnancy repeatedly occurs but ends in miscarriage.

This is technically different from ordinary infertility, but male factors may still contribute.

AUA/ASRM recommends male karyotype assessment and sperm DNA fragmentation testing in selected couples with recurrent pregnancy loss.

The male partner should therefore not automatically be excluded because conception occurred.

Unexplained Male Infertility

Sometimes:

- history is normal,
- examination is normal,
- hormones are normal,
- genetic testing is unrevealing,
- no clear disease is identified,

yet semen remains abnormal or conception does not occur.



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EAU notes that in a substantial proportion of male infertility cases, no definitive male-associated explanation is identified. Previously this was commonly described as **idiopathic male infertility**.

Possible mechanisms continue to be investigated, including:

- oxidative stress,
- environmental endocrine disruption,
- genetic changes not detected on routine testing,
- epigenetic factors.

The Unani Perspective on Male Infertility

As a physician trained in Unani medicine and working with sexual disorders and infertility, I approach male infertility as a condition involving not only the semen report but the reproductive health of the entire patient.

Classical Unani medicine discusses abnormalities of sperm quantity and reproductive capacity through concepts such as:

Qillat-e-Huwaniya — reduced sperm quantity or oligospermia-related states, together with assessment of:

- **Mizaj** or constitutional temperament,
- reproductive-organ function,
- general strength,
- nutrition,
- digestion,
- sleep,
- physical activity,
- emotional condition,
- sexual function.

This broad approach can complement modern infertility assessment when used responsibly.

The Importance of Asbab-e-Sitta Zarooriya



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Traditional Unani medicine places great importance on the **six essential factors of health**, commonly discussed as *Asbab-e-Sitta Zarooriya*.

These include principles relating to:

- air and environment,
- food and drink,
- movement and rest,
- sleep and wakefulness,
- psychological state,
- retention and elimination.

In a man with infertility, this framework encourages us to consider the patient beyond one laboratory value.

For example:

Is he obese?

Does he smoke?

Does he sleep properly?

Is diabetes controlled?

Is he taking anabolic steroids?

Is sexual activity regular?

Are digestive and general-health problems being ignored?

This whole-patient assessment fits well with modern medicine's increasing recognition that metabolic and lifestyle health can influence reproductive function.

What Does Unani Research Show?

There is published Unani clinical research in men with oligospermia.

A CCRUM-associated retrospective analysis from investigators at A.K. Tibbiya College, Aligarh Muslim University examined earlier studies involving **126 men with idiopathic oligospermia** treated with various Unani formulations and reported improvements in different semen parameters, including sperm count and motility in some groups.

Researchers at the National Institute of Unani Medicine have also conducted observational clinical work investigating classical Unani formulations in oligospermia.



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This demonstrates that male infertility is an active field of Unani clinical research.

However, these studies have important limitations.

Many are:

- relatively small,
- observational,
- uncontrolled,
- based on older semen-reference definitions,
- focused on semen parameters rather than pregnancy or live-birth outcomes.

Therefore, they cannot prove that one Unani medicine will cure all primary or secondary male infertility.

Why This Evidence Still Matters

The correct conclusion is not:

“Unani medicine has no role.”

Nor is the correct conclusion:

“Unani medicine can cure every infertility problem.”

The more scientifically appropriate interpretation is:

some traditional Unani approaches have preliminary clinical evidence for improving selected semen parameters, but larger modern randomized trials using current WHO semen standards, pregnancy rates and live-birth outcomes are still needed.

This is how I prefer to present Unani medicine professionally.

Where Unani Medicine May Be Particularly Useful

After serious and treatable causes have been appropriately investigated, individualized Unani management may have a supportive role in selected patients with:

- idiopathic oligospermia,
- impaired general reproductive health,
- lifestyle and nutritional concerns,



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- associated sexual-health symptoms,
- general weakness or metabolic concerns.

But its use should depend upon the diagnosis.

Five Men With Infertility Need Five Different Plans

Consider five patients.

Patient 1

Never achieved pregnancy, has very small testes, very high FSH and severe oligospermia.

Patient 2

Previously fathered two children but now has a large clinical varicocele and deteriorating semen parameters.

Patient 3

Previously fertile but started bodybuilding testosterone injections and now has azoospermia.

Patient 4

Primary infertility with very low LH, FSH and testosterone because of pituitary disease.

Patient 5

Normal evaluation apart from moderate idiopathic oligospermia.

All five men are infertile.

But their treatment should **not** be identical.

Giving the same herbal or conventional medicine to all five would ignore the actual biology of their conditions.

My Integrative Approach at Saira Health Care

At **Saira Health Care**, my first goal is to define the fertility problem correctly.

I ask:

Is this primary or secondary infertility?

Then:



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What changed?

Then:

Is sperm production abnormal?

Is sperm transport abnormal?

Is the hormone system abnormal?

Is there a varicocele?

Is a medicine suppressing spermatogenesis?

Is sexual dysfunction preventing conception?

Is genetic evaluation required?

What is the female partner's fertility status?

Only then do I decide how Unani treatment can be responsibly incorporated.

Special Treatment Planning by Dr. Nizamuddin Qasmi

My focused practice in **Sexual Disorders & Infertility** allows the infertility assessment to include both reproductive and sexual factors.

Depending upon the patient's presentation, evaluation may include:

- detailed reproductive history,
- classification as primary or secondary infertility,
- sexual history,
- semen analysis,
- repeat semen testing,
- hormonal assessment,
- examination of testes,
- varicocele assessment,
- review of childhood and surgical history,
- medication and steroid review,
- lifestyle and metabolic assessment,
- genetic evaluation or referral when indicated,



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- consideration of obstruction,
- assessment of erectile and ejaculatory function.

Where appropriate, an individualized Unani treatment plan can be integrated with contemporary fertility care.

What “Special Treatment” Should Mean

In my view, special treatment should not mean giving a secret medicine to every patient.

It should mean:

treating the specific patient rather than treating the word “infertility.”

A patient with varicocele needs attention to the varicocele.

A patient with hormonal deficiency needs proper endocrine treatment.

A patient using anabolic steroids must stop the causative exposure.

A patient with significant genetic infertility requires counselling.

A patient whose main problem is erectile dysfunction may need sexual-medicine treatment.

A patient with idiopathic oligospermia may be considered for individualized supportive therapy.

That is a more rational and professional approach.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At **Saira Health Care**, our clinical focus includes the close relationship between fertility and sexual health.

Infertile men may also experience:

- erectile dysfunction,
- premature ejaculation,
- low sexual desire,
- painful ejaculation,
- performance anxiety,
- chronic pelvic symptoms.



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These conditions should be evaluated rather than assumed to be consequences of “weakness.”

Similarly, couples may require guidance regarding:

- fertile-window timing,
- semen analysis,
- fertility treatment,
- IUI,
- IVF,
- ICSI,
- appropriate referrals.

The objective is not simply to increase sperm count.

The ultimate objective is to help the couple achieve their reproductive goal safely and realistically.

Why Treating the Couple Matters

Male infertility treatment can sometimes require several months.

During that time, the female partner is also ageing.

Therefore, treatment decisions should be based upon **couple prognosis**, not male laboratory improvement alone.

Current EAU guidance strongly recommends simultaneous investigation of both partners.

This is particularly important in secondary infertility, where people sometimes incorrectly assume that because the couple conceived before, both partners must still have normal fertility.

How Long Does Male Fertility Treatment Take?

Sperm do not change overnight.

Spermatogenesis requires several weeks, followed by additional maturation and transport.



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Therefore, treatments designed to improve sperm production generally need to be evaluated over **months rather than days**.

This is one reason advertisements promising major sperm improvement within a few days should be treated cautiously.

Preventing Male Infertility Where Possible

Not every case is preventable.

Genetic disorders and many congenital conditions cannot simply be prevented through lifestyle.

However, some reproductive risks can be reduced.

Useful measures include:

- avoid tobacco,
- avoid anabolic steroids,
- avoid unnecessary testosterone,
- maintain appropriate weight,
- exercise regularly,
- manage diabetes,
- reduce heavy alcohol intake,
- obtain early treatment for genital infections,
- protect the testes from injury,
- discuss sperm preservation before gonadotoxic cancer therapy.

WHO's 2025 infertility guideline specifically emphasizes prevention alongside diagnosis and treatment and highlights risks including untreated STIs and tobacco use.

Frequently Asked Questions

What is primary male infertility?

It means a pregnancy has never previously been achieved with the man's reproductive contribution and the current couple meets the clinical criteria for infertility.

WHO defines primary infertility as infertility when a pregnancy has never been achieved.



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What is secondary male infertility?

Secondary infertility occurs when at least one previous pregnancy has been achieved, but pregnancy can no longer be achieved despite current attempts.

Does the previous pregnancy need to have resulted in a child?

Under the current WHO definition, secondary infertility is based on a **previous pregnancy**, not necessarily a previous live birth.

Can a man become infertile after having children?

Yes.

Varicocele, ageing, hormonal problems, diabetes, infections, surgery, medications, anabolic steroids, chemotherapy and other conditions can reduce fertility later.

Does secondary infertility mean the woman is responsible?

No.

A man who previously fathered a pregnancy can still develop male-factor infertility.

Both partners should be reassessed.

Is primary infertility more severe than secondary infertility?

Not necessarily.

The terms describe reproductive history, not disease severity.

Can varicocele cause secondary infertility?

Yes.

Varicocele is frequently identified in men presenting with secondary infertility and may be associated with progressive deterioration of testicular function in some patients.

Can testosterone cause secondary infertility?

Yes.

External testosterone can suppress LH and FSH and markedly reduce sperm production.

It should not be used as standard testosterone replacement in a man actively trying to conceive.

Can bodybuilding steroids make a previously fertile man infertile?

Yes.

Anabolic steroids can suppress sperm production severely, sometimes producing azoospermia.

Recovery after stopping them can take months and varies among individuals.

Can infection cause secondary infertility?

Certain genital infections can damage the testes or cause reproductive-tract obstruction.

Appropriate investigation is required rather than assuming infection from the semen report alone.

Does having normal sexual performance mean sperm must be normal?

No.

A man can have excellent erections and ejaculation but severely abnormal sperm production.

Sexual function and fertility are related but distinct.

Does having low sperm count cause erectile dysfunction?

Usually not directly.

However, hormonal disorders may cause both low sperm production and sexual symptoms.

Psychological stress related to infertility can also influence erections.



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How many semen tests are needed?

When the first semen analysis is abnormal, current EAU guidance recommends at least **two consecutive analyses** before definitive interpretation.

Can one normal semen analysis prove fertility?

No.

Semen testing provides important information but cannot absolutely classify a man as fertile or infertile by itself.

Do I need hormone tests?

Hormone testing becomes especially important with abnormal sperm production, azoospermia, low libido, small testes or signs of endocrine disease.

FSH, LH and testosterone are among the most useful hormones.

Do I need genetic testing?

Not everyone does.

It is particularly relevant in severe oligospermia, azoospermia and clinical patterns suggesting significant impaired sperm production.

Should every infertile man have an ultrasound?

No.

Scrotal or transrectal ultrasound should be selected when the examination or semen pattern suggests a specific reason. Routine imaging of every infertile man is not recommended.

Should I get sperm DNA fragmentation testing?

Not routinely as the first investigation.

It is more useful in selected situations such as recurrent pregnancy loss, failed ART or unexplained infertility.



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Can primary male infertility be treated?

Often yes, depending upon the cause.

Potentially treatable conditions include:

- varicocele,
- selected hormonal disorders,
- some obstructive abnormalities,
- ejaculatory dysfunction,
- medication-related suppression.

Other patients may require IVF/ICSI.

Can secondary male infertility be treated?

Yes.

Treatment depends upon what changed after the previous pregnancy.

For example, addressing steroid use, varicocele, hormonal disease or sexual dysfunction may improve reproductive potential in selected patients.

Can Unani medicine help male infertility?

Unani medicine has a long tradition of treating male reproductive disorders, and published Unani clinical studies have reported improvements in selected semen parameters among some men with idiopathic oligospermia.

However, evidence remains insufficient to claim that Unani treatment cures every cause of primary or secondary male infertility.

I therefore consider it most useful within an **individualized integrative plan after identifying important genetic, hormonal, anatomical and sexual causes.**

Can Unani medicine treat azoospermia?

Azoospermia has multiple causes.

A man with obstructive azoospermia requires a different approach from a man with severe genetic testicular failure.



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No responsible treatment should promise that one herbal formulation will restore sperm in every case.

Can supplements cure unexplained infertility?

Current major guidelines find the clinical usefulness of routine antioxidant or fertility supplements uncertain.

They should not replace proper evaluation.

When should IVF/ICSI be considered?

It may be considered when:

- sperm parameters are severely abnormal,
 - treatment of the male factor is unsuccessful,
 - the female partner's reproductive age makes delay undesirable,
 - significant male and female factors coexist,
 - sperm have been surgically retrieved.
-

Does ICSI guarantee pregnancy?

No.

ICSI improves the opportunity for fertilization in severe male-factor infertility, but pregnancy also depends upon:

- egg quality,
 - embryo development,
 - uterine factors,
 - female age,
 - other reproductive variables.
-

A Message From Dr. Nizamuddin Qasmi

When a couple comes to me with secondary infertility and says:

“Doctor, we already have one child, so I don't think the husband needs testing,”



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I explain very clearly:

Fertility is not fixed for life.

The semen that produced a pregnancy seven years ago is not the semen report of today.

The man's health may have changed.

The woman's fertility may also have changed.

This is why the present couple should be assessed based upon their **present reproductive health**.

Likewise, when a man with primary infertility becomes frightened because he has never achieved a pregnancy, I explain:

Primary does not automatically mean permanent.

Some causes are treatable.

Some can be corrected surgically.

Some can be treated hormonally.

Some couples need IUI.

Some require IVF/ICSI.

And some men with very poor semen parameters can still become biological fathers.

The first step is not fear.

The first step is diagnosis.

Current Medical Understanding

The latest medical approach to infertility has moved increasingly toward **person-centred and couple-centred care**.

WHO issued its first comprehensive global guideline for infertility prevention, diagnosis and treatment in **November 2025**, emphasizing evidence-based fertility care and appropriate prevention and treatment rather than reliance on unproven therapies.

Current EAU guidance recommends that:

- both partners be investigated simultaneously,
- male evaluation include reproductive history, examination, semen analysis and hormones,
- abnormal semen analyses be repeated,



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- genetic or imaging tests be selected according to the clinical picture.

The 2024 AUA/ASRM update has also refined genetic-testing criteria, particularly in men with severe impaired sperm production.

This means modern male infertility treatment is increasingly moving away from:

“Your sperm count is low—take a supplement.”

toward:

“Why is your fertility impaired, and what is the best reproductive strategy for this couple?”

Conclusion

Primary and secondary male infertility are classifications of reproductive history, not separate diseases.

Primary infertility means a pregnancy has never previously been achieved.

Secondary infertility means at least one pregnancy occurred in the past but pregnancy is not now occurring despite appropriate attempts.

The possible male causes include:

- oligospermia,
- severe oligospermia,
- azoospermia,
- poor sperm motility,
- abnormal morphology,
- varicocele,
- hormonal abnormalities,
- genetic disease,
- undescended testes,
- testicular damage,
- genital infection,
- obstruction,
- anabolic steroid or testosterone use,



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- cancer treatment,
- metabolic disease,
- erectile or ejaculatory dysfunction.

Secondary infertility should never be dismissed simply because the man has previously fathered a pregnancy.

Likewise, primary infertility does not automatically mean that successful treatment is impossible.

Evaluation should include:

- detailed reproductive and sexual history,
- examination,
- semen analysis,
- repeat semen analysis when abnormal,
- hormonal assessment,
- genetic testing where indicated,
- imaging where clinically necessary,
- parallel evaluation of the female partner.

Treatment is then directed toward the cause.

Options may include:

- lifestyle modification,
- varicocele repair,
- hormonal treatment,
- treatment of obstruction,
- management of erectile or ejaculatory dysfunction,
- IUI,
- IVF,
- ICSI,
- surgical sperm retrieval.



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From the **Unani perspective**, male reproductive health can be considered within the broader context of constitution, nutrition, digestion, lifestyle, sexual function and general wellbeing.

Published Unani research has demonstrated potential improvement in selected semen parameters in men with idiopathic oligospermia, but the current evidence does not justify claiming that one formulation can cure all male infertility.

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

understand whether infertility is primary or secondary, identify the male factor, assess the female partner simultaneously, correct reversible problems, improve reproductive and general health, incorporate individualized Unani supportive treatment where appropriate, and use modern assisted reproduction when it offers the couple the best realistic opportunity for pregnancy.

The most important message I give every patient is:

Previous fertility does not guarantee fertility today—and never having achieved a pregnancy does not mean there is no hope.

What matters is identifying the present cause and choosing the correct treatment for the present couple.

About the Author

Dr. Nizamuddin Qasmi

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

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health (ISRH) — UNFPA

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** focuses on sexual disorders, male and female reproductive-health concerns and infertility.



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His approach to male infertility emphasizes understanding the patient's complete reproductive and sexual history rather than treating fertility simply according to one semen-analysis value.

Where clinically appropriate, principles of Unani medicine are integrated with contemporary semen assessment, hormonal evaluation, genetic investigation, urological assessment and modern fertility-treatment planning.

Medical Disclaimer

This article is intended for health education and general public awareness. It does not establish an individual diagnosis and does not replace consultation, examination or treatment by an appropriately qualified fertility specialist, male reproductive urologist, gynecologist or other healthcare professional.

Primary and secondary infertility may have male, female, combined or unexplained causes.

Men should not begin testosterone injections, anabolic steroids, prescription fertility hormones or herbal/Unani infertility medicines without appropriate professional assessment.

Severe sperm abnormalities, azoospermia, testicular lumps, significant testicular atrophy, unexplained hormonal abnormalities and suspected genetic infertility require appropriate specialist evaluation.

Fertility treatment should generally be planned for the **couple**, because the age, ovarian reserve and reproductive health of the female partner can substantially influence the appropriate timing and choice of treatment.



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