Uterine Fibroids (Leiomyoma / Myoma / Sal'āt al-Raḥim)

Causes, Symptoms, Diagnosis, Fertility Effects, Modern Treatment and the Unani Approach

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Introduction

Uterine fibroids are among the most common benign growths affecting the uterus. In my clinical practice, women often come to me frightened after reading an ultrasound report mentioning a **"fibroid," "myoma," "leiomyoma," or "uterine mass."** Their first questions are usually:

"Doctor, is this cancer?"
"Will it become cancer later?"
"Will I be able to become pregnant?"
"Will I need my uterus removed?"

The first thing I want women to understand is that **uterine fibroids are benign, or non-cancerous, growths arising mainly from the smooth muscle and connective tissue of the uterus**. They are also called *leiomyomas* or *myomas*. Mayo Clinic's latest September 2026 guidance emphasizes that fibroids are not cancer and almost never transform into cancer.

Another equally important fact is that **not every fibroid requires treatment**.

Some women have one very small fibroid that causes no symptoms throughout life. Another woman may have several fibroids and develop heavy bleeding, anemia, pelvic pressure or infertility. A third woman may have a relatively small fibroid inside the uterine cavity that affects fertility more than a much larger fibroid situated on the outside of the uterus.

Therefore, size alone does not decide everything.

The **number, location, symptoms, age of the woman and future fertility plans** are all important.

In Unani medicine, uterine fibroids are commonly discussed under the term **Sal'āt al-Raḥim**, referring to a tumour or growth involving the uterus. Contemporary Unani literature also evaluates the condition through concepts such as **Mizaj**, *Akhlat* and particularly certain *Balghami* patterns. A 2025 observational study from a Unani women's-health department reported different temperamental patterns among women with fibroids, with *Balghami Mizaj* being the most frequent in that particular sample.

At **Saira Health Care**, I prefer an integrated and individualized approach. I use the holistic strengths of Unani medicine—dietary regulation, lifestyle assessment, Mizaj and carefully selected treatment—while also using modern ultrasound, blood tests, fertility evaluation and gynecological referral whenever required.

The objective is not merely to "remove a fibroid."

The objective is to treat **the woman and the problems the fibroid is actually causing**.

What Exactly Is a Uterine Fibroid?

A fibroid develops from the muscular layer of the uterus, known as the **myometrium**.

Fibroids may occur as a single growth or as multiple growths of very different sizes.

Some are only a few millimetres across.

Others may become several centimetres in diameter and, in uncommon cases, become large enough to noticeably enlarge the abdomen.

The growth pattern is also unpredictable. A fibroid may remain almost unchanged for years, grow gradually, sometimes enlarge more rapidly or shrink later in life.

Fibroids commonly tend to become smaller after menopause as reproductive hormone levels decrease, although this does not happen in every patient. ACOG notes that reduction in estrogen around menopause can lead to fibroid shrinkage in many women.

Fibroids Are Not the Same as Ovarian Cysts

This is a very common misunderstanding.

A **fibroid** is a solid benign growth arising from uterine muscle.

An **ovarian cyst** is a fluid-containing or partly solid structure arising from an ovary.

They are different conditions.

Likewise, fibroids should not be confused with:

- PCOS/PMOS.

- Adenomyosis.
- Endometriosis.
- Endometrial polyps.
- Ovarian tumours.

These conditions can sometimes produce overlapping symptoms such as heavy menstruation or pelvic pain, which is why ultrasound and clinical assessment are valuable.

Where Can Fibroids Develop?

The location of a fibroid is extremely important because location often influences symptoms and fertility more than size alone.

Intramural Fibroids

These grow **within the muscular wall of the uterus**.

They are among the most common types.

Small intramural fibroids may cause no problem. Larger ones may increase menstrual bleeding, produce pelvic heaviness or enlarge the uterus.

Submucosal Fibroids

These project **toward or into the uterine cavity**.

Submucosal fibroids are especially important when a woman has:

- Heavy menstruation.
- Infertility.
- Repeated pregnancy loss.
- Difficulty with embryo implantation.

Even a relatively small fibroid can matter if it distorts the uterine cavity.

A recent 2025 review of fibroids and fertility emphasizes that submucosal fibroids and other fibroids distorting the endometrial cavity are the fibroid types most clearly associated with impaired implantation and pregnancy loss.

Subserosal Fibroids

These grow toward the **outer surface of the uterus**.

They are less likely to interfere directly with the uterine cavity, but a large subserosal fibroid may create pressure symptoms affecting the bladder or bowel.

Pedunculated Fibroids

Some fibroids are connected to the uterus by a stalk.

They may project either toward the cavity or outward from the uterus.

The Mayo Clinic's updated 2026 guidance uses the same major anatomical classification: intramural, submucosal and subserosal fibroids, with some growing on a stalk.

How Common Are Uterine Fibroids?

Fibroids are extremely common during the reproductive years.

Many women never know they have them because the fibroids produce no symptoms and are discovered accidentally during an ultrasound or routine examination.

Recent Mayo Clinic material describes uterine fibroids as the most common pelvic lesions among premenopausal women and notes that lifetime prevalence may be very high, although the exact estimate varies depending on age, ethnicity and whether ultrasound screening is used.

Fibroids are particularly common during the 30s and 40s, although they can occur earlier.

What Causes Uterine Fibroids?

We still do not know one single cause.

This is important because patients are often told that their fibroids developed because they ate the wrong food or because they failed to exercise.

That is an oversimplification.

Modern evidence suggests that several biological factors interact.

Genetic Changes

Many fibroids contain genetic changes that differ from normal uterine muscle.

A family tendency is also well recognized.

If a mother or sister has fibroids, the risk may be higher.

Estrogen and Progesterone

Estrogen and progesterone appear to promote fibroid growth.

Fibroids contain receptors for these hormones and commonly develop during reproductive years.

They often become smaller after menopause as hormone levels decline.

However, it would be inaccurate to say that every patient has “high estrogen.”

The issue is biologically more complex than one blood hormone measurement.

Growth Factors

Biological substances involved in tissue growth, including insulin-like growth factors, may influence fibroid development.

Extracellular Matrix

Fibroid tissue contains increased **extracellular matrix**, the structural material surrounding cells.

This contributes to the characteristically firm, fibrous nature of these tumours and also influences cell signalling.

Risk Factors

Certain factors are associated with a higher likelihood of fibroids.

These include:

- Increasing reproductive age, especially the 30s and 40s.
- Family history of uterine fibroids.
- Earlier age at first menstruation.
- Obesity.
- Certain ethnic backgrounds.

Fibroids are especially common and may occur at younger ages or behave more severely among Black women. Both ACOG and Mayo Clinic recognize this important health disparity.

Diet and vitamin D status are also being investigated, but these associations do not mean that a particular food directly causes a fibroid.

Symptoms of Uterine Fibroids

Many women have no symptoms at all.

When symptoms occur, they depend mainly upon the **location, number and size of the fibroids**.

Common symptoms include:

- Heavy menstrual bleeding.
- Periods lasting longer than usual.
- More frequent menstruation.
- Passage of large blood clots.
- Painful menstrual cramps.
- Pelvic heaviness or pressure.
- Lower abdominal pain.
- Lower-back pain.
- Frequent urination.
- Difficulty completely emptying the bladder.
- Constipation.
- Abdominal enlargement.
- Pain during sexual intercourse.
- Fatigue or weakness caused by anemia.
- Fertility problems in selected women.
- Pregnancy complications in some cases.

Current Mayo Clinic and ACOG guidance list heavy or prolonged menstruation, pelvic pressure, urinary symptoms, constipation, lower-back or abdominal pain and pain during sex among the most common manifestations.

Heavy Menstrual Bleeding

Heavy menstruation is one of the symptoms most likely to bring a woman to the clinic.

She may tell me:

“Doctor, my period lasts eight or ten days.”

or:

“I need to change pads almost every hour.”

or:

“Large clots keep coming.”

Chronic blood loss can cause **iron-deficiency anemia**.

Symptoms of anemia can include:

- Fatigue.
- Weakness.
- Breathlessness with activity.
- Dizziness.
- Headache.
- Palpitations.
- Reduced concentration.

Therefore, when a patient with fibroids has significant heavy bleeding, I generally consider a **complete blood count and, where appropriate, iron assessment**.

Mayo Clinic specifically recommends laboratory evaluation for anemia in women with irregular or heavy bleeding.

Pain and Pelvic Pressure

Fibroids may cause a feeling of heaviness rather than sharp pain.

Some women describe:

“It feels as if there is weight in my lower abdomen.”

Larger fibroids can press against surrounding organs.

Pressure on the bladder may produce frequent urination.

Pressure toward the rectum may cause constipation or difficulty passing stool.

Occasionally, a fibroid can outgrow its blood supply and undergo degeneration, producing sudden significant pain.

Sudden severe pelvic pain requires medical evaluation rather than simply assuming ordinary fibroid discomfort.

Pain During Sexual Intercourse

Fibroids can sometimes contribute to **dyspareunia**, or painful intercourse.

The exact mechanism depends upon the location of the fibroid and other pelvic conditions.

However, fibroids are not the only cause of intercourse pain.

Other possibilities include:

- Endometriosis.
- Adenomyosis.
- Pelvic inflammatory disease.
- Vaginal dryness.
- Pelvic-floor dysfunction.

Therefore, I do not automatically blame every sexual pain complaint on an ultrasound finding of fibroids.

Uterine Fibroids and Infertility

This is one of the subjects most relevant to my focused practice in **sexual disorders and infertility**.

First, I want patients to understand:

Most women with uterine fibroids are not infertile.

ACOG specifically notes that fibroids can contribute to infertility, but other causes are more common and should be investigated before automatically considering a fibroid responsible.

The location of the fibroid is particularly important.

Submucosal fibroids and fibroids that distort the uterine cavity have the strongest association with fertility problems.

These may interfere with:

- Embryo implantation.
- Endometrial receptivity.
- The shape of the uterine cavity.
- Early pregnancy.

The 2025 fertility review cited earlier concluded that fibroids involving or distorting the uterine cavity can impair conception and potentially increase spontaneous pregnancy loss.

Does Every Fibroid Need to Be Removed Before Pregnancy?

No.

This is a major clinical mistake I try to prevent.

A woman should not automatically undergo surgery simply because ultrasound shows a fibroid.

Before deciding upon myomectomy, we consider:

- Location.
- Size.
- Number.
- Whether the uterine cavity is distorted.
- Previous pregnancy losses.
- Age.
- Duration of infertility.
- Ovarian reserve when relevant.
- Tubal status.
- Semen analysis of the male partner.
- Previous fertility treatment.

For fertility alone, surgical treatment of fibroids that **do not disturb the uterine cavity remains much more controversial**.

This is why individualized fertility assessment is essential.

Fibroids and Pregnancy

Many women with fibroids have completely normal pregnancies.

However, depending upon size and location, fibroids may increase the likelihood of certain complications, including:

- Pregnancy loss in selected circumstances.
- Preterm delivery.
- Placental problems.
- Fetal growth problems.
- Pain due to fibroid degeneration.

Mayo Clinic notes that fibroids, particularly some submucosal lesions, may contribute to infertility or pregnancy loss and may also increase risks such as placental abruption, fetal growth restriction and preterm birth.

A woman with fibroids who becomes pregnant therefore needs appropriate obstetric follow-up, not panic.

Are Fibroids Cancer?

Fibroids themselves are **benign**.

A rare cancer called **uterine leiomyosarcoma** arises from uterine smooth muscle, but current medical understanding does not suggest that ordinary fibroids routinely transform into leiomyosarcoma.

This distinction is important because many patients are frightened by the word “tumour.”

Tumour simply means an abnormal growth. It does not automatically mean cancer.

However, a pelvic mass that is atypical, especially after menopause or associated with unusual clinical findings, deserves appropriate investigation.

Rapid growth alone cannot reliably diagnose cancer, but unexpected growth or an uncertain diagnosis may lead the clinician to obtain MRI or specialist evaluation.

How Are Uterine Fibroids Diagnosed?

Medical History

I first ask about:

- Menstrual flow.
- Duration of bleeding.
- Clots.
- Pain.
- Urinary symptoms.
- Constipation.
- Sexual pain.
- Fertility concerns.
- Previous pregnancies.

- Family history.
- Age.
- Medication use.

Pelvic Examination

A significantly enlarged or irregular uterus may sometimes be detected during pelvic examination.

Ultrasound

Ultrasound is usually the most important first imaging test.

Both transabdominal and transvaginal ultrasound can help identify:

- Fibroid size.
- Number.
- Location.
- Relationship to the uterine cavity.

A 2025 rapid evidence review identifies combined transvaginal and transabdominal ultrasonography as the initial imaging approach for fibroid evaluation.

MRI

MRI is not required for every woman with fibroids.

It may be useful when:

- Fibroids are numerous.
- The uterus is very enlarged.
- Ultrasound is inconclusive.
- Treatment planning requires more anatomical detail.
- An unusual uterine tumour needs further evaluation.

Mayo Clinic's current 2026 guidance recommends MRI selectively rather than as a routine test for every patient.

Saline Infusion Sonography

A **sonohysterogram**, or saline infusion ultrasound, can give a clearer picture of the uterine cavity.

It is particularly useful when:

- Heavy bleeding is present.
- Submucosal fibroids are suspected.
- Fertility is a concern.

A small amount of sterile fluid is placed into the uterus before ultrasound so the cavity can be visualized more clearly.

Hysteroscopy

Hysteroscopy allows direct visualization of the uterine cavity using a thin telescope passed through the cervix.

It can be particularly useful for diagnosing and sometimes treating submucosal fibroids.

ACOG and Mayo Clinic both recognize hysteroscopy as an important option when fibroids involve the uterine cavity.

Blood Tests

Fibroid diagnosis itself is not made through blood tests.

However, blood tests can help identify consequences or alternative explanations.

These may include:

- CBC for anemia.
- Iron studies.
- Thyroid testing when bleeding patterns suggest another disorder.
- Pregnancy testing where relevant.

Investigations should be selected according to the patient's clinical situation.

Does Every Fibroid Require Treatment?

No.

This is one of the most important principles of fibroid management.

If a fibroid is:

- Small.
- Not causing significant bleeding.
- Not causing pain.
- Not producing pressure symptoms.
- Not affecting fertility.
- Not clinically suspicious.

then **observation may be entirely appropriate**.

ACOG and Mayo Clinic both recommend watchful waiting for many asymptomatic or mildly symptomatic women.

A fibroid is not something that must automatically be “removed from the body.”

When Treatment Is More Likely to Be Needed

Treatment becomes more important when there is:

- Heavy bleeding causing anemia.
- Periods seriously affecting daily life.
- Severe pelvic pain.
- Significant bladder or bowel pressure.
- Rapidly increasing abdominal bulk.
- Persistent pain during intercourse.
- Infertility where fibroids are likely contributing.
- Repeated pregnancy loss associated with cavity distortion.
- Uncertainty regarding the diagnosis.

The treatment should then be selected according to the woman's goals.

Modern Medical Treatment

There is **no single best treatment for every patient**.

The Mayo Clinic's updated September 2026 guidance explicitly emphasizes individualized treatment based on symptoms, fibroid characteristics and fertility preferences.

Tranexamic Acid

Tranexamic acid is a **non-hormonal medicine** used during menstruation to reduce heavy bleeding.

It does not remove or shrink the fibroid.

Its role is symptom control.

ACOG and NICE include tranexamic acid among established treatments for fibroid-related heavy menstrual bleeding.

NSAIDs and Pain Relief

Medicines such as ibuprofen may help reduce menstrual pain.

They can be useful when cramps are a major symptom.

However, NSAIDs do not shrink fibroids. Mayo Clinic specifically notes that their main role is pain relief rather than fibroid treatment.

Hormonal Contraception

Combined hormonal contraception or progestin-based methods may reduce menstrual bleeding in selected women.

The main objective is symptom control.

They do not necessarily eliminate fibroids.

The choice of hormonal treatment depends upon:

- Age.
- Blood pressure.
- Smoking.
- Migraine history.
- Blood-clot risk.
- Fertility goals.
- Other medical conditions.

Levonorgestrel-Releasing IUD

A hormonal IUD can significantly reduce heavy menstruation in suitable women.

However, the fibroid should not substantially distort the uterine cavity.

ACOG notes that the levonorgestrel-releasing IUD reduces bleeding but does **not remove the fibroid itself**.

NICE considers it an important treatment for heavy menstrual bleeding in women with smaller fibroids that do not distort the uterine cavity.

GnRH Agonists

GnRH agonists temporarily suppress ovarian hormone production.

They may:

- Stop menstruation.
- Improve anemia.
- Reduce fibroid size temporarily.

They are sometimes used before surgery.

However, they can cause menopause-like side effects such as:

- Hot flashes.
- Vaginal dryness.
- Bone loss.

Fibroids often increase in size again after treatment stops.

For this reason, these medicines are usually used for limited periods.

GnRH Antagonists — An Important Modern Development

Modern oral **GnRH antagonists combined with hormonal add-back therapy** have expanded medical options for women with moderate-to-severe fibroid-related bleeding.

ACOG describes these medicines as options for controlling heavy menstrual bleeding for up to approximately two years in appropriate patients.

NICE currently includes **relugolix–estradiol–norethisterone acetate** and **linzagolix** among options for selected patients with moderate-to-severe fibroid symptoms.

These treatments should be prescribed and monitored appropriately because hormonal effects and bone health remain relevant.

Treating Anemia

Heavy bleeding should not be treated while ignoring anemia.

A woman may require:

- Oral iron.
- Occasionally intravenous iron.
- Dietary improvement.
- Control of the menstrual bleeding itself.

Severe anemia sometimes requires more urgent treatment.

Correcting the fibroid-related bleeding without restoring iron stores may leave the patient tired for months.

Myomectomy — Removing the Fibroid While Preserving the Uterus

Myomectomy removes fibroids while leaving the uterus in place.

This is particularly important for women who wish to preserve fertility.

Depending upon size and location, myomectomy may be:

- Hysteroscopic.
- Laparoscopic.
- Robotic.
- Open abdominal surgery.

Submucosal fibroids projecting into the uterine cavity can often be treated hysteroscopically without abdominal incisions.

For women whose fertility is affected by appropriate fibroid types, myomectomy is often the preferred uterine-preserving procedure.

However, myomectomy is still surgery.

Possible issues include:

- Bleeding.

- Infection.
- Scar formation.
- Adhesions.
- New fibroids developing later.

Removing existing fibroids does not prevent completely new fibroids from appearing.

Uterine Artery Embolization

Uterine artery embolization, or UAE, is a minimally invasive procedure.

Tiny particles are introduced into blood vessels supplying the fibroid.

Reducing blood flow causes fibroid tissue to shrink.

UAE can be an effective uterus-preserving option for selected women, particularly when bleeding and bulk symptoms are important.

However, future fertility requires careful discussion.

ACOG and Mayo Clinic note that evidence regarding pregnancy outcomes after UAE is less clear than with myomectomy, so it may not be the preferred option when future pregnancy is a high priority.

Radiofrequency Ablation

Radiofrequency ablation uses heat energy to destroy fibroid tissue.

It may be performed laparoscopically, through the vagina or through the cervix depending upon the technology used.

The fibroid then gradually shrinks over subsequent months.

Mayo Clinic's current 2026 guidance recognizes radiofrequency ablation as one of the important minimally invasive fibroid treatments.

However, fertility data remain less established than for myomectomy.

A 2025 review of fertility and fibroids likewise notes that evidence supporting procedures such as RFA specifically to improve fertility remains limited.

MRI-Guided Focused Ultrasound

Focused ultrasound uses high-energy sound waves to heat and destroy selected fibroid tissue while MRI helps guide treatment.

It does not require a conventional surgical incision.

This technique is attractive because it preserves the uterus, but patient selection is important and long-term fertility evidence is still developing.

Hysterectomy

Hysterectomy means removal of the uterus.

It is the only proven permanent solution because fibroids cannot recur once the uterus has been removed.

However, pregnancy is no longer possible afterward.

Hysterectomy therefore should not be presented as the automatic treatment for every woman with fibroids.

It may be appropriate when:

- Symptoms are severe.
- Fibroids are very large.
- Other treatments have failed.
- Fertility is no longer desired.
- The patient herself chooses definitive treatment after counselling.

Mayo Clinic notes that many patients who are initially told hysterectomy is their only option may have uterus-preserving alternatives depending upon their clinical circumstances.

The Importance of Fertility Goals Before Treatment

Before recommending any procedure, I want to know one very important thing:

“Do you want pregnancy now or in the future?”

That single answer can substantially change the treatment plan.

A 26-year-old woman with infertility and a cavity-distorting fibroid requires a different strategy from a 47-year-old woman with severe bleeding who has completed her family.

This is one of the reasons personalized fibroid care has become increasingly important internationally. Mayo Clinic's 2026 fibroid programme specifically emphasizes individualized treatment and future fertility in selecting minimally invasive options.

Fibroids According to the Unani System of Medicine

In Unani medical literature, uterine fibroid is commonly discussed under **Sal'āt al-Raḥim**.

The term *Sal'ah* refers broadly to a tumour or abnormal swelling/growth, while *Raḥim* refers to the uterus.

Classical Unani theory approaches such conditions through concepts including:

Mizaj — temperament
Akhlat — humours
A'za — organs
Quwa — faculties
Af'al — bodily functions

The four principal humours are:

Dam — blood
Balgham — phlegm
Safra — yellow bile
Sauda — black bile

Modern Unani authors frequently interpret Sal'āt al-Raḥim in relation to accumulation of **Ghaliz Balgham**, or thick phlegmatic material, and *Balghami* temperament, although these are traditional explanatory concepts rather than modern histopathological mechanisms. A 2025 Unani observational study found *Balghami Mizaj* to be the most common temperament in its fibroid sample, but several other Mizaj types were also represented.

Therefore, it would be an oversimplification to say that every fibroid is caused by one humour.

Unani Theory and Modern Fibroid Biology Are Not the Same Thing

This distinction is important in a professional textbook-style article.

Modern medicine explains fibroids through:

- Genetic changes.
- Hormone-sensitive smooth-muscle growth.
- Growth factors.

- Extracellular matrix.
- Local tissue signalling.

Classical Unani medicine uses:

- Mizaj.
- Akhlat.
- Quwwat.
- Organ function.
- Accumulation or transformation of pathological matter.

These frameworks developed in different periods of medical history.

I do not tell patients that **Balgham is literally estrogen** or that a humoral imbalance is identical to a modern genetic mutation.

That would be scientifically incorrect.

Instead, I use Unani concepts where they are clinically helpful for individualized diet, lifestyle and pharmacotherapeutic planning while relying on ultrasound and contemporary medicine to define the structural disease.

Why I Find the Unani Approach Useful

Fibroid management is not only about ultrasound measurements.

A woman may also have:

- Chronic anemia.
- Poor nutrition.
- Constipation.
- Obesity.
- Poor sleep.
- Sedentary lifestyle.
- Menstrual pain.
- Fertility anxiety.
- Sexual pain.
- Stress.

The Unani system encourages the physician to assess all of these areas rather than concentrating solely on the fibroid.

This holistic perspective can be particularly useful in long-term care.

Ilaj-bil-Ghiza — Dietary Management

Ilaj-bil-Ghiza means treatment through diet.

I use diet to improve the woman's **overall metabolic and reproductive health**, not to promise that a particular food will dissolve a fibroid.

A sensible dietary pattern can include:

- Adequate vegetables and fruits.
- Good protein intake.
- Whole grains where suitable.
- Appropriate healthy fats.
- Adequate iron when menstrual bleeding is heavy.
- Correction of nutritional deficiencies.
- Weight management where medically appropriate.

I advise against extreme “fibroid detox diets.”

There is currently no high-quality evidence that eliminating one specific food, drinking a particular juice or following a detox programme reliably makes established uterine fibroids disappear.

Mayo Clinic's updated 2026 review specifically notes that alternative diets and herbal programmes promoted for fibroids have not yet been shown convincingly to treat the condition.

Weight and Metabolic Health

Obesity is associated with an increased risk of uterine fibroids.

Therefore, appropriate weight management can support general hormonal, metabolic and cardiovascular health.

However, a woman should not be told:

“Your fibroid exists because you are overweight.”

Fibroids are multifactorial.

Weight is only one possible factor.

Ilaj-bil-Tadbir — Lifestyle and Regimental Management

Unani medicine traditionally uses **Ilaj-bil-Tadbir**, or regimental/lifestyle treatment.

In my clinical approach, this may involve:

- Regular physical activity.
- Sleep regulation.
- Stress reduction.
- Management of constipation.
- Appropriate daily routine.
- General reproductive-health care.

These measures can improve health and quality of life even when the anatomical fibroid remains visible.

Hijama and "Detoxification" for Fibroids

Patients sometimes ask whether cupping or **Hijama** can remove uterine fibroids.

I would not tell a patient that Hijama is scientifically established to shrink a uterine fibroid.

There is currently no robust clinical evidence demonstrating that cupping can eliminate leiomyomas.

If a selected Unani regimental therapy is used for general well-being under appropriate supervision, that is different from claiming that it physically removes a tumour.

This distinction protects patients from unrealistic expectations.

Unani Pharmacotherapy — Ilaj-bil-Dawa

Unani medicine includes a large pharmacopoeia of single and compound medicines.

Selection traditionally depends upon:

- Mizaj.
- Nature of the growth.

- Menstrual symptoms.
- Pain.
- Associated disorders.
- General health.
- Age.
- Fertility goals.

I do not believe it is good clinical practice to prescribe the same “fibroid medicine” to every woman.

The patient with a 1.5-cm asymptomatic fibroid requires a very different approach from a woman with multiple 8-cm fibroids and hemoglobin of 6 g/dL.

A Note About Herbs Commonly Mentioned Online

Many internet articles mix Ayurvedic, Unani and other herbal traditions together and present them as though they are one system of medicine.

For a professionally written Unani disease article, I prefer not to automatically list substances such as **Ashoka, Lodhra and Dashmool as established Unani fibroid therapy** merely because they are widely marketed for women's health.

When discussing Unani medicine, treatments should come from appropriately documented Unani practice or research, and even then clinical evidence should be evaluated separately from traditional use.

This distinction strengthens rather than weakens the credibility of traditional medicine.

What Scientific Evidence Exists for Unani Fibroid Treatment?

This is an area where research is developing, but evidence remains **preliminary**.

Sal Ammoniac Study

A small single-blind randomized placebo-controlled study presented in 2015 involved **40 women** with uterine leiomyoma.

Twenty-five received sal ammoniac with glycerin, while fifteen received placebo over 12 weeks.

The investigators reported improvement in heavy bleeding and menstrual pain and a reduction in mean fibroid size in the treatment group.

Importantly, the authors themselves concluded that **additional studies were required before efficacy and safety could be confirmed**.

This is encouraging but far too small to justify promising that the same treatment will shrink every patient's fibroid.

A 2025 Unani Case Report

A 2025 case report described one woman with a small **1.2 × 1.1 cm intramural fibroid** who received a polyherbal Unani formulation together with Majoon Dabeedul Ward for 90 days.

The authors reported symptomatic improvement and no fibroid visible on follow-up ultrasound.

That finding is worth reporting as an interesting clinical observation.

However, **one patient cannot establish a cure rate or prove that the treatment will work in larger, multiple or submucosal fibroids**.

Case reports are useful for generating research questions; they are not substitutes for large randomized trials.

Ongoing Unani Research

Clinical research in India continues.

A registered study from the **National Institute of Unani Medicine** has been designed to evaluate oral and topical Unani formulations in women with uterine fibroids, with fibroid volume measured by ultrasound and symptom scores used as outcomes.

Another registered Unani study has investigated a polyherbal formulation for women with small fibroids.

This is encouraging because it shows that traditional treatment is increasingly being subjected to objective measures such as:

- Ultrasound volume.
- Menstrual blood-loss scores.
- Pain scores.
- Quality-of-life assessment.

This is the direction I support.

Can Unani Medicine Shrink a Fibroid?

For selected small or moderately symptomatic fibroids, Unani medicine may offer **supportive and potentially beneficial individualized management**, particularly for symptoms such as menstrual disturbance, pain and overall constitutional health.

Some preliminary studies report reduction in fibroid measurements.

However, available research is not strong enough to state that Unani medicines reliably shrink every fibroid or eliminate the need for surgery in all women.

I therefore avoid claims such as:

“100% fibroid cure without surgery.”

or

“Guaranteed dissolution in three months.”

Those claims are not supported by the current level of evidence.

The more responsible question is:

Can we manage this particular patient's symptoms safely while monitoring fibroid behaviour and preserving fertility whenever possible?

My Specialized Treatment Approach at Saira Health Care

When a woman consults me for uterine fibroids at **Saira Health Care**, I do not begin by prescribing medicines from the ultrasound report alone.

I first try to understand:

1. Is the Fibroid Actually Causing the Symptoms?

A patient may have a small incidental fibroid while her heavy bleeding is actually related to adenomyosis, hormonal dysfunction or another disorder.

Therefore, correlation matters.

2. Where Is the Fibroid?

Submucosal?

Intramural?

Subserosal?

Does it distort the uterine cavity?

3. How Large Is It?

I record measurements from ultrasound and compare them on appropriate follow-up rather than judging treatment from symptoms alone.

4. How Many Fibroids Are Present?

A single small fibroid and multiple large fibroids require different planning.

5. How Heavy Is the Menstrual Bleeding?

I assess symptoms of anemia and request appropriate blood investigations where indicated.

6. Is There Pain or Pressure?

Urinary symptoms, constipation and sexual pain provide important information about the effect of the fibroid.

7. Does the Woman Want Pregnancy?

This is crucial.

If fertility is important, the uterine cavity and the couple's complete fertility status need to be considered.

8. Are There Other Causes of Infertility?

This may include:

- Ovulation problems.
- PMOS/PCOS.
- Tubal disease.
- Endometriosis.
- Male-factor infertility.
- Age-related fertility decline.

I do not automatically blame the fibroid.

9. What Is Her Unani Mizaj and General Health?

I then assess:

- Mizaj.
- Diet.
- Digestion.
- Weight.
- Sleep.

- Physical activity.
- Menstrual pattern.
- General strength.
- Stress.

10. What Is the Safest Treatment Goal?

For one woman, the goal may simply be observation.

For another, it may be reduction of menstrual bleeding.

For another, correction of anemia.

For another, individualized Unani treatment with ultrasound follow-up.

For another, hysteroscopic myomectomy may clearly offer the best fertility outcome.

This is what individualized treatment means to me.

How I Judge Whether Treatment Is Working

A successful treatment should not be judged only by saying:

"I feel better."

I prefer to evaluate objective and subjective outcomes together.

These may include:

- Reduction in menstrual blood loss.
- Improvement in hemoglobin.
- Reduction in pelvic pain.
- Reduced pressure symptoms.
- Improvement in quality of life.
- Improvement in fertility outcome where relevant.
- Stability or reduction of fibroid size on follow-up ultrasound.

This also prevents the mistake of assuming that symptom improvement always means the fibroid has disappeared.

Why Follow-Up Ultrasound Matters

If a non-surgical approach is being used, follow-up should be planned according to the patient's symptoms and the characteristics of the fibroid.

Ultrasound allows us to compare:

- Maximum diameter.
- Number.
- Location.
- Uterine cavity distortion.
- Overall uterine size.

I prefer objective monitoring rather than telling a patient that a fibroid has “melted” without imaging confirmation.

Uterine Fibroids, Sexual Health and Saira Health Care

Fibroids are primarily a gynecological condition, but they can overlap considerably with **sexual and reproductive health**.

A woman may experience:

- Pain during intercourse.
- Reduced sexual desire because of chronic pain.
- Anxiety regarding pregnancy.
- Heavy bleeding interfering with intimacy.
- Infertility.
- Relationship stress related to fertility treatment.

This is why uterine fibroids can become relevant within my focused clinical work in **sexual disorders and infertility**.

The sexual-health problem should not be treated separately from the gynecological condition if the two are connected.

Contribution of Saira Health Care in Sexual Disorders & Infertility

At **Saira Health Care**, our approach to reproductive and sexual-health conditions is based on the principle that patients deserve a diagnosis rather than exaggerated promises.

Women often reach us after being told:

“The fibroid must immediately be removed.”

or, from the opposite direction:

“No matter how large it is, herbs will definitely cure it.”

Neither extreme is appropriate for every woman.

Our approach emphasizes:

- Confidential consultation.
- Detailed reproductive and menstrual history.
- Individualized Unani assessment.
- Proper interpretation of ultrasound findings.
- Assessment of anemia and other complications.
- Fertility-oriented decision-making.
- Lifestyle and dietary guidance.
- Objective follow-up.
- Appropriate referral for hysteroscopy, myomectomy, embolization or another procedure when required.

This is especially important in infertility because an unnecessary uterine procedure can itself have consequences, while failure to treat a cavity-distorting fibroid may also reduce reproductive success.

The goal is to find the correct balance.

About Dr. Nizamuddin Qasmi

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

My professional training includes:

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 clinical work in infertility has taught me an important lesson:

A fertility problem should never be reduced to one ultrasound finding.

When a woman has fibroids and infertility, I want to understand the complete reproductive picture.

If the fibroid is not affecting the uterine cavity, another factor may be more important.

If the male partner has significantly abnormal semen parameters, treating a tiny fibroid alone will not solve the couple's infertility.

If the woman has a large submucosal fibroid distorting the cavity, on the other hand, that finding may deserve much greater attention.

The patient benefits when treatment decisions are made from the **whole clinical picture rather than from fear**.

Can Fibroids Disappear Naturally?

Some fibroids remain stable for years.

Some shrink.

Fibroids commonly become smaller around or after menopause as estrogen levels decrease, although this is not guaranteed.

Fibroids arising during pregnancy may also decrease after pregnancy as the uterus returns toward its pre-pregnancy state.

Therefore, observing an asymptomatic fibroid is sometimes a medically sound decision.

Can Diet Alone Cure Fibroids?

There is no scientifically proven food plan that reliably eliminates established fibroids.

A healthy diet can still be extremely useful for:

- Weight management.
- Correcting iron deficiency.
- Supporting metabolic health.
- Improving general reproductive health.

But I would not promise that eating one herb, fruit or seed will dissolve a leiomyoma.

Does Vitamin D Cure Fibroids?

Vitamin D and fibroids are actively being studied.

A 2025 rapid evidence review noted emerging evidence suggesting that correcting vitamin D deficiency may possibly slow fibroid progression or reduce size in some circumstances.

However, this does not mean high-dose vitamin D should be taken as an unsupervised fibroid treatment.

Deficiency should be identified and treated appropriately.

More research is required before vitamin D can be presented as a primary fibroid therapy.

Can Exercise Shrink Fibroids?

Regular exercise benefits metabolic, cardiovascular and mental health and can help with appropriate weight management.

However, exercise alone is not established as a direct treatment that reliably shrinks an existing fibroid.

I encourage exercise because it benefits the **patient**, not because I can promise it will make a fibroid disappear.

Will a Fibroid Come Back After Myomectomy?

The specific fibroid that is surgically removed does not regrow.

However, other very small fibroids that were not previously visible may grow, and new fibroids may develop in the remaining uterus.

ACOG notes that some women therefore require additional treatment later.

Only hysterectomy permanently prevents future uterine fibroids because the uterus itself is removed.

Does Every Large Fibroid Require Hysterectomy?

No.

Treatment depends upon:

- Size.
- Number.

- Location.
- Symptoms.
- Age.
- Fertility wishes.
- Previous treatment.
- Surgical feasibility.

Some women with large fibroids can undergo myomectomy or another uterus-preserving procedure.

Others may reasonably choose hysterectomy.

The decision should be individualized.

Can Fibroids Cause Miscarriage?

Some can.

The strongest concern is generally with **submucosal or cavity-distorting fibroids**.

However, miscarriages have many possible causes, including chromosomal abnormalities, maternal age and other uterine or medical conditions.

A woman with one miscarriage and a small subserosal fibroid should not automatically be told that the fibroid caused the loss.

When Should You Consult a Doctor?

Please seek medical evaluation if you experience:

- Menstrual bleeding heavy enough to interfere with normal life.
- Periods lasting unusually long.
- Large or frequent blood clots.
- Persistent pelvic pain.
- Significant abdominal enlargement.
- Difficulty urinating.
- Persistent constipation caused by pelvic pressure.
- Pain during intercourse.

- Symptoms of anemia.
- Bleeding between periods.
- Fertility difficulty.
- Repeated pregnancy loss.
- A fibroid diagnosed after menopause.
- A pelvic mass whose diagnosis is uncertain.

When Is Urgent Assessment Needed?

Seek prompt medical care if there is:

- Very heavy vaginal bleeding.
- Fainting or severe weakness.
- Severe shortness of breath associated with anemia.
- Sudden severe pelvic pain.
- Pregnancy accompanied by severe pain or bleeding.

Mayo Clinic specifically advises urgent evaluation for severe vaginal bleeding or sudden sharp pelvic pain.

Common Myths About Uterine Fibroids

“Fibroids are cancer.”

Usually false. Fibroids are benign and almost never become cancer.

“Every fibroid must be operated on.”

False. Many asymptomatic fibroids require only observation.

“A 5-cm fibroid is always worse than a 2-cm fibroid.”

Not necessarily. A smaller submucosal fibroid affecting the uterine cavity may matter more for bleeding or fertility than a larger subserosal fibroid.

“Fibroids always cause infertility.”

False. Many women with fibroids conceive naturally.

“Fibroids are ovarian cysts.”

False. Fibroids arise from uterine muscle.

“Any herbal medicine can dissolve a fibroid.”

There is no evidence supporting such a general claim.

“Hijama removes fibroids.”

There is no robust clinical evidence demonstrating that cupping physically eliminates uterine fibroids.

“Hysterectomy is the only treatment.”

False. Modern options include medication, myomectomy, UAE, RFA and focused ultrasound in appropriate patients.

Frequently Asked Questions

Can a small fibroid be left untreated?

Yes, particularly when it causes no symptoms and does not significantly affect fertility. Monitoring may be appropriate.

What is the most important factor for fertility: fibroid size or location?

Both matter, but **relationship to the uterine cavity is particularly important**. Submucosal and cavity-distorting fibroids have the clearest adverse fertility association.

Can medicines permanently remove fibroids?

Most established medicines primarily control symptoms or temporarily influence fibroid size. Fibroids may regrow after certain hormonal medicines are discontinued.

Is myomectomy better if I want pregnancy?

When treatment is genuinely needed and fertility preservation is important, myomectomy is often the preferred procedure. The decision still depends on fibroid location and other fertility factors.

Is uterine artery embolization suitable before pregnancy?

It can preserve the uterus, but future fertility and pregnancy evidence is less clear than for myomectomy, so careful counselling is required.

Can Unani medicine help uterine fibroids?

Unani medicine can provide an individualized holistic approach involving Mizaj assessment, diet, lifestyle, management of menstrual symptoms and carefully selected pharmacotherapy. Small studies and case reports have reported encouraging results, but stronger large-scale trials are still required before universal fibroid-shrinking claims can be made.

Does Unani treatment always prevent surgery?

No.

Some patients may be appropriately managed conservatively, while others require surgery or interventional treatment because of severe bleeding, large fibroids, infertility, significant pressure symptoms or another clinical concern.

Can I take herbal medicines while trying to conceive?

Do not assume that every herbal medicine is safe in the preconception period or early pregnancy. Treatment should be selected by a qualified practitioner who knows you are actively trying to conceive.

A Personal Message From Dr. Nizamuddin Qasmi

If your ultrasound report says you have a uterine fibroid, I want you to remember one thing first:

Do not panic simply because the report contains the word "tumour" or "fibroid."

Most fibroids are benign.

The next step is not automatically surgery, and it is also not automatically herbal treatment.

First, we need to understand your fibroid.

Where is it?

How large is it?

How many are there?

Is it actually causing your heavy bleeding?

Is your hemoglobin low?

Is it pressing on your bladder?

Does it distort the uterine cavity?

Are you trying to become pregnant?

Are there other fertility factors that need assessment?

Only after answering these questions should we decide treatment.

As a Unani physician, I value the traditional principles of **Mizaj, Ilaj-bil-Ghiza, Ilaj-bil-Tadbir and Ilaj-bil-Dawa** because they encourage us to treat the individual rather than only the ultrasound image.

At the same time, responsible Unani medicine must make proper use of ultrasound, blood investigations and fertility science.

If an appropriately selected patient can be managed conservatively while symptoms improve and ultrasound remains stable, that may be an excellent outcome.

If a cavity-distorting fibroid is preventing pregnancy and hysteroscopic myomectomy offers the better option, I believe that should be discussed clearly.

If heavy bleeding has caused severe anemia, we must treat the anemia—not simply wait for a herbal medicine to work.

And if a large fibroid requires surgery, delaying necessary treatment in order to make a claim of “100% non-surgical cure” does not serve the patient.

My aim is not to treat every fibroid in the same way. My aim is to help each woman receive the treatment appropriate to her symptoms, fertility goals and overall health.

Conclusion

Uterine fibroids, or **leiomyomas**, are very common benign tumours arising from uterine muscle.

Many women have no symptoms and require no treatment. When symptoms occur, they most commonly include **heavy menstrual bleeding, painful periods, pelvic pressure, urinary or bowel symptoms, abdominal enlargement and sometimes pain during sexual intercourse**.

Fibroids can affect fertility, but the impact depends strongly upon **location**, with submucosal and cavity-distorting fibroids carrying the clearest reproductive significance.

Modern treatment ranges from simple observation to medicines for bleeding and pain, GnRH-based hormonal treatment, myomectomy, uterine artery embolization, radiofrequency ablation, focused ultrasound and hysterectomy. The Mayo Clinic's latest 2026 guidance emphasizes that **there is no single best treatment for every woman**.

Within the Unani system, uterine fibroid is commonly discussed as **Sal‘āt al-Raḥim**, with individualized assessment through Mizaj and the traditional humoral framework. Emerging Unani studies, including a small randomized trial and recent case reports, have produced encouraging observations, but current evidence remains insufficient to promise universal fibroid shrinkage or guaranteed avoidance of surgery.

At **Saira Health Care**, my approach is therefore to combine **careful clinical diagnosis, fertility-oriented planning, individualized Unani treatment, diet and lifestyle management, objective ultrasound follow-up and appropriate modern gynecological intervention whenever required**.

A fibroid should not automatically become a reason for fear.

In many women, it can be monitored.

In many others, symptoms can be successfully controlled.

And when intervention is necessary, modern medicine now provides several uterus-preserving options.

Dr. Nizamuddin Qasmi
Founder & Chief Physician
Saira Health Care
Focused Practice in Sexual Disorders & Infertility

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

Medical Disclaimer: This article is intended for general patient education and health awareness. It does not replace individualized gynecological examination or treatment. Fibroid management should be selected according to symptoms, size, number, location, anemia, age and fertility goals. Severe bleeding, sudden pelvic pain or significant anemia requires prompt medical assessment. Herbal or Unani medicines should not be used to delay necessary imaging, fertility treatment, myomectomy, abscess/cancer evaluation or other indicated specialist care.