Blocked Fallopian Tubes: Causes, Diagnosis, Can They Open Without Surgery? Modern and Unani Treatment

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Introduction: "Doctor, My Fallopian Tubes Are Blocked. Can They Be Opened Without Surgery?"

One of the most stressful reports a woman can receive during an infertility evaluation is:

"Fallopian tubes blocked."

When a patient comes to me with an HSG report showing:

- unilateral tubal blockage,
- bilateral tubal blockage,
- cornual block,
- distal block,
- hydrosalpinx,

the first question is usually:

"Doctor, can my tubes be opened?"

The second question is often:

"Can blocked tubes be treated without surgery or IVF?"

And many women ask me:

"Is there any Unani treatment that can naturally open the tube?"

My answer begins with an important point:

Every tubal blockage is not the same.

A tube may appear blocked because of:

- temporary muscular spasm,
- mucus or small debris,
- true scar tissue,
- previous infection,
- endometriosis,
- external adhesions,
- severe hydrosalpinx,
- previous sterilization.

Some apparently blocked tubes—particularly:

proximal or cornual blocks

—may prove open when the test is repeated.

The American Society for Reproductive Medicine notes that in one study approximately **60% of women whose HSG suggested proximal tubal blockage showed patent tubes when HSG was repeated one month later**. Similar discrepancies have been observed when HSG findings were compared with laparoscopy.

This can happen because the first test may have been affected by:

- tubal spasm,
- mucus,
- debris,
- technical factors.

Therefore:

one HSG report saying "blocked tube" does not always mean permanent anatomical destruction of the tube.

On the other hand, when there is:

- dense fibrosis,
- severe distal disease,

- badly damaged fimbriae,
- a large hydrosalpinx,

the problem is very different.

No responsible physician should promise that a tablet or herbal medicine can reliably rebuild a severely scarred fallopian tube.

The purpose of treatment at **Saira Health Care** is therefore not simply to give every woman the same “tube opening medicine.”

My approach is:

Confirm the blockage, identify its location and probable cause, determine whether it is functional or structural, protect the woman's reproductive time, provide individualized Unani supportive care where appropriate, and recommend cannulation, surgery or IVF when those treatments offer the better chance of pregnancy.

What Are the Fallopian Tubes?

A woman normally has two fallopian tubes:

- one on the right,
- one on the left.

They extend from the upper part of the uterus toward the ovaries.

The fallopian tube is not simply a hollow pipe.

It is a highly specialized reproductive organ with:

- delicate internal folds,
- ciliated cells,
- smooth muscle,
- fimbriae at the outer end.

These structures help:

- collect the ovulated egg,
- transport sperm,
- allow fertilization,
- move the early embryo toward the uterus.

Where Does Fertilization Normally Occur?

Fertilization usually takes place in the:

ampullary portion of the fallopian tube.

The sequence is:

1. the ovary releases an egg;
2. fimbriae help collect the egg;
3. sperm travel through the cervix and uterus;
4. sperm enter the fallopian tube;
5. sperm and egg meet;
6. fertilization occurs;
7. the embryo travels toward the uterus;
8. implantation occurs in the uterine cavity.

A damaged tube can interfere with one or more of these steps.

What Is Tubal Factor Infertility?

Tubal factor infertility means that abnormalities of the fallopian tubes interfere with pregnancy.

The problem may involve:

- complete obstruction,
- partial narrowing,
- damaged fimbriae,
- external adhesions,
- hydrosalpinx,
- severely damaged internal cilia.

ASRM estimates that tubal disease contributes to approximately:

25–35% of female-factor infertility.

More than half of these cases may be related to previous salpingitis or inflammatory tubal damage.

WHO's 2025 infertility guideline also recognizes tubal disease as a major cause of female infertility.

Important: An "Open Tube" Is Not Always a Normal Tube

This is a very important concept.

A test may show:

contrast spilling through the tube

which means the tube is technically patent.

But pregnancy also depends on:

- healthy fimbriae,
- healthy tubal lining,
- functioning cilia,
- normal muscular movement.

A badly damaged tube can therefore be:

open but functionally impaired.

This is one reason pregnancy rates after reconstructive surgery do not always equal the percentage of tubes that become technically patent.

Types of Fallopian Tube Blockage

The location of the obstruction significantly affects treatment.

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1. Proximal Tubal Blockage

This occurs near the uterus at the:

uterotubal junction or cornual region.

Possible causes include:

- tubal spasm,
- mucus plug,
- small debris,
- inflammation,

- endometriosis,
- fibrosis,
- salpingitis isthmica nodosa.

This is the type of blockage most likely to produce a:

false-positive HSG result.

ASRM states that proximal obstruction accounts for approximately **10–25% of tubal disease** and may result from either temporary material/spasm or genuine anatomical fibrosis.

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2. Mid-Segment Blockage

Obstruction can occur in the middle portion of the tube.

Causes may include:

- previous tubal surgery,
- previous sterilization,
- infection,
- fibrosis,
- endometriosis.

When the tube was intentionally cut or sealed during sterilization, treatment is a different subject involving:

- tubal reversal,
- or IVF.

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3. Distal Tubal Blockage

This occurs near the ovary and fimbrial end.

Common causes include:

- pelvic inflammatory disease,
- previous infection,
- endometriosis,
- adhesions,
- previous pelvic surgery.

Distal disease is particularly important because:

the fimbriae are responsible for collecting the egg.

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4. Hydrosalpinx

Hydrosalpinx means:

a distally blocked fallopian tube that has become enlarged and filled with fluid.

This is not simply a little mucus plug.

The tube may be:

- distended,
- inflamed,
- scarred,
- structurally damaged.

Hydrosalpinx is especially important before IVF because fluid from the damaged tube can enter the uterus and adversely affect embryo implantation.

Current WHO guidance recommends:

salpingectomy or tubal occlusion before IVF

for women with hydrosalpinx rather than leaving a communicating hydrosalpinx untreated.

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5. Peritubal Adhesions

Sometimes the inside of the fallopian tube is open, but scar tissue surrounds the:

- tube,
- ovary,
- fimbriae.

These adhesions may prevent the tube from:

properly collecting the ovulated egg.

Causes include:

- endometriosis,
- pelvic infection,

- previous abdominal/pelvic surgery,
- appendicitis/peritonitis.

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6. Unilateral Tubal Blockage

Only one tube is blocked.

The other is open.

Natural pregnancy may still be possible.

This is particularly true when:

- the opposite tube is healthy,
- ovulation occurs,
- semen is adequate,
- no important additional infertility factor exists.

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7. Bilateral Tubal Blockage

Both tubes appear obstructed.

This has much greater fertility significance.

However, especially when both blocks are reported as:

proximal/cornual

on HSG, confirmation is important because bilateral tubal spasm can occasionally produce a misleading result.

What Causes Blocked Fallopian Tubes?

There are several important causes.

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1. Pelvic Inflammatory Disease – PID

PID is one of the most important causes of tubal damage.

It can result from ascending infection involving:

- uterus,

- fallopian tubes,
- surrounding pelvic tissue.

Sexually transmitted organisms such as:

- Chlamydia trachomatis,
- Neisseria gonorrhoeae

are important causes.

Inflammation may heal with:

- fibrosis,
- adhesions,
- loss of normal cilia.

Can an Infection Be Treated After the Tube Is Scarred?

The infection itself can be treated.

But:

antibiotics cannot reliably reverse established dense scar tissue.

This distinction is extremely important.

Antibiotics may:

- stop ongoing infection,
- prevent further damage.

They should not be advertised as a guaranteed treatment for an old fibrotic tubal blockage.

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2. Genital Tuberculosis

In India and other regions where tuberculosis remains relevant, genital TB is an important consideration in selected infertility patients.

It may damage:

- endometrium,
- fallopian tubes,
- pelvic structures.

Possible outcomes include:

- bilateral obstruction,
- strictures,
- adhesions,
- distorted tubes.

When genital TB is genuinely diagnosed, appropriate anti-tubercular treatment is essential.

However:

anti-TB treatment does not necessarily restore a severely scarred tube to normal function.

Fertility treatment may still be required.

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3. Endometriosis

Endometriosis can cause:

- inflammation,
- pelvic adhesions,
- altered tubal anatomy,
- ovarian disease.

A tube may be technically open while external adhesions prevent normal:

egg pickup.

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4. Previous Ectopic Pregnancy

An ectopic pregnancy may:

- damage a fallopian tube,
- require surgical removal,
- reflect pre-existing tubal disease.

Women with previous ectopic pregnancy require careful counselling because subsequent ectopic risk can remain elevated.

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5. Previous Pelvic or Abdominal Surgery

Surgery can sometimes produce adhesions.

Examples include:

- ovarian surgery,
- fibroid surgery,
- cesarean-related pelvic adhesions,
- appendicitis surgery,
- bowel surgery.

Not every operation causes infertility.

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6. Ruptured Appendicitis or Peritonitis

Severe abdominal infection can produce:

- inflammation,
- pelvic adhesions

that interfere with tubal function.

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7. Tubal Sterilization

Tubal ligation intentionally blocks the tubes.

Treatment may involve:

- microsurgical tubal reversal,
- IVF.

ASRM recommends microsurgical anastomosis as the principal surgical technique for appropriately selected women seeking sterilization reversal.

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8. Congenital Abnormalities

Some women are born with unusual:

- tubal anatomy,
- uterine abnormalities,
- reproductive-tract abnormalities.

These are uncommon compared with acquired tubal disease.

Symptoms of Blocked Fallopian Tubes

Tubal blockage often causes:

no symptoms at all.

Many women have:

- normal periods,
- normal hormones,
- normal sexual function,
- normal ultrasound,

and only discover the problem during infertility testing.

The Main Symptom Is Infertility

The usual presentation is:

difficulty achieving pregnancy.

This is why tubal patency forms an important part of female infertility evaluation.

Symptoms of the Underlying Disease

Depending on the cause, a woman may experience:

- chronic pelvic pain,
- painful menstruation,
- pain during intercourse,
- unusual discharge,
- previous pelvic infection,
- previous ectopic pregnancy.

But these symptoms are not necessary.

Does a Normal Ultrasound Mean the Tubes Are Open?

No.

Routine pelvic ultrasound can assess:

- ovaries,
- uterus,
- fibroids,
- cysts,
- hydrosalpinx when visible.

But an ordinary ultrasound cannot reliably prove:

both fallopian tubes are patent.

Specific tubal testing is required.

How Are Blocked Fallopian Tubes Diagnosed?

Modern fertility medicine offers several methods.

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1. Hysterosalpingography – HSG

HSG is one of the most widely used tubal tests.

A thin catheter is placed through the cervix.

Contrast is injected into:

- uterine cavity,
- tubes.

X-ray imaging shows whether contrast:

- passes through the tubes,
- spills into the pelvis.

Free spill generally suggests:

tubal patency.

WHO's 2025 infertility guideline recommends either:

- **HSG**
- or **HyCoSy**

for assessment of tubal patency in women with suspected tubal disease.

Is HSG 100% Accurate?

No.

This is particularly important for:

proximal blockage.

Tubal spasm or technical factors can produce an apparent obstruction.

ASRM reports that in one study:

60%

of women with proximal blockage on initial HSG had patent tubes when the test was repeated one month later.

Therefore, I do not like to tell a woman:

“Both tubes are permanently destroyed”

based only on one questionable cornual-block HSG.

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2. HyCoSy

HyCoSy means:

Hysterosalpingo-Contrast Sonography.

Contrast is introduced while ultrasound is used to evaluate tubal passage.

Advantages can include avoiding:

- ionizing radiation,
- iodinated X-ray contrast in some techniques.

WHO considers HSG and HyCoSy both reasonable options depending on:

- availability,
- expertise,
- allergy considerations.

How Accurate Are HSG and HyCoSy?

The evidence reviewed in WHO's 2025 guideline reported approximate pooled sensitivity/specificity of:

HyCoSy

- sensitivity: **0.93**
- specificity: **0.89**

HSG

- sensitivity: **0.92**
- specificity: **0.90**

for tubal patency assessment in the evidence base reviewed.

No test should be interpreted without clinical context.

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3. Laparoscopy With Chromopertubation

During laparoscopy:

- the pelvis is visualized directly,
- dye is passed through the cervix,
- passage through the tube can be observed.

It can also identify:

- endometriosis,
- external adhesions,
- tubal damage.

It is considered an important reference method but:

should not be performed routinely in every infertile woman simply to test tubes

because it requires:

- anesthesia,
- surgery,
- greater cost.

WHO therefore supports HSG or HyCoSy as less invasive initial approaches.

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4. Selective Salpingography and Tubal Cannulation

This procedure is particularly important when:

proximal blockage

is suspected.

A very small catheter and guidewire can be directed into the tubal opening.

This can:

- confirm the obstruction,
- sometimes dislodge mucus/debris,
- restore patency.

It is generally considered:

minimally invasive rather than major abdominal surgery.

ASRM recommends tubal cannulation as the treatment of choice in appropriately selected young women with proximal obstruction and otherwise favorable fertility factors.

Can Blocked Fallopian Tubes Open Without Major Surgery?

Yes—in selected situations.

But the answer depends entirely on:

- location,
- cause,
- extent of damage.

Situation 1: Tubal Spasm

The tube may only appear blocked during HSG because the uterotubal region temporarily contracts.

In this case:

there may never have been a true permanent blockage.

A repeat study may show the tube to be open.

Situation 2: Mucus or Small Debris

A proximal tube may be obstructed by:

- mucus,
- amorphous debris.

Selective cannulation or sometimes contrast flushing can restore patency.

ASRM specifically recognizes mucus, debris and spasm among important causes of proximal HSG obstruction.

Situation 3: Proximal Blockage Suitable for Cannulation

Selective tubal cannulation can be performed without open abdominal surgery.

A meta-analysis cited by ASRM found a pooled:

- clinical pregnancy rate of approximately **22% at six months**,
- rising to about **28.5% at four years**,
- live-birth rate around **22%**.

The pooled ectopic pregnancy rate was approximately:

4%.

About one-third of successfully opened tubes can reocclude.

These numbers are averages, not individual guarantees.

Situation 4: HSG Tubal Flushing

The diagnostic HSG itself can sometimes have a fertility-enhancing effect.

A landmark randomized trial of **1,119 women** compared oil-based with water-based contrast.

Within six months:

Oil-based contrast

- ongoing pregnancy: **39.7%**
- live birth: **38.8%**

Water-based contrast

- ongoing pregnancy: **29.1%**
- live birth: **28.1%**

The oil-based group therefore had significantly better outcomes in that study.

This finding is sometimes called the:

tubal flushing effect.

Does the H2Oil Study Prove Oil Can Open Every Blocked Tube?

No.

This must be explained carefully.

The H2Oil trial supports a fertility-enhancing effect of oil-based HSG in selected infertile women.

It does **not** prove that:

- drinking oil,
- applying oil vaginally,
- abdominal oil massage,
- herbal oil preparations

can reopen:

- dense fibrosis,
- severe hydrosalpinx.

HSG involves:

contrast being mechanically passed through the uterine cavity and tubes under medical imaging.

This cannot be equated scientifically with traditional external or vaginal oil therapy.

Situation 5: Severe Fibrotic Blockage

When a guidewire cannot pass through a proximal tube with gentle cannulation, ASRM notes that true anatomical disease such as:

- chronic salpingitis,
- salpingitis isthmica nodosa,
- obliterative fibrosis

is commonly found.

In these situations:

IVF is generally preferred

over repeated attempts to force the tube open.

Can Severe Distal Blockage Be Opened?

Sometimes surgery can reconstruct mildly damaged distal tubes.

Possible procedures include:

- fimbrioplasty,
- neosalpingostomy,
- adhesiolysis.

Results depend heavily on:

- degree of damage,
- age,
- fimbrial health,
- mucosal health.

In severe disease:

reconstructive surgery becomes much less successful.

Mild Versus Severe Hydrosalpinx

ASRM distinguishes between:

Favorable mild disease

- limited adhesions,
- mildly dilated tube,
- thin pliable walls,
- preserved internal folds.

and:

Poor-prognosis disease

- extensive dense adhesions,

- large dilated tube,
- thick fibrotic walls,
- absent/damaged mucosa.

For severe hydrosalpinx:

salpingectomy followed by IVF is usually the better fertility strategy.

Latest WHO 2025 Recommendations for Tubal Infertility

WHO's first global infertility guideline provides a particularly useful age- and severity-based approach.

Women Under 35 With Mild-to-Moderate Tubal Disease

WHO suggests:

surgery rather than immediate IVF

for appropriately selected women under 35 with mild-to-moderate tubal disease.

If pregnancy does not occur after surgery, approximately one year is considered a reasonable period before considering alternatives such as IVF.

The evidence certainty is low, so individual factors remain important.

Women Under 35 With Severe Tubal Disease

WHO suggests:

IVF rather than reconstructive surgery.

Women Age 35 or Above

For women:

35 years or older

with tubal disease, WHO generally suggests:

IVF rather than surgery.

The reason is largely reproductive time.

Waiting for surgery and then waiting many months for natural pregnancy may reduce fertility opportunities as ovarian age advances.

Hydrosalpinx Before IVF

WHO recommends:

salpingectomy or tubal occlusion

before IVF for women with hydrosalpinx.

The purpose is to prevent hydrosalpingeal fluid from adversely affecting the uterine cavity and implantation.

Why Hydrosalpinx Matters So Much

ASRM summarizes evidence showing that:

- pregnancy,
- implantation,
- delivery rates

may be approximately:

50% lower

during IVF when significant hydrosalpinx is present.

Treatment of the hydrosalpinx before IVF can restore outcomes closer to those seen in women without hydrosalpinx.

This is why I would never advise a patient with a large hydrosalpinx to spend years taking medicine simply waiting for the tube to become normal.

Can You Become Pregnant With One Blocked Tube?

Yes.

Natural conception may remain possible when:

- the other tube is healthy,
- ovulation occurs,
- semen is adequate,

- no significant additional infertility factor exists.

ASRM even notes that treatment may not always be required for an isolated unilateral proximal obstruction when the distal tube is normal.

Does the Egg Need to Come From the Same Side as the Open Tube?

Pregnancy is more likely when ovulation occurs on the side of the open tube.

However, the reproductive anatomy is not completely rigid.

There are documented pregnancies suggesting that a healthy tube can occasionally capture an egg released from the opposite ovary.

Therefore:

one blocked tube does not mean half-zero fertility in a simple mathematical way.

Can Pregnancy Occur With Bilateral Blocked Tubes?

If both tubes are:

truly and completely anatomically obstructed

natural sperm and egg cannot meet through the normal route.

Treatment may then require:

- successful cannulation,
- reconstructive surgery,
- or IVF.

IVF bypasses the fallopian tubes completely.

What Is IVF and Why Does It Work for Tubal Blockage?

In IVF:

1. follicles are stimulated;
2. eggs are retrieved directly from the ovaries;
3. fertilization occurs in the laboratory;
4. embryos develop;
5. an embryo is transferred into the uterus.

The fallopian tubes are:

bypassed.

This is why IVF is particularly effective for severe bilateral tubal disease.

Risk of Ectopic Pregnancy

Damaged tubes increase the risk that an embryo may implant:

inside the fallopian tube rather than the uterus.

This is an ectopic pregnancy.

Tubal reconstructive procedures and cannulation can also carry ectopic risk.

After a positive pregnancy test in a woman with significant previous tubal disease:

early ultrasound is especially important

to confirm that the pregnancy is inside the uterus.

Can Blocked Tubes Be Prevented?

Not every cause is preventable.

But some important risks can be reduced.

Preventing Sexually Transmitted Infection

Appropriate:

- condom use,
- STI testing,
- timely treatment

can reduce risk of PID and subsequent tubal damage.

Treat Pelvic Infection Promptly

Untreated infection can progress to:

- salpingitis,
- fibrosis,

- adhesions.

Avoid Unnecessary Intrauterine Procedures

Uterine procedures should be performed:

- for clear medical indications,
- under appropriate sterile conditions.

Seek Early Care After Ectopic Pregnancy or Severe Pelvic Disease

Women with previous:

- ectopic pregnancy,
- endometriosis,
- severe pelvic infection

may benefit from earlier fertility assessment if pregnancy does not occur.

Blocked Fallopian Tubes in the Unani System of Medicine

The Unani system has a longstanding tradition of managing:

- female infertility,
- menstrual disorders,
- reproductive weakness,
- pelvic complaints.

Traditional Unani physiology uses the concepts of:

- Mizaj,
- Akhlat,
- Suddah,
- Waram,
- general reproductive-organ function.

The background material for this disease page uses the term:

Suddah-e-Qazifain

to describe tubal obstruction and discusses traditional relationships with:

- Balgham,
- Sauda,
- Su'-e-Mizaj,
- Waram.

These are useful for describing:

the traditional Unani theoretical framework.

But they should not be confused with modern anatomical pathology.

Suddah – The Unani Concept of Obstruction

In traditional Unani terminology:

Suddah

means obstruction.

Modern Unani clinicians may use this concept when discussing impaired passage in narrow bodily channels.

For a woman with tubal infertility, a traditional assessment may therefore examine:

- constitutional factors,
- inflammation-like symptoms,
- menstrual health,
- nutrition,
- metabolic health.

Akhlat

Classical Unani theory describes four humors:

Dam

Blood

Balgham

Phlegm

Safra

Yellow bile

Sauda

Black bile

Alterations in the balance and quality of these humors form part of traditional Unani explanations of disease.

These concepts should not be translated literally into modern statements such as:

"Hydrosalpinx is scientifically caused by Balgham."

Hydrosalpinx in modern medicine results primarily from:

- tubal damage,
- distal obstruction,
- inflammation/scarring.

The Unani explanation is a different traditional framework.

Waram – Inflammation

The traditional concept of:

Waram

has some practical overlap with the clinical importance of:

- pelvic inflammation,
- infection.

But again, this does not mean the two concepts are biologically identical.

A woman with active bacterial PID requires:

appropriate antimicrobial treatment.

Herbal anti-inflammatory treatment should not replace antibiotics when a bacterial infection is present.

The Four Main Unani Therapeutic Approaches

In the Unani system, treatment broadly includes:

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bit-Tadbir

Regimenal therapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical/manual intervention where appropriate

This broad framework can make Unani medicine useful as part of an:

integrative infertility programme.

Where Unani Medicine Can Be Useful in Tubal Infertility

I consider its role most rational for:

- general reproductive health,
- nutritional optimization,
- healthy body weight,
- metabolic health,
- menstrual health,
- associated sexual problems,
- general constitutional weakness,
- stress/sleep management.

Traditional pharmacotherapy may also be considered under physician supervision.

However:

supporting fertility is not the same as physically proving that a scarred tube has reopened.

That distinction is extremely important.

Ilaj-bil-Ghiza – Dietotherapy

A healthy reproductive diet can support:

- metabolic health,

- inflammation control,
- general fertility,
- appropriate body weight.

I generally encourage an individualized diet containing:

- adequate protein,
- vegetables,
- pulses,
- whole foods,
- fruits,
- nuts,
- seeds,
- healthy fats.

The patient should reduce:

- smoking,
- excessive alcohol,
- excessive refined sugar,
- frequent ultra-processed foods.

But:

there is no specific food proven to dissolve fallopian-tube fibrosis.

Can Ginger, Turmeric or Cinnamon Open a Blocked Tube?

Traditional herbs such as:

- Zanjabeel – ginger,
- Darchini – cinnamon,
- turmeric

may have studied biological effects relating to:

- inflammation,
- metabolism,

- antioxidant activity.

But:

anti-inflammatory activity in a laboratory is not evidence that an oral herb physically removes dense human tubal scar tissue.

These should be used, if appropriate, for:

supportive health objectives

rather than sold as guaranteed tubal-opening drugs.

Ilaj-bit-Tadbir – Regimenal Therapy

Unani regimenal medicine may include:

- exercise,
- sleep optimization,
- stress reduction,
- selected traditional procedures.

Lifestyle care can improve overall reproductive and metabolic health.

Hijama and Blocked Fallopian Tubes

Hijama has a recognized place within traditional Unani regimenal medicine.

However:

there is currently insufficient high-quality evidence showing that Hijama reopens anatomically scarred fallopian tubes.

It should not be claimed to:

- dissolve hydrosalpinx,
- break deep pelvic adhesions,
- restore destroyed tubal cilia.

If used for general wellbeing under qualified supervision, it should remain:

supportive care

rather than replacing proper tubal treatment.

Leech Therapy and Tubal Adhesions

Leech therapy—**Irsal-e-Alaq**—also belongs to traditional regimenal practice.

Although leech saliva contains biologically active substances, there is no good clinical evidence demonstrating that externally applied leeches:

dissolve internal pelvic adhesions and reopen obstructed fallopian tubes.

I would therefore not advise a patient to delay fertility treatment on this basis.

Vaginal or Intrauterine Herbal Preparations

This area requires considerable caution.

Inserting:

- oils,
- herbs,
- powders,
- unsterile substances

into the vagina or uterus can potentially cause:

- irritation,
- infection,
- ascending pelvic infection.

A woman with infertility should never undergo an intrauterine herbal procedure outside a properly regulated, sterile medical environment.

Modern evidence that oil-based:

HSG contrast flushing

can improve pregnancy rates does **not** validate traditional vaginal oil or herbal instillation.

They are not the same procedure.

Ilaj-bid-Dawa – Unani Pharmacotherapy

Traditional Unani fertility practice includes formulations such as:

- uterine tonics,
- reproductive-support formulations,

- medicines selected according to Mizaj and clinical findings.

The exact treatment should be individualized.

I do not recommend self-prescribing:

- herbomineral medicines,
- menstrual stimulants,
- fertility mixtures.

Pregnancy may occur unexpectedly, and some traditional medicines may be unsuitable during early pregnancy.

What Does Published Unani Research Actually Show?

This is a very important section.

There is published evidence of:

Unani fertility case reports

in women with tubal findings.

However, the evidence is currently:

- limited,
- largely case-based.

The National Institute of Unani Medicine Case Report

A 2011 report from the:

National Institute of Unani Medicine, Bangalore

described a 25-year-old woman with:

- primary infertility for 2.5 years,
- unilateral right tubal blockage.

She received:

- Hab Hamal,
- Majoon Hamal Amberi Alvi Khani,
- Majoon Supari Pak.

The woman conceived within:

two months.

The authors suggested that the formulations may have assisted fertility.

What Does This Case Prove?

It demonstrates:

a successful conception after Unani fertility treatment in one woman with unilateral tubal blockage.

That is encouraging.

However, it does not prove:

the blocked tube reopened.

The publication did not establish that the previously blocked tube became patent by:

- repeat HSG,
- laparoscopy.

And because the woman had:

one unilateral blocked tube

pregnancy could potentially have occurred through the opposite open tube.

The authors themselves used cautious language such as:

“might have assisted in conception.”

Therefore, a scientifically responsible article should say:

this case supports further research into Unani fertility treatment, but it does not prove that Unani medicines reopen a scarred fallopian tube.

Why Case Reports Still Matter

A case report can:

- generate a research hypothesis,
- identify interesting clinical observations,
- encourage larger trials.

But case reports cannot establish:

- cure rate,
- superiority,
- guaranteed efficacy.

What is needed are controlled studies measuring:

1. pre-treatment HSG,
2. specific type of obstruction,
3. treatment,
4. repeat tubal testing,
5. natural conception,
6. ectopic pregnancy,
7. live birth.

Is There a Scientifically Proven Unani "Tube-Opening Medicine"?

At present:

No specific Unani oral formulation has high-quality clinical evidence proving reliable reopening of true fibrotic fallopian tube obstruction.

This does not mean Unani medicine has no value.

It means we should define its value accurately.

It may be valuable for:

- whole-person fertility support,
- diet,
- lifestyle,
- menstrual health,
- metabolic factors,
- sexual health,
- individualized traditional care.

But:

a fibrotic tube is an anatomical problem.

Anatomical claims require anatomical evidence.

Dr. Nizamuddin Qasmi's Approach at Saira Health Care

At Saira Health Care, I would not begin treatment by simply asking:

"Which medicine opens tubes?"

I prefer the following structured approach.

Step 1: Confirm the Diagnosis

I review the actual HSG or HyCoSy report.

I want to know:

- right or left?
- unilateral or bilateral?
- proximal or distal?
- complete or partial?
- hydrosalpinx?
- free spill?
- delayed spill?

Step 2: Do Not Overinterpret One Proximal HSG Block

If the report shows:

- proximal,
- cornual obstruction,

I consider the possibility of:

- spasm,
- mucus,
- technical false-positive findings.

ASRM data showing repeat patency in a substantial proportion of proximal HSG blocks make this especially important.

Step 3: Assess the Woman's Age

Age changes everything.

A 26-year-old with mild unilateral tubal disease has a very different treatment timeline from a:

39-year-old

with bilateral tubal disease.

WHO now explicitly makes tubal-treatment recommendations age-dependent.

Step 4: Assess Ovarian Reserve When Appropriate

I may review:

- AMH,
- antral follicle count

when clinically relevant.

A woman with:

- severe tubal disease,
- very low ovarian reserve

should not spend years waiting for an uncertain natural tubal treatment.

Step 5: Assess Ovulation

Blocked tubes may not be the only issue.

A woman may simultaneously have:

- PMOS/PCOS,
- anovulation,
- thyroid dysfunction.

Step 6: Evaluate the Male Partner

This is essential.

A woman may have a repairable unilateral tubal problem while her husband has:

- severe oligozoospermia,
- azoospermia.

In that situation:

IVF/ICSI may be more appropriate than prolonged tubal treatment.

ASRM specifically includes male-factor infertility among the factors that should influence the decision between tubal repair and IVF.

Step 7: Review Infection and Tuberculosis History

I ask about:

- STI,
- PID,
- genital tuberculosis,
- pelvic infection,
- previous antibiotic treatment.

Active disease must be treated appropriately.

Step 8: Ask About Endometriosis

Clues include:

- severe period pain,
- painful intercourse,
- chronic pelvic pain,
- endometrioma.

Endometriosis can cause:

- adhesions,
- tubal dysfunction.

Step 9: Review Previous Surgery

I ask about:

- ectopic pregnancy surgery,
- ovarian surgery,
- appendicitis,
- fibroid surgery,
- abdominal infection,
- tubal sterilization.

Step 10: Decide Whether Non-Surgical Reassessment Is Reasonable

For suspected proximal blockage, options may include:

- repeat HSG,
- selective salpingography,
- cannulation.

Step 11: Use Individualized Unani Support Where Appropriate

I may include:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised traditional pharmacotherapy.

The objectives may include:

- reproductive nutrition,
- menstrual health,
- metabolic health,
- general fertility support.

Step 12: Do Not Promise Anatomical Reopening Without Proof

If the treatment claim is:

“the tube opened”

then the appropriate proof should be:

- repeat HSG,
- HyCoSy,
- or another valid tubal test.

Feeling healthier or having regular periods does not prove tubal patency.

Step 13: Use Tubal Cannulation for Suitable Proximal Obstruction

In young women with appropriate proximal disease, ASRM recommends cannulation as a useful treatment.

This is an important middle ground between:

- oral medicine,
- major surgery.

Step 14: Consider Surgery When It Offers a Reasonable Prognosis

WHO suggests surgery in women:

- under 35,
- mild-to-moderate tubal disease,

when other fertility factors are favorable.

Step 15: Do Not Delay IVF in Severe Disease

For:

- severe tubal disease in women under 35,
- any tubal disease in women 35 or older,

WHO generally favors:

IVF

over tubal surgery.

Step 16: Treat Hydrosalpinx Before IVF

Where significant hydrosalpinx is present, I advise appropriate gynecological/reproductive-surgical consultation.

WHO recommends:

- salpingectomy,
- or tubal occlusion

before IVF.

Step 17: Confirm Early Pregnancy Location

After treatment, if pregnancy occurs, I advise early:

serum pregnancy assessment and ultrasound

because tubal-disease patients have increased ectopic risk.

Can Saira Health Care Treat Blocked Fallopian Tubes?

Saira Health Care's current female-infertility service list specifically includes:

Blocked Fallopian Tubes

as one of the female fertility conditions addressed by the clinic.

At Saira Health Care, the treatment approach can include:

- review of fertility reports,
- individualized Unani assessment,
- diet and lifestyle guidance,
- supervised reproductive-health treatment,
- identification of cases requiring modern tubal procedures,
- timely referral for cannulation, surgery or IVF where appropriate.

The aim is not to create the false promise:

“Every blocked tube can be naturally opened.”

The aim is to help each couple determine:

the safest and most realistic route to pregnancy.

Saira Health Care's Contribution to Sexual Disorders and Infertility

Saira Health Care describes itself as a registered Unani clinic with a focus on:

sexual disorders and infertility.

Its female infertility services include:

- low AMH,
- PMOS/PCOS,
- blocked fallopian tubes,
- unexplained infertility,
- irregular menstruation,
- recurrent reproductive problems.

The clinic describes its overall philosophy as:

- patient-centered,
- individualized,
- combining traditional knowledge,
- modern diagnostic understanding,
- lifestyle guidance.

This is particularly relevant for tubal infertility because the correct fertility decision requires more than looking at:

one HSG image.

About Dr. Nizamuddin Qasmi

I am:

Dr. Nizamuddin Qasmi

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

My professional education and additional training include:

- **BUMS – Hamdard University, Delhi**
- **MD**

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

Saira Health Care's public profile identifies me as its physician working in sexual disorders and infertility and publicly lists:

- BUMS,
- MD,
- CGO,
- Certificate in Infertility,
- Certificate in Urology – London, UK.

Saira Health Care's current published professional material additionally lists:

- **Masters in Male Infertility – MasterHealthPro**
- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**

within my professional byline.

Why Male Infertility Training Is Relevant in a Female Tubal Disease

A woman may ask:

“Why do you mention male infertility training in an article about fallopian tubes?”

Because:

infertility belongs to the couple.

Suppose a woman has:

- one blocked tube,
- one normal tube.

If her husband has:

- normal semen,

she may have a reasonable natural fertility chance.

If her husband has:

- severe oligozoospermia,

the correct plan may be completely different.

Therefore:

a tubal report should never be interpreted independently from the male partner's fertility.

Success Stories: How They Should Be Reported

Patients naturally want to read:

success stories.

A good blocked-tube case report should ideally include:

1. woman's age,
2. infertility duration,
3. HSG diagnosis,
4. right/left/bilateral disease,
5. proximal/distal location,
6. hydrosalpinx status,
7. treatment,
8. repeat tubal testing where reopening is claimed,
9. male semen analysis,
10. conception method,
11. pregnancy location,
12. live birth,
13. patient consent.

Pregnancy Is Not Always Proof That the Blocked Tube Opened

This is particularly important in:

unilateral blockage.

If:

- right tube blocked,
- left tube open,

and the woman later becomes pregnant:

the pregnancy does not automatically prove the right tube opened.

She may simply have conceived through the healthy left tube.

Therefore, any website claiming:

“100% tube opening because pregnancy occurred”

would be scientifically incorrect unless repeat testing documented tubal patency.

Can a Blocked Tube Close Again After Treatment?

Yes.

Even after successful:

tubal cannulation

ASRM reports that approximately:

one-third

of reopened tubes may subsequently reocclude.

After reconstructive surgery:

- adhesions,
- scar tissue

can also recur.

Therefore, successful opening does not mean fertility is permanently guaranteed.

Does Opening the Tube Guarantee Pregnancy?

No.

Pregnancy still depends on:

- age,
- ovarian reserve,
- ovulation,

- sperm quality,
- tubal function,
- uterine health,
- embryo development.

A technically open tube can still have damaged:

- cilia,
- fimbriae.

Common Myths About Blocked Fallopian Tubes

Myth 1: One HSG showing blocked tubes proves permanent infertility.

Fact: Proximal HSG blockage can sometimes be false-positive because of spasm or debris.

Myth 2: Every blocked tube needs surgery.

Fact: Selected proximal obstructions may be treated using minimally invasive tubal cannulation.

Myth 3: Every blocked tube can be opened with medicines.

Fact: Dense fibrosis and severe hydrosalpinx cannot be reliably reversed with oral medicine.

Myth 4: A blocked tube means the ovary is damaged.

Fact: Ovarian function and tubal patency are separate issues.

Myth 5: One blocked tube means pregnancy is impossible.

Fact: Pregnancy can occur through the other healthy tube.

Myth 6: Both proximal tubes blocked on HSG always means IVF immediately.

Fact: Confirmation may be appropriate because proximal spasm and false-positive HSG results can occur.

Myth 7: Hydrosalpinx is just fluid that can be dried with medicine.

Fact: It usually reflects structural tubal damage and has important implications for IVF.

Myth 8: Antibiotics reopen old scarred tubes.

Fact: Antibiotics treat infection, not established fibrosis.

Myth 9: Oil-based HSG proves vaginal herbal oils open tubes.

Fact: Oil-contrast HSG is a medically controlled intrauterine contrast procedure; it is not equivalent to traditional oil application.

Myth 10: Hijama has been proven to dissolve tubal scar tissue.

Fact: High-quality evidence establishing this effect is not available.

Myth 11: Leech therapy has been proven to break pelvic adhesions.

Fact: No high-quality fertility trial proves this.

Myth 12: A natural pregnancy proves the previously blocked tube became patent.

Fact: In unilateral disease, conception may occur through the other tube.

Myth 13: IVF repairs the tubes.

Fact: IVF bypasses them.

Myth 14: IVF should always be avoided because surgery treats the root cause.

Fact: In severe tubal disease or women age 35 or older, WHO often favors IVF because reproductive time and success probabilities matter.

Myth 15: Every hydrosalpinx should be opened.

Fact: Severely damaged hydrosalpinges may be better removed or occluded before IVF.

Frequently Asked Questions

What is the most common test for blocked tubes?

HSG is commonly used.

WHO also supports:

HyCoSy

as a reasonable initial tubal-patency test.

Can HSG itself open the tubes?

Sometimes the flushing procedure may:

- dislodge mucus/debris,
- improve fertility temporarily.

Oil-based HSG has been associated with higher pregnancy and live-birth rates than water-based contrast in a large randomized study.

Can HSG open a scarred tube?

Not reliably.

Dense fibrosis may not respond to flushing.

Can proximal tubal blockage be opened?

Yes, selected cases can be treated with:

selective tubal cannulation.

Does cannulation require major surgery?

No.

Radiological tubal cannulation is generally a:

minimally invasive catheter procedure.

What is the pregnancy rate after tubal cannulation?

A meta-analysis summarized by ASRM reported approximately:

- **22.3% clinical pregnancy by six months**
- **26.4% at one year**
- **22% live birth**

across pooled studies.

Ectopic pregnancy occurred in approximately **4%**.

These figures should not be used as guaranteed individual results.

Can one blocked tube cause infertility?

It can reduce fertility, but natural conception remains possible through the healthy tube.

Can both blocked tubes be treated?

Possibly, depending on:

- location,
- severity.

Proximal obstruction may sometimes be treated with cannulation.

Severe bilateral distal disease may require:

IVF.

What is hydrosalpinx?

A damaged, blocked tube that has become:

- dilated,
- fluid-filled.

Can hydrosalpinx be treated naturally?

There is no high-quality evidence that oral natural medicine reliably reverses a structurally damaged hydrosalpinx.

Should hydrosalpinx be treated before IVF?

Yes, generally.

WHO suggests:

- salpingectomy,
- or tubal occlusion

before IVF.

Can I conceive with one hydrosalpinx?

It depends on the other tube and reproductive factors.

A communicating hydrosalpinx can also adversely affect IVF, even if only one side is affected.

What treatment does WHO recommend for a woman under 35?

For:

- mild-to-moderate tubal disease,

WHO conditionally suggests surgery.

For:

- severe disease,

WHO suggests IVF.

What if I am 35 or older?

WHO generally suggests:

IVF rather than tubal surgery

for tubal infertility in women age 35 or older.

Can Unani medicine help blocked tubes?

Unani medicine may provide valuable support through:

- diet,
- lifestyle,

- menstrual-health care,
- general reproductive support,
- individualized traditional pharmacotherapy.

Current evidence does not establish that it reliably reopens all true anatomical tubal occlusions.

What is the Unani term for blockage?

Traditional discussions use:

Suddah

for obstruction.

The supplied Unani material uses:

Suddah-e-Qazifain

for fallopian-tube obstruction.

Is there research on Unani treatment and tubal infertility?

Yes, but it is limited mainly to:

- case reports.

A published NIUM case described conception after Unani treatment in a woman with unilateral tubal blockage.

Did the NIUM study prove the tube opened?

No.

The main outcome was:

conception

rather than documented post-treatment HSG confirmation of tubal opening.

Because the blockage was unilateral, conception could have occurred through the other tube.

Can Unani and modern medicine be combined?

Yes, when done responsibly.

A woman can receive:

- appropriate lifestyle/diet care,
- supervised traditional fertility support,

while simultaneously using:

- modern tubal diagnostics,
- cannulation,
- surgery,
- IVF

when required.

Latest Scientific Perspective: 2025–2026

Tubal infertility treatment has become more:

age-specific and severity-specific.

WHO's first global infertility guideline, published on:

28 November 2025

provides formal recommendations for:

- tubal diagnosis,
- surgery,
- IVF,
- hydrosalpinx treatment.

HSG or HyCoSy Are Recommended for Initial Patency Assessment

WHO suggests:

- HSG,
- or HyCoSy

rather than routine invasive laparoscopy as the first assessment in women with suspected tubal infertility.

Age Now Explicitly Changes Treatment Recommendations

WHO separates treatment into:

Under 35 + mild/moderate disease

Surgery can be considered.

Under 35 + severe disease

IVF is favored.

Age 35 or older + tubal disease

IVF is generally favored.

Hydrosalpinx Has a Clear Pre-IVF Treatment Pathway

WHO suggests:

salpingectomy or tubal occlusion

rather than leaving hydrosalpinx untreated before IVF.

Proximal HSG Blockage Should Not Be Overdiagnosed

ASRM continues to emphasize that proximal occlusion on HSG can be false-positive.

This is particularly important because:

some women may be told they need IVF when their tubes are not truly permanently obstructed.

Tubal Cannulation Remains an Important Minimally Invasive Option

For appropriate proximal obstruction:

selective cannulation

can restore patency without major abdominal surgery.

Tubal Flushing Has Real—but Specific—Evidence

The H2Oil randomized trial supports a fertility benefit from:

oil-based HSG contrast

in selected infertile women.

But this evidence should not be misused to market unrelated:

- oral oils,
- vaginal oils,
- massage therapy

as proven tubal-opening techniques.

My Final Message to Women With Blocked Fallopian Tubes

If your HSG says:

“Tube blocked”

do not immediately think:

“I can never become pregnant naturally.”

But do not automatically believe:

“A herbal medicine will definitely reopen it.”

Instead ask:

Which tube is blocked?

Is it one tube or both?

Is the block proximal or distal?

Could it be tubal spasm?

Could mucus or debris be responsible?

Should the HSG be repeated?

Would selective cannulation be appropriate?

Is there a hydrosalpinx?

Are the fimbriae damaged?

Do I have endometriosis?

Have I had PID, tuberculosis or pelvic surgery?

What is my age?

What is my ovarian reserve?

Am I ovulating?

Has my husband had a semen analysis?

Can I reasonably try for natural conception with one healthy tube?

Can individualized Unani treatment support my reproductive health?

Would tubal surgery give a reasonable chance?

Would IVF protect my reproductive time better?

These questions lead to rational treatment.

Conclusion

Blocked fallopian tubes are an important cause of female infertility, but:

tubal blockage is not one single disease.

The obstruction may be:

- proximal,
- mid-segment,
- distal,
- unilateral,
- bilateral,
- functional,
- fibrotic,
- associated with hydrosalpinx.

The causes may include:

- pelvic inflammatory disease,
- sexually transmitted infection,
- genital tuberculosis,
- endometriosis,
- previous ectopic pregnancy,
- pelvic surgery,

- adhesions,
- sterilization.

Tubal patency should generally be evaluated using:

HSG or HyCoSy

according to current WHO guidance.

A proximal blockage reported on HSG is not always permanent.

ASRM reports substantial false-positive proximal obstruction, including a study in which approximately:

60%

showed an open tube on repeat HSG.

Therefore, selected women may avoid major surgery through:

- repeat assessment,
- selective salpingography,
- tubal cannulation.

Tubal flushing with oil-based HSG contrast has also been shown to improve pregnancy and live-birth rates in selected infertile women.

But:

dense scar tissue and severe hydrosalpinx are different problems.

For severe tubal disease, IVF often offers the more appropriate fertility pathway.

WHO 2025 now recommends:

- surgery for selected women under 35 with mild-to-moderate tubal disease,
- IVF for severe disease under 35,
- IVF generally for tubal disease at age 35 or above.

Hydrosalpinx should generally be treated with:

- salpingectomy,
- or tubal occlusion

before IVF.

The **Unani system of medicine** has a valuable traditional approach to female infertility using:

- Mizaj,

- Akhlat,
- Suddah,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa.

Traditional concepts may support individualized:

- diet,
- lifestyle,
- reproductive-health,
- menstrual-health care.

Published Unani literature includes a case report from the National Institute of Unani Medicine in which a woman with unilateral tubal blockage conceived after traditional fertility formulations.

This is encouraging but:

it does not prove that the blocked tube itself reopened.

Current evidence is not sufficient to claim that Unani medicines, Hijama, leech therapy or herbal oils reliably:

- dissolve dense adhesions,
- reverse severe fibrosis,
- cure hydrosalpinx,
- reopen every anatomically obstructed tube.

At **Saira Health Care**, blocked fallopian tubes form part of the clinic's publicly listed female-infertility services.

My approach as **Dr. Nizamuddin Qasmi** is therefore:

Confirm whether the tube is genuinely blocked.

Differentiate spasm or mucus from true fibrosis.

Determine whether blockage is proximal or distal.

Distinguish unilateral from bilateral disease.

Identify hydrosalpinx early.

Consider PID, genital TB, endometriosis and previous surgery.

Assess female age and ovarian reserve.

Evaluate ovulation.

Evaluate the male partner.

Use individualized Unani diet, lifestyle and supervised pharmacotherapy where appropriate.

Do not claim anatomical tube opening unless a valid test confirms it.

Use tubal cannulation when appropriate.

Use surgery when the disease is mild enough to make surgery worthwhile.

Use IVF without unnecessary delay when the disease is severe or reproductive time is limited.

Treat hydrosalpinx appropriately before IVF.

And never guarantee pregnancy simply because a tube has become technically patent.

For every woman who asks:

“Doctor, can my blocked fallopian tube be opened without surgery?”

my answer is:

Sometimes, yes—especially when the apparent blockage is proximal and related to spasm, mucus or debris, or when minimally invasive tubal cannulation can restore patency. But a truly scarred or severely damaged tube cannot reliably be rebuilt with oral medicine alone. The correct treatment depends on where the tube is blocked, why it is blocked, how damaged it is, your age, ovarian reserve and your partner's fertility. Our aim should always be the best realistic chance of a healthy pregnancy—not simply making an HSG report look normal.

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About the Author

Dr. Nizamuddin Qasmi

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

Professional Education & Training

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

Saira Health Care's public physician profile identifies Dr. Nizamuddin Qasmi's focused work in **Sexual Disorders & Infertility** and includes male and female reproductive conditions in the practice.

Saira Health Care's published material also lists his additional training in **Male Infertility – MasterHealthPro** and **Integrated Sexual and Reproductive Health – ISRH, UNFPA**.

Medical Disclaimer

This article is intended for:

- patient education,

- fertility awareness,
- general reproductive-health information.

It does not replace:

- gynecological consultation,
- HSG,
- HyCoSy,
- laparoscopy when indicated,
- tubal cannulation assessment,
- infection testing,
- tuberculosis evaluation,
- semen analysis,
- ovarian-reserve assessment,
- reproductive surgery,
- IVF consultation.

Do not assume that:

- one HSG result proves permanent blockage,
- one open tube guarantees pregnancy,
- pregnancy proves a previously blocked tube opened,
- herbs can dissolve every scar,
- hydrosalpinx is merely “fluid” that can be dried with medicine.

Do not independently begin:

- antibiotics,
- anti-tubercular drugs,
- fertility hormones,
- Unani herbomineral preparations,
- vaginal herbal medicines,
- intrauterine oils,
- Hijama,

- leech therapy

as a substitute for appropriate medical evaluation.

Any woman with:

- hydrosalpinx,
- bilateral tubal blockage,
- previous ectopic pregnancy,
- severe pelvic pain,
- suspected PID,
- suspected genital tuberculosis,
- age 35 years or older,
- low ovarian reserve,
- significant male-factor infertility

should receive timely specialist fertility assessment.

Where:

- tubal cannulation,
- reconstructive surgery,
- salpingectomy,
- tubal occlusion,
- IVF,
- ICSI

is medically indicated, Unani supportive treatment should not cause unnecessary delay.

No modern, Unani, surgical or assisted-reproductive treatment can ethically guarantee:

- tubal reopening,
- natural conception,
- IVF success,
- pregnancy,
- live birth.

Saira Health Care

www.sairahealthcare.com

Medical literature reviewed and updated: September 2026