

When Should You Seek a Fertility Evaluation?

How Long Should You Try for Pregnancy Before Seeing a Fertility Specialist? Age-Based Guidance, Early Warning Signs, Male and Female Evaluation, Fertility Tests, Infertility Prevention and the Supportive Role of Unani Medicine

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A Message From Dr. Nizamuddin Qasmi

One of the most common questions couples ask me is:

“Doctor, how long should we keep trying naturally before we get fertility tests?”

Some couples come to me after only two or three months of trying and are already frightened that they are infertile.

Others have been trying for:

three years,

five years,

sometimes much longer,

but continue to hear:

“Keep trying, it will happen.”

Both situations can be problematic.

Not becoming pregnant in the first few months does **not** automatically mean infertility.

But waiting too long can also waste valuable reproductive time, particularly when:

the woman is 35 or older,

menstrual cycles are irregular,



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there is previous pelvic infection or ectopic pregnancy,
endometriosis is suspected,
ovarian reserve may be reduced,
the man has a known reproductive problem,
ejaculation or erection is preventing effective intercourse.

The correct answer is therefore not simply:

“Everyone should wait one year.”

Modern fertility medicine uses:

age + duration of trying + medical history + reproductive history + sexual history.

Current ASRM guidance recommends evaluation after **12 months** of regular unprotected intercourse when the female partner is younger than 35 and there is no known infertility risk factor. Evaluation should generally begin after **6 months** when she is 35 or older, while women over 40 may warrant more immediate evaluation and treatment. ACOG's current guidance follows the same general age-based approach.

But the most important qualification is:

If a known fertility problem may already exist, do not wait for the calendar.

That is the message I want couples to understand.

What Is Infertility?

The World Health Organization defines infertility as a disease of the male or female reproductive system characterized by failure to achieve pregnancy after:

12 months or more of regular unprotected sexual intercourse.

WHO's latest fact sheet, published alongside its first global infertility guideline in November 2025, estimates that approximately:

1 in 6 people

experience infertility during their lifetime.

This tells us two important things.

First:

infertility is common.

Second:



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infertility is not only a woman's problem.

It may result from:

female factors,

male factors,

combined male and female factors,

unexplained factors.

Infertility Is a Couple's Condition

When a couple has difficulty conceiving, one of the mistakes I most strongly try to avoid is evaluating only the woman.

In many families, the woman undergoes:

blood tests,

ultrasound,

HSG,

repeated medicines,

while the male partner has never even had:

a semen analysis.

That is not good fertility medicine.

The AUA/ASRM male-infertility guideline, amended in 2024, specifically recommends:

concurrent evaluation of both partners.

The male evaluation should begin with:

reproductive history,

one or more semen analyses.

ASRM similarly states that when a male partner contributes to conception, both partners should begin assessment at the same time.

At Saira Health Care, I therefore explain:

Fertility belongs to the couple, not to one partner alone.

How Long Should You Try Before Seeking Fertility Evaluation?



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A simple practical framework is:

Female partner younger than 35 years

If she has regular menstrual cycles and there is no known male or female fertility problem:

seek evaluation after 12 months of regular unprotected intercourse without pregnancy.

Female partner aged 35–40 years

Do not routinely wait a full year.

Seek evaluation after approximately 6 months.

Female partner older than 40 years

Seek fertility evaluation without unnecessary delay.

Current ACOG guidance says women older than 40 should discuss fertility evaluation immediately, while ACOG's 2025 ovarian-age counselling statement likewise recommends immediate evaluation in this age group.

Why Does the Waiting Period Become Shorter After Age 35?

Because female reproductive ageing is different from many other health issues.

A woman's ovarian follicle pool:

declines continuously with age.

Egg quality also changes with age, particularly because the probability of chromosomal abnormalities rises.

ACOG states that healthy couples in their 20s and early 30s may have approximately a **25–30% chance of pregnancy per menstrual cycle**, while by age 40 the chance falls to below approximately **10% per cycle**.

Therefore, six or twelve months do not have the same reproductive significance at:

age 25,

age 38,

age 42.

This is why:

age is part of the diagnosis.



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Is Age 35 a “Fertility Cliff”?

No.

A woman does not suddenly become infertile on her 35th birthday.

Fertility decline is:

gradual.

But the decline accelerates with increasing age, particularly through the later 30s.

Age 35 is therefore best understood as:

a clinical decision threshold,

not an on/off switch.

The reason we investigate earlier is because:

time becomes more valuable.

Should a Woman Over 40 Wait Six Months?

Generally:

No.

If pregnancy is desired at age 40 or beyond, particularly above 40, I recommend seeking fertility advice promptly rather than deliberately waiting for six or twelve months.

ACOG specifically recommends immediate discussion of fertility evaluation for women older than 40.

This does not mean IVF is automatically required.

It means:

do not waste time before understanding your reproductive situation.

When Should You Seek Fertility Evaluation Immediately?

The age-based waiting periods apply mainly when:

menstrual cycles appear normal,

intercourse is occurring regularly,

neither partner has a known reproductive disorder.



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ASRM specifically recommends **not delaying evaluation** when a history or condition known to cause infertility is present.

The following situations deserve earlier assessment.

1. Irregular Menstrual Periods

Do not automatically wait a year if menstrual cycles are:

very irregular,

widely spaced,

absent.

Irregular periods may indicate:

irregular or absent ovulation.

Possible causes include:

PCOS,

thyroid disease,

elevated prolactin in selected patients,

hypothalamic dysfunction,

diminished ovarian function,

premature ovarian insufficiency.

ASRM lists:

irregular menstrual cycles,

oligomenorrhea,

amenorrhea

among conditions warranting fertility evaluation without delay.

2. No Periods — Amenorrhea

If a woman is not menstruating naturally, she should not wait twelve months merely to satisfy a definition of infertility.

The question should be:

Why are the periods absent?



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Possibilities include:

pregnancy,

PCOS,

hypothalamic amenorrhea,

thyroid disorder,

high prolactin,

primary ovarian insufficiency,

anatomical abnormality.

The underlying cause needs evaluation.

3. Very Short Menstrual Cycles

ASRM specifically identifies menstrual cycles shorter than approximately:

25 days

as a reason earlier assessment may be appropriate.

Shortening cycles can sometimes reflect changes in:

follicular development,

ovarian ageing.

This does not automatically diagnose diminished ovarian reserve.

But it deserves attention in the right clinical setting.

4. Bleeding Between Periods

Persistent:

intermenstrual bleeding

is another reason to seek earlier assessment.

Possible causes include:

polyps,

fibroids,

cervical disease,



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hormonal disorders,
other uterine conditions.

ASRM includes intermenstrual bleeding among findings that can justify early fertility investigation.

5. Known or Suspected Endometriosis

If a woman has:

severe period pain,
deep painful intercourse,
chronic pelvic pain,
previous endometriosis diagnosis,
endometrioma,

I do not advise automatically waiting a full year.

Endometriosis can affect fertility through several mechanisms, including:

pelvic inflammation,
adhesions,
ovarian involvement,
altered tubal anatomy.

ASRM specifically lists known or suspected endometriosis as an indication for earlier evaluation.

6. Previous Pelvic Inflammatory Disease

A previous episode of PID may damage:

the fallopian tubes.

The risk is particularly relevant when there was:

recurrent PID,
severe infection,
tubo-ovarian abscess,
previous chlamydia or gonorrhoea.



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A woman with this history and fertility concerns may benefit from earlier:

tubal evaluation.

Waiting a year without considering the tubes may unnecessarily delay diagnosis.

7. Previous Ectopic Pregnancy

A previous ectopic pregnancy can indicate underlying tubal disease.

The remaining reproductive situation depends on:

condition of both tubes,

previous surgery,

age,

other fertility factors.

A couple with a meaningful history of ectopic pregnancy may therefore deserve earlier fertility assessment.

8. Known Tubal Disease or Hydrosalpinx

If previous testing has already shown:

blocked fallopian tube,

bilateral tubal obstruction,

hydrosalpinx,

there is little value in saying:

“Try naturally for another year before evaluation.”

The problem is already known.

The question becomes:

What is the most appropriate treatment strategy?

WHO's 2025 infertility guideline includes specific recommendations for:

tubal disease,

hydrosalpinx,

tubal surgery,



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IVF.

9. Previous Pelvic or Abdominal Surgery

Certain surgeries can potentially lead to:

adhesions,

altered pelvic anatomy.

Examples include selected surgeries involving:

fallopian tubes,

ovaries,

uterus,

bowel or pelvis.

A surgical history does not automatically mean infertility, but it may justify earlier evaluation depending on the procedure and symptoms.

10. Known Uterine Abnormality

Earlier assessment is appropriate when there is known or suspected:

uterine septum,

significant fibroids,

endometrial polyps,

intrauterine adhesions,

congenital uterine abnormality.

ASRM specifically identifies known or suspected uterine disease among reasons not to delay fertility investigation.

11. History of D&C, Uterine Infection or Asherman Syndrome

If menstruation became:

much lighter,

absent

after:



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miscarriage treatment,

postpartum curettage,

uterine surgery,

intrauterine adhesions should be considered.

A patient with suspected Asherman syndrome should not wait twelve months before evaluation.

12. Previous Chemotherapy

Certain chemotherapy medicines can damage:

ovarian follicles,

sperm-producing cells.

A person with previous gonadotoxic chemotherapy deserves individualized fertility assessment.

ASRM specifically lists:

chemotherapy exposure

among acquired conditions that can predispose to diminished ovarian reserve and justify earlier evaluation.

13. Previous Pelvic or Testicular Radiation

Radiotherapy can affect:

ovaries,

uterus,

testes,

sperm production

depending upon the:

location,

dose,

age at treatment.



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Patients with previous reproductive-organ radiation exposure should not necessarily wait for routine infertility timelines.

14. Cancer Treatment Planned but Not Yet Started

This situation deserves immediate attention.

If a patient is about to undergo treatment that can impair fertility, fertility preservation should ideally be discussed:

before treatment begins.

Options may include:

sperm freezing,

egg freezing,

embryo cryopreservation,

depending upon the patient.

This is not infertility treatment after infertility has occurred.

It is:

fertility preservation.

15. Known Diminished Ovarian Reserve

If previous testing or clinical history suggests diminished ovarian reserve, do not rely on:

“You are younger than 35, so keep trying for a year.”

Management depends heavily on:

age,

AMH,

antral follicle count,

reproductive history,

treatment goals.

However, one important point must be understood:

AMH is not a pregnancy test.

Low AMH does not mean:



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natural pregnancy is impossible.

And high AMH does not mean:

egg quality is excellent.

ASRM specifically cautions that ovarian-reserve testing should not be used as a general fertility screening test in women who do not otherwise meet indications for infertility evaluation.

16. Family History of Early Menopause or Primary Ovarian Insufficiency

If several close female relatives experienced:

very early menopause,

premature ovarian insufficiency,

earlier reproductive counselling can be reasonable.

The purpose is not to create fear.

It is to avoid discovering a potentially time-sensitive reproductive issue too late.

17. Known Genetic Conditions Affecting Fertility

Examples can include selected:

chromosomal disorders,

FMR1 premutation,

genetic causes of male infertility.

ASRM specifically includes genetic conditions predisposing to diminished ovarian reserve among reasons for prompt evaluation.

18. Known or Suspected Male Infertility

You do not need to wait one year if the man already has a known reproductive problem.

Examples include:

azoospermia,

severe oligospermia,

previous abnormal semen analysis,



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known testicular disease.

ASRM identifies known or suspected male subfertility as an indication for immediate infertility evaluation.

19. History of Undescended Testis

Men with previous:

cryptorchidism

may have impaired sperm production, particularly when:

both testes were affected,

orchiopexy was delayed.

A couple does not need to wait unnecessarily if significant male-risk history already exists.

20. Previous Testicular Torsion or Testicular Injury

A history of:

torsion,

severe trauma,

testicular surgery

may affect testicular function.

Semen analysis can provide much more useful information than simply waiting month after month.

21. Previous Mumps Orchitis or Severe Testicular Infection

Post-pubertal mumps with orchitis can occasionally impair:

testicular function,

sperm production.

The reproductive impact varies greatly between men.

If pregnancy is desired, evaluation can be considered early.



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22. Varicocele With Fertility Concerns

Varicocele is common and not every varicocele causes infertility.

But a man with:

a clinically significant varicocele,

fertility difficulty,

abnormal semen analysis

deserves male reproductive assessment.

Simply giving supplements for years without obtaining a semen analysis can waste time.

23. Erectile Dysfunction Preventing Intercourse

This is one of the most overlooked reasons for delayed conception.

ASRM explicitly identifies:

sexual dysfunction

as a reason fertility evaluation should not be delayed.

If vaginal intercourse is not occurring effectively because of:

erectile dysfunction,

severe performance anxiety,

the couple may not truly have had twelve months of regular exposure to pregnancy.

In such a case:

treating the sexual problem may be part of fertility treatment.

This is particularly important in my practice because I work at the intersection of:

Sexual Disorders & Infertility.

24. Ejaculatory Dysfunction

Pregnancy may be difficult when a man has:

anejaculation,

retrograde ejaculation,



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severe delayed ejaculation,

ejaculation that does not occur intravaginally.

These conditions should trigger early assessment.

Waiting for twelve months cannot solve a mechanical problem preventing sperm from reaching the female reproductive tract.

25. Very Low Sexual Frequency

Some couples say:

“We have been trying for a year.”

But after discussion, I find intercourse occurred only:

once or twice each month,

sometimes outside the fertile window.

This changes the interpretation.

For natural conception, ASRM describes the fertile window as roughly the **six-day interval ending on the day of ovulation** and notes that intercourse every **1–2 days during the fertile window** can maximize chances of conception.

Therefore:

duration alone is not enough.

We must ask whether pregnancy had a realistic opportunity to occur.

26. Vaginal Pain Preventing Intercourse

Conditions such as:

vaginismus,

pelvic-floor dysfunction,

severe dyspareunia,

vulvodynia

can make intercourse:

impossible,

incomplete,



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too infrequent.

These are legitimate fertility-related problems.

The correct approach is not:

“Try harder for another year.”

The sexual pain disorder itself needs evaluation and treatment.

27. Recurrent Miscarriage

Repeated pregnancy loss is not exactly the same as failure to conceive.

A couple may conceive easily but repeatedly lose pregnancies.

This deserves a different type of reproductive evaluation.

ASRM recognizes recurrent pregnancy loss and certain genetic situations as reasons reproductive evaluation may be appropriate even outside the ordinary infertility definition.

The AUA/ASRM male-infertility guideline also states that male evaluation should be considered in couples with:

two or more pregnancy losses.

Therefore:

repeated miscarriage should not be managed simply by telling the couple to keep trying indefinitely.

28. Secondary Infertility

Some couples say:

“We already have one child, so we cannot be infertile.”

That is incorrect.

WHO recognizes:

secondary infertility,

meaning difficulty achieving another pregnancy after a previous pregnancy has already occurred.

A person can develop fertility problems later because of:



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age,
infection,
surgery,
tubal disease,
diminished ovarian reserve,
male semen changes.

The same age-based evaluation principles generally apply.

29. No Pregnancy After Previous Easy Conception

If a first pregnancy occurred very easily but several years later another pregnancy is not occurring, do not assume fertility remains unchanged.

Both partners can change over time.

The woman may have developed:

endometriosis,
fibroids,
tubal damage,
ovarian ageing.

The man may have developed:

varicocele,
hormonal problems,
lifestyle-related sperm impairment.

Secondary infertility deserves the same seriousness as primary infertility.

30. Long Period of Trying With Poorly Timed Intercourse

Before labeling a couple infertile, I ask whether intercourse has occurred around:
ovulation.

The fertile period is not limited to one exact day.

Sperm can remain capable of fertilization for several days.



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ASRM defines the fertile window as approximately six days ending on ovulation, with peak fertility generally around the days immediately preceding ovulation.

Couples should not become so obsessed with one “perfect” ovulation day that intercourse becomes:

stressful,

infrequent,

mechanical.

What Does “Regular Unprotected Intercourse” Actually Mean?

In fertility medicine, this generally means intercourse frequent enough that sperm are repeatedly present during possible fertile days.

For many couples:

intercourse every 1–2 days during the fertile window

is reasonable.

Alternatively, intercourse:

two to three times per week throughout the cycle

often provides adequate coverage without excessive scheduling.

The objective is not:

maximum frequency.

The objective is:

regular opportunity for sperm and egg to meet.

Do You Need an Ovulation App Before Seeking Help?

No.

Apps can estimate fertile days, but they do not directly prove that ovulation occurred.

Some women with very regular cycles can estimate ovulation reasonably well.

Others have:

variable cycles,

PCOS,



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irregular ovulation,

making app predictions unreliable.

If menstruation is clearly irregular:

seek evaluation rather than spending a year trying to perfect an app prediction.

What Happens During a Fertility Evaluation?

A good fertility evaluation should be:

systematic, focused and cost-conscious.

ASRM emphasizes beginning with the least invasive methods likely to identify common causes rather than ordering every available fertility test.

I usually think about four broad questions:

1. Is ovulation occurring?

2. Are the female reproductive organs structurally suitable?

3. Are the fallopian tubes patent when tubal evaluation is appropriate?

4. Is the male partner producing and delivering sufficient functional sperm?

These four questions identify a large proportion of clinically important fertility problems.

The First Step Is the History

Before ordering a test, I want to understand:

For the woman

age,

duration of trying,

menstrual-cycle pattern,

previous pregnancy,

miscarriage,

ectopic pregnancy,

pelvic infection,

surgery,



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endometriosis symptoms,
previous chemotherapy/radiation.

For the man

previous conception,
undescended testes,
testicular infection/injury,
surgery,
medications,
anabolic steroids,
testosterone use,
sexual function.

For the couple

frequency of intercourse,
timing,
erectile function,
ejaculation,
painful intercourse.

Sometimes the history tells us which investigation should come first.

Semen Analysis Should Usually Be an Early Test

In a couple with infertility and a male partner contributing sperm:

semen analysis should not be postponed until the woman finishes every investigation.

AUA/ASRM recommends semen analysis as part of the initial male evaluation.

A semen analysis provides information about:

semen volume,
sperm concentration,
total sperm number,



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motility,

morphology.

It does not provide a simple:

fertile / infertile

label.

But it can quickly identify important male factors.

One Abnormal Semen Analysis Does Not Always Give the Final Answer

Semen parameters vary naturally.

They may change after:

fever,

illness,

stress,

medication,

collection difficulties.

When an initial semen analysis is abnormal, repeat testing may be appropriate depending upon the result and clinical situation.

Severe abnormalities may also require:

hormonal testing,

examination,

genetic testing,

ultrasound

according to indication.

What About Ovulation?

A woman with regular, predictable cycles is often ovulating.

ASRM states that in women with regular menstrual cycles roughly within:

21–35 days,



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additional testing solely to confirm ovulation is usually unnecessary unless another concern such as hirsutism is present.

This is important because some women undergo:

repeated progesterone tests,

repeated follicular scans

without a clear indication.

Testing should answer a question.

When Are Hormone Tests Needed?

Hormonal evaluation is individualized.

Examples may include:

TSH when thyroid disease is relevant,

prolactin with galactorrhea or amenorrhea,

FSH/estradiol in selected amenorrhea,

androgens when hyperandrogenism is present,

AMH as part of ovarian-reserve assessment where clinically appropriate.

But:

not every hormone should be ordered for every couple.

ASRM specifically advises against routine indiscriminate hormone testing without indication.

What Is AMH?

AMH—Anti-Müllerian Hormone—is produced by cells surrounding developing ovarian follicles.

It is useful mainly as a marker of:

ovarian reserve / expected ovarian response.

It does **not** directly measure:

egg quality,

ability to conceive naturally this month.



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Therefore:

a low AMH result is not the same as infertility.

And:

a high AMH result does not guarantee pregnancy.

This distinction is particularly important when younger women purchase AMH tests online without any infertility indication.

Should Every Woman Check AMH Before Trying?

Current ASRM guidance says:

ovarian reserve testing should not be used as a routine screening test in women who do not otherwise meet infertility criteria.

It is an adjunct used in the appropriate clinical context.

ACOG's 2025 age-related fertility statement acknowledges that ovarian-reserve assessment may sometimes contribute to counselling, particularly when childbearing is being delayed, but it remains an imperfect measure and does not remove the central importance of age.

How Are the Fallopian Tubes Checked?

When tubal evaluation is indicated, common tests include:

Hysterosalpingography — HSG

and ultrasound-based contrast methods such as:

HyCoSy / SHG-related tubal assessment.

ASRM recommends HSG or sonographic methods for evaluation of tubal patency.

Not every woman needs immediate:

laparoscopy.

Laparoscopy is generally reserved for specific indications.

What Does Pelvic Ultrasound Show?

Ultrasound may assess:



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uterus,
endometrium,
ovaries,
fibroids,
ovarian cysts,
endometriomas,
antral follicles.

It may identify conditions that change treatment.

But:

a normal ultrasound does not prove that the fallopian tubes are open.

Different tests answer different questions.

Is Laparoscopy Required for Every Infertile Woman?

No.

Routine diagnostic laparoscopy is not recommended in every infertility evaluation.

ASRM specifically lists laparoscopy among investigations that should not be routinely performed without another clinical indication.

It becomes useful when there is a meaningful reason to suspect:

endometriosis,
adhesions,
pelvic pathology
that may benefit from surgical evaluation.

Do All Men Need Sperm DNA Fragmentation Testing?

No.

Sperm DNA-fragmentation testing has selected uses, but it is not part of every initial infertility evaluation.

The AUA/ASRM approach begins with:

history,



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semen analysis.

More specialized testing follows only when indicated.

Likewise, ASRM does not recommend advanced sperm-function testing as a universal first-line infertility investigation.

What About the Post-Coital Test?

Older fertility practice sometimes examined cervical mucus after intercourse to see whether sperm were present.

Modern ASRM guidance does not recommend routine:

post-coital testing

in standard infertility evaluation.

This is a good example of why fertility evaluation should evolve with evidence rather than continuing every historical test.

Do You Need Immune Tests?

Routine:

immunologic testing,

thrombophilia panels

are not appropriate for every infertile couple.

ASRM lists these among tests that should not be routinely ordered without specific indications.

Large panels can:

increase expense,

produce incidental abnormal results,

lead to treatments with uncertain benefit.

Fertility Evaluation Does Not Automatically Mean IVF

Many couples delay coming to a fertility clinic because they think:

“If we go, the doctor will immediately advise IVF.”



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That is not how good fertility medicine should work.

A fertility evaluation is first:

an investigation.

Treatment might involve:

better timing of intercourse,

treatment of sexual dysfunction,

ovulation induction,

thyroid management,

varicocele treatment in selected cases,

surgery for selected uterine/tubal conditions,

IUI,

IVF,

ICSI.

IVF is only one part of a much wider fertility-care pathway.

WHO's New 2025 Approach to Fertility Care

In November 2025, WHO published its:

first global guideline for the prevention, diagnosis and treatment of infertility.

The guideline provides evidence-based recommendations covering:

infertility prevention,

diagnosis,

ovulatory disorders,

tubal disease,

uterine-cavity problems,

male-factor infertility,

unexplained infertility,

medically assisted reproduction.

One of the broader messages is extremely important:



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fertility care should progress from accurate diagnosis toward the least invasive effective treatment appropriate to the cause.

This helps protect patients from both:

unnecessary delay,

unnecessary expensive treatment.

What Is Primary Infertility?

Primary infertility means:

pregnancy has never been achieved.

WHO uses this distinction in its current infertility framework.

What Is Secondary Infertility?

Secondary infertility means:

at least one pregnancy occurred previously, but another pregnancy is now not occurring.

That prior pregnancy may have ended as:

live birth,

miscarriage,

ectopic pregnancy

depending upon the clinical history.

Secondary infertility deserves proper investigation.

A previous pregnancy does not guarantee fertility forever.

When Should a Man Seek Fertility Evaluation Independently?

A man does not need to wait until his wife has completed every test.

Earlier evaluation may be reasonable when he has:

known abnormal semen analysis,

azoospermia,

severe oligospermia,



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bilateral undescended testes history,
testicular injury/torsion,
testicular surgery,
chemotherapy/radiation,
ejaculatory disorder,
erectile dysfunction preventing intercourse,
genetic condition associated with infertility.

The AUA/ASRM guideline considers the male partner an equal part of the fertility evaluation.

Testosterone and Fertility

One particularly important male history is:

testosterone treatment or anabolic steroid use.

External testosterone can suppress:

LH,

FSH,

testicular sperm production.

A man trying to conceive should tell his fertility physician about:

testosterone injections,

testosterone gels,

bodybuilding steroids.

This information can fundamentally change the evaluation.

Does a Normal Semen Analysis Mean the Man Has Perfect Fertility?

No.

Semen analysis is essential, but no routine semen result perfectly predicts whether conception will or will not occur.

AUA/ASRM notes that semen values alone usually do not cleanly separate:

fertile men,



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infertile men,

except in extreme situations such as azoospermia.

Fertility is ultimately:

a couple-level outcome.

When Should a Couple Seek Help for Sexual Problems?

Immediately when the sexual problem is preventing conception.

Examples include:

erectile dysfunction,

premature loss of erection before penetration,

vaginismus,

severe dyspareunia,

anejaculation,

retrograde ejaculation,

very low libido preventing intercourse.

There is no medical benefit in waiting twelve months when:

sperm are not reaching the vagina.

ASRM specifically includes sexual dysfunction among reasons for prompt infertility evaluation.

This area is especially important in my clinical practice at Saira Health Care.

Performance Anxiety and Infertility

Some couples begin trying for pregnancy and intercourse suddenly becomes:

a scheduled performance.

The man thinks:

“Today is ovulation day. I must perform perfectly.”

Anxiety then produces:

erectile difficulty,



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delayed ejaculation,

loss of erection.

The couple may become increasingly stressed.

In such cases:

sexual counselling is fertility care.

Treating performance anxiety may restore natural conception opportunity without immediately moving to assisted reproduction.

How Long Should Couples Try After a Miscarriage?

A previous miscarriage does not automatically mean infertility.

Many couples conceive again naturally.

However, recurrent pregnancy loss—particularly:

two or more losses—

deserves a structured reproductive assessment rather than indefinite repeated attempts without evaluation. Male evaluation may also be appropriate.

Should You Wait After an Ectopic Pregnancy?

Management depends upon:

how the ectopic pregnancy was treated,

condition of the fallopian tubes,

age,

healing,

methotrexate use where relevant,

physician advice.

Once medically safe to try again, a woman with previous ectopic pregnancy deserves a lower threshold for fertility evaluation if conception is delayed because tubal factors may be present.

A future pregnancy should also be assessed early to confirm that it is located:

inside the uterus.



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When Should You Seek Evaluation After PID?

If a woman had significant:

recurrent PID,

tubo-ovarian abscess,

hydrosalpinx,

known tubal disease,

I would not automatically ask her to wait the full standard period.

The severity of previous disease and her age should determine how quickly:

tubal assessment

is considered.

When Should Someone Seek Fertility Advice Even Before Trying?

This is another important category.

You do not need to be infertile to seek:

fertility counselling.

It may be appropriate before trying when:

pregnancy is being postponed into the later reproductive years,

cancer treatment is planned,

ovarian surgery is planned,

family history suggests early ovarian failure,

a known genetic condition exists,

one partner has a major reproductive diagnosis.

ACOG's 2025 fertility-age counselling guidance specifically supports counselling or referral for people who plan to delay childbearing.

Fertility Preservation Is Different From Infertility Treatment

If a healthy person freezes:



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eggs,

sperm,

embryos

before a future risk or before age-related decline becomes more advanced, this is:

fertility preservation.

The purpose is to preserve options.

It does not mean the person is currently infertile.

Should Every Couple Get “Complete Fertility Tests” Before Marriage?

Usually:

no.

A broad infertility investigation in an asymptomatic couple who is not attempting pregnancy is generally unnecessary.

However, preconception counselling may be valuable when there is:

known reproductive disease,

genetic risk,

cancer history,

severe male reproductive history.

Testing should follow:

clinical need.

Not anxiety alone.

Lifestyle Before Fertility Evaluation

Lifestyle factors matter but should not become an excuse to delay diagnosis.

WHO identifies factors such as:

smoking,

excessive alcohol,

obesity,



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environmental exposures

as potential contributors to infertility.

ASRM similarly advises:

avoiding smoking,

avoiding recreational drugs,

maintaining general health

for couples trying to conceive.

But I do not tell a couple with bilateral tubal obstruction:

“Just lose weight and try for another year.”

Lifestyle treatment and fertility diagnosis should occur in the correct context.

Does Stress Cause Infertility?

Stress can affect:

libido,

intercourse frequency,

sleep,

sexual function,

quality of life.

In some women, severe physiological or psychological stress can also contribute to hypothalamic menstrual disturbance.

But I do not tell an infertile couple:

“Just relax and you will become pregnant.”

That statement can be emotionally harmful and medically inaccurate.

Infertility deserves proper evaluation.

The Emotional Burden of Waiting

WHO recognizes infertility as a condition that can cause substantial:

distress,



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stigma,
financial burden,
psychosocial consequences.

In my experience, uncertainty is often one of the most difficult parts.

A couple may think:

“Is something wrong?”

“Are we wasting time?”

“Should we try naturally?”

“Do we need IVF?”

A rational evaluation can replace uncertainty with:

information.

Even when treatment is not immediately required, knowing the reproductive situation can reduce unnecessary fear.

The Unani Perspective on Fertility Evaluation

In the Unani system of medicine, infertility has traditionally been discussed under concepts such as:

‘Uqr

and broader disturbances involving male and female reproductive health.

Traditional Unani physicians have emphasized:

Mizaj or constitutional temperament,

reproductive strength,

nutrition,

digestion,

sexual health,

menstrual health,

semen quality,

general physical wellbeing.

CCRUM continues to identify infertility—‘Uqr—as an area for Unani clinical research.



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These principles remain useful in modern integrative fertility practice.

But I believe the most important improvement in modern Unani infertility care is:

combining traditional whole-person assessment with objective reproductive diagnosis.

Why Diagnosis Should Come Before a “Fertility Tonic”

A woman who is not becoming pregnant might have:

anovulation,

blocked fallopian tubes,

diminished ovarian reserve,

uterine adhesions.

A man might have:

varicocele,

severe oligospermia,

azoospermia,

hormonal disease,

ejaculation dysfunction.

These problems are:

not interchangeable.

Giving every couple the same fertility medicine without first understanding the cause is unlikely to provide the best care.

This is why at Saira Health Care I prefer:

diagnosis-led Unani treatment.

Where Unani Medicine May Be Useful

Depending upon the identified cause, carefully selected Unani management may contribute supportively to:

nutrition,

metabolic health,



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digestive wellbeing,
menstrual regularity in selected functional disorders,
sexual health,
erectile confidence,
semen-related health in selected men,
sleep and stress,
general reproductive wellbeing.

This may be especially useful when the condition is:

functional,
metabolic,
lifestyle-associated
rather than permanently structural.

Unani Research in Male Infertility

Unani researchers have performed small clinical studies in:

oligospermia.

For example, research published through the CCRUM-associated *Hippocratic Journal of Unani Medicine* described a National Institute of Unani Medicine observational study of a traditional formulation in men with low sperm count. The study involved only around 30 participants and was uncontrolled, so its findings should be considered preliminary rather than definitive proof of improved fertility or live-birth outcomes.

Other traditional Indian herbal interventions have also shown signals of improvement in semen parameters in controlled studies, but results from one formulation cannot automatically be applied to:

every Unani medicine,
every cause of male infertility.

The correct conclusion is:

traditional medicines deserve study, but diagnosis still determines whether they are appropriate.



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Unani Medicine and Tubal Blockage

A published case report from the National Institute of Unani Medicine described natural conception in a woman with:

unilateral tubal blockage

after Unani treatment.

This is interesting.

But scientifically:

one case report cannot prove that a blocked tube was reopened.

Why?

Because a woman with:

one blocked tube,

one patent tube

may conceive through the patent tube.

Also, some apparent proximal tubal blockage on HSG can reflect:

temporary spasm.

Therefore I do not promise patients:

“Unani medicine will definitely open blocked tubes.”

Dense structural tubal fibrosis may require:

surgery,

IVF.

Unani Medicine Should Not Delay Time-Sensitive Fertility Treatment

This is especially important when:

the woman is in her late 30s or 40s,

ovarian reserve is markedly reduced,

bilateral tubal disease exists,

severe male infertility exists.

Spending one or two years trying successive unproven remedies can cause:



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irreversible loss of reproductive time.

My preferred integrative approach is:

use Unani medicine where it has a rational supportive role without delaying treatment whose success is strongly time-dependent.

What “Special Treatment” Means by Dr. Nizamuddin Qasmi

Specialized fertility care does not mean giving every patient:

one infertility package.

It means understanding:

why pregnancy is not occurring.

When a couple consults me, I ask:

How old are both partners?

How long have you actually been trying?

How often do you have intercourse?

Are cycles regular?

Is intercourse painful?

Is erection adequate?

Does ejaculation occur normally?

Has either partner conceived previously?

Has there been miscarriage or ectopic pregnancy?

Any history of PID, STI, endometriosis or surgery?

Any testicular disease?

Any chemotherapy or radiation?

Any previous semen analysis?

These questions determine:

which tests should come next.

Patient Example — Woman Age 27, Trying for Four Months



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Her cycles are:

regular,

no significant reproductive history,

partner has no known male-risk factors,

intercourse is regular.

She usually does **not** need an extensive infertility work-up after only four months.

The better approach may be:

reassurance,

optimize intercourse timing,

healthy preconception care.

Patient Example — Woman Age 36, Trying for Seven Months

This is different.

She has crossed the:

six-month evaluation threshold.

I would not advise:

“Wait another six months because infertility means one year.”

Current fertility guidance supports beginning assessment now.

Patient Example — Woman Age 42, Planning Her First Pregnancy

I would advise:

prompt fertility assessment.

Even if she has not yet tried for six months.

The objective is to understand:

ovarian reserve,

reproductive anatomy,

male fertility,

realistic natural and assisted-reproduction options.



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Time matters.

Patient Example — Woman Age 29 With Periods Every Two or Three Months

She should not automatically wait twelve months.

Her irregular periods suggest:

ovulatory dysfunction.

Evaluation can begin now.

Patient Example — Woman Age 30 With Severe Endometriosis

Again:

do not automatically wait one year.

Known endometriosis is an established reason for earlier evaluation.

Patient Example — Woman With Previous Bilateral PID

If tubal damage is suspected, I may consider earlier:

HSG,

HyCoSy

according to her history and clinical situation.

Waiting does not repair damaged tubes.

Patient Example — Husband Cannot Maintain an Erection

This couple may describe themselves as:

“trying for pregnancy for ten months.”

But if effective intravaginal ejaculation occurs only occasionally, the problem may fundamentally be:

sexual dysfunction.

Treating the erectile problem may be the first fertility intervention.



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Patient Example — Husband With Azoospermia on Previous Semen Analysis

Do not spend another year simply “trying naturally.”

Azoospermia requires structured male evaluation.

The clinician may need to distinguish:

obstructive,

non-obstructive azoospermia

and determine whether:

hormones,

genetics,

ultrasound,

surgical sperm retrieval

are relevant.

Patient Example — Couple With Two Miscarriages

They may conceive without difficulty.

Their problem is:

pregnancy loss,

not failure to conceive.

Repeated pregnancy loss deserves appropriate evaluation and male assessment may also have a role.

Patient Example — Normal Tests but No Pregnancy

Some couples undergo:

semen analysis,

ovulation assessment,

tubal testing

and no clear explanation is found.

This may be classified as:



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unexplained infertility.

ESHRE emphasizes that unexplained infertility is:

a diagnosis of exclusion,

meaning appropriate basic investigation should first rule out recognized factors.

“No explanation found” does not mean:

nothing is wrong.

It means current standard investigations have not identified a specific cause.

When Should You See a Fertility Specialist Rather Than Only a General Doctor?

Initial assessment can often begin with:

gynecologist,

appropriately trained physician.

Referral to reproductive medicine becomes particularly useful when:

age is advanced,

severe male factor exists,

tubal disease is known,

ovarian reserve is reduced,

multiple treatments have failed,

IVF may be required,

complex reproductive surgery is being considered.

Similarly, abnormal male findings may warrant evaluation by:

urologist,

male reproductive specialist.

ACOG notes that infertility assessment may involve an obstetrician-gynecologist, reproductive endocrinologist and, for men, a urologist.

What Should You Bring to Your First Fertility Appointment?

I advise couples to bring:



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previous semen reports,
ultrasound reports,
HSG reports,
hormone tests,
surgical records,
previous pregnancy/miscarriage records,
cancer-treatment history,
list of current medications.

For women, it can also help to know:

cycle length,
menstrual dates.

This prevents unnecessary repetition of tests.

Questions I Want Couples to Think About Before Consultation

For the woman

How old are you?
Are periods regular?
Have you ever been pregnant?
Any miscarriage or ectopic pregnancy?
Any pelvic infection?
Severe period pain?
Any pelvic surgery?
Any chemotherapy/radiation?

For the man

Have you fathered a pregnancy previously?
Any undescended testis?
Testicular injury?
Varicocele?



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Surgery?

Testosterone or steroid use?

Previous semen analysis?

For both

How frequently do you have intercourse?

Is intercourse comfortable?

Does ejaculation occur intravaginally?

How long have you actually had regular exposure?

These questions can be as valuable as laboratory tests.

Common Mistakes Couples Make Before Seeking Fertility Evaluation

Waiting too long because the woman is “still having periods”

Regular menstruation does not guarantee:

normal tubes,

normal ovarian reserve,

normal sperm.

Blaming only the woman

Male-factor infertility is common and should be assessed from the beginning.

Repeating the same medicines without diagnosis

Ovulation medicines will not fix:

bilateral tubal obstruction.

Herbal semen tonics will not correct:

some genetic forms of azoospermia.

Doing every advanced test immediately

More testing does not always mean better medicine.

Moving directly to IVF before completing basic evaluation

Some couples have treatable causes that do not require IVF.

Delaying appropriate treatment for years



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This can be particularly harmful when female age is advancing.

Red Flags: Do Not Wait the Standard 6–12 Months

Seek fertility assessment sooner when there is:

woman over 40,
irregular menstruation,
absent menstruation,
cycle length under approximately 25 days,
abnormal bleeding,
known endometriosis,
previous PID,
previous ectopic pregnancy,
known tubal blockage,
hydrosalpinx,
uterine abnormality,
suspected Asherman syndrome,
chemotherapy or radiation,
known diminished ovarian reserve,
strong risk of premature ovarian insufficiency,
known male infertility,
previous abnormal semen analysis,
history of bilateral undescended testes,
significant testicular surgery/injury,
erectile dysfunction preventing intercourse,
ejaculatory dysfunction,
severe painful intercourse or vaginismus,
recurrent pregnancy loss.

These conditions justify a:



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lower threshold for evaluation.

Frequently Asked Questions

How long should we try before seeing a fertility doctor?

If the female partner is under 35 and there are no known risk factors:

approximately 12 months.

If she is 35 or older:

approximately 6 months.

If she is over 40:

seek evaluation promptly.

Does everyone have to wait 12 months?

No.

Known fertility risk factors justify earlier evaluation.

I'm 32 and have irregular periods. Should I wait one year?

No.

Irregular menstrual cycles are a reason to investigate earlier.

I'm 36. Should I wait one year?

No.

Generally seek evaluation after about six months of appropriately timed attempts.

I'm 41. Should I try naturally for six months before testing?

Current guidance supports more immediate fertility assessment rather than waiting routinely.

Why does age change the timing?



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Because the quantity and quality of oocytes decline with age and the effectiveness of many fertility treatments also declines as reproductive age advances.

Does age affect men?

Yes, male reproductive ageing also occurs, though it is generally more gradual and less predictable than female age-related decline.

Should both partners attend the first fertility consultation?

Ideally:

yes.

Current male and female infertility guidelines support concurrent couple evaluation.

Should the husband get a semen analysis immediately?

When a couple meets criteria for infertility evaluation:

yes, semen analysis is generally an early component of the work-up.

Should we test only the woman first?

No.

That approach can delay diagnosis of male-factor infertility.

My husband already fathered a child. Does he still need testing?

Yes, if the current couple is experiencing infertility.

Male fertility can change.

This is called secondary infertility when pregnancy has occurred previously.

I already have one child. Can I still have infertility?

Yes.

Secondary infertility is common.



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Does regular menstruation prove fertility?

No.

Regular cycles make ovulation more likely, but do not prove:

tubal patency,

normal uterus,

normal ovarian reserve,

normal semen.

Do I need ovulation testing if cycles are regular?

ASRM says additional confirmation of ovulation is generally unnecessary in women with regular cycles approximately 21–35 days unless another clinical concern is present.

Should every woman get AMH?

No.

AMH is not recommended as a universal fertility screening test in women who do not otherwise have an indication.

Does low AMH mean I cannot become pregnant naturally?

No.

AMH mainly reflects ovarian reserve and expected response to stimulation.

It is not a direct measure of egg quality or a yes/no test for natural conception.

Does high AMH mean my fertility is excellent?

No.

Age and other reproductive factors still matter.

What is the first male fertility test?

Usually:

semen analysis.



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Does one abnormal semen analysis mean permanent infertility?

No.

Results may require confirmation and interpretation in clinical context.

Does a normal semen analysis guarantee pregnancy?

No.

It is an important test but not a guarantee.

Do I need HSG?

HSG is useful when tubal patency needs assessment.

Whether you need it depends on:

history,

duration of infertility,

treatment plan.

Does everyone need laparoscopy?

No.

Routine laparoscopy is not recommended for every infertile woman.

Do I need sperm DNA fragmentation testing at the first appointment?

Usually not.

Advanced sperm testing is not universally recommended in the initial infertility work-up.

Do I need immune tests?

Not routinely.

Do I need thrombophilia tests?



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Not for ordinary infertility without another indication.

What if intercourse is not happening because of erectile dysfunction?

Seek evaluation now.

Sexual dysfunction itself can prevent conception and ASRM specifically lists it as a reason not to delay fertility assessment.

What if I have vaginismus?

Seek sexual and fertility assessment early.

You do not have to wait a year if intercourse itself is not possible.

Can premature ejaculation cause infertility?

Most premature ejaculation does not cause infertility if semen is deposited inside the vagina.

But ejaculation before penetration every time can interfere with conception.

Can delayed ejaculation cause infertility?

It can if ejaculation rarely or never occurs intravaginally.

Can retrograde ejaculation affect fertility?

Yes.

Semen enters the bladder instead of exiting normally and may require specific evaluation.

We had two miscarriages. Should we wait until we meet the infertility definition?

No.

Recurrent pregnancy loss deserves its own evaluation and male evaluation may also be considered.



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Does previous PID mean I need fertility testing?

If there is significant PID history—particularly recurrent or severe disease—earlier tubal assessment may be appropriate.

Does previous ectopic pregnancy mean infertility?

No.

Many women conceive naturally afterward.

But it raises concern about tubal health and may justify earlier evaluation.

Does endometriosis mean I should seek help early?

Yes, known or suspected endometriosis is a reason not to delay infertility evaluation.

Does fibroid mean infertility?

Not every fibroid affects fertility.

Impact depends on:

size,

number,

location,

whether the uterine cavity is distorted.

Can polyps affect fertility?

Some endometrial polyps may interfere with fertility, particularly depending on size, location and planned fertility treatment.

Does varicocele mean the man is infertile?

No.

Many men with varicocele are fertile.

Treatment decisions depend on:

clinical examination,



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semen analysis,
couple's fertility status.

Does testosterone improve male fertility?

External testosterone can actually suppress sperm production.
Men attempting conception should disclose testosterone or anabolic-steroid use.

How often should we have sex when trying?

Intercourse every one to two days during the fertile window maximizes exposure according to ASRM guidance.

Do we need intercourse every day?

Not necessarily.
Every one to two days during the fertile window is usually adequate.

What is the fertile window?

Approximately the six-day interval ending on the day of ovulation.

Does fertility evaluation mean we will need IVF?

No.
Evaluation determines the cause.
Treatment may be much simpler than IVF.

Can infertility remain unexplained?

Yes.
Sometimes standard tests show:
ovulation,
patent tubes,



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reasonable semen parameters

without revealing a clear cause.

This is known as unexplained infertility.

Can Unani medicine help infertility?

It may have a supportive role in selected fertility conditions, particularly through individualized attention to:

nutrition,

metabolism,

menstrual health,

sexual function,

reproductive wellbeing.

But treatment should be based on the actual cause.

Has Unani medicine been researched in infertility?

Yes, small observational studies and case reports have evaluated Unani formulations in areas such as:

oligospermia,

female infertility.

However, much of this evidence is preliminary and is not sufficient to claim effectiveness for every infertility diagnosis.

Can Unani medicine open blocked tubes?

There is not enough high-quality evidence to promise reversal of established dense tubal fibrosis.

A single published Unani case report of conception with unilateral tubal blockage cannot prove that the blocked tube reopened.

Can Unani medicine improve sperm count?



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Some small Unani and broader herbal studies report improvements in selected semen parameters, but results depend on:

formulation,

underlying cause,

study quality.

Severe or specific causes such as:

genetic azoospermia,

major obstruction

cannot responsibly be treated as though they are simply a nutritional sperm weakness.

Should I try Unani medicine before getting fertility tests?

I prefer:

diagnosis first.

Once we know why pregnancy is not occurring, an appropriate integrative plan can be designed.

This prevents valuable time being lost.

A Message From Dr. Nizamuddin Qasmi to Young Couples

If you are young, healthy and have been trying for only a few months:

do not diagnose yourself with infertility too soon.

Natural conception is a probability, not a guarantee in every menstrual cycle.

Use:

regular intercourse,

healthy lifestyle,

appropriate timing.

But if a meaningful red flag exists:

do not wait merely because you are young.

Age is only one part of the fertility story.



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A Message to Women Over 35

I particularly want women over 35 to understand:

seeking evaluation earlier does not mean giving up on natural pregnancy.

It simply means using time intelligently.

We may discover:

everything appears favourable,

and advise continued natural attempts.

Or we may discover a time-sensitive problem that would otherwise have been recognized six months later.

Information gives you options.

A Message to Women Over 40

Please do not feel that:

“I must first try for one full year to prove that I am infertile.”

Current guidance does not require this.

Seek evaluation promptly.

We need to understand:

ovarian reserve,

ovulation,

tubes,

uterus,

partner semen.

Then we can discuss realistic options.

A Message to Men

Do not wait outside the fertility clinic believing:

“This is a woman's issue.”

Modern reproductive guidelines are very clear:



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both partners should be evaluated.

A semen analysis is:

relatively simple,

highly informative,

one of the earliest fertility investigations.

Seeking evaluation does not challenge masculinity.

It is simply good medical practice.

A Message to Couples With Sexual Dysfunction

Sometimes the reproductive organs are healthy but pregnancy is not occurring because:

intercourse itself is not functioning normally.

This can happen with:

erectile dysfunction,

performance anxiety,

vaginismus,

painful intercourse,

ejaculation disorders.

These are treatable clinical problems.

At Saira Health Care, because my work focuses on both:

Sexual Disorders & Infertility,

I consider sexual function part of the fertility evaluation rather than a separate embarrassing issue.

A Message About Unani Medicine

As a physician trained in Unani medicine, I believe fertility care benefits from attention to the person as a whole.

I consider:

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nutrition,
digestive health,
sleep,
metabolic wellbeing,
menstrual health,
sexual health,
general strength.

These areas can be important.

But in infertility:

time matters.

Therefore I do not want traditional treatment to become an excuse for postponing diagnosis.

A woman with:

bilateral tubal blockage
needs a tubal-factor plan.

A man with:

azoospermia
needs a male-infertility diagnosis.

A woman of 41 with:

very low ovarian reserve
needs time-sensitive counselling.

The strongest role of integrative Unani medicine is:

to complement accurate diagnosis—not replace it.

Special Treatment Planning by Dr. Nizamuddin Qasmi

At **Saira Health Care**, my fertility assessment is built around:

the couple rather than one isolated laboratory result.

Depending upon the patient's history, a treatment plan may include:



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menstrual and ovulatory evaluation,
ovarian reserve assessment where appropriate,
pelvic ultrasound,
HSG or another tubal test,
semen analysis,
male reproductive examination,
hormonal evaluation,
infection assessment,
sexual-function assessment,
lifestyle and metabolic optimisation.

Only after the likely cause has been identified do I decide what combination of:

natural conception guidance,
conventional fertility treatment,
sexual-disorder management,
carefully selected Unani supportive treatment,
referral for IUI/IVF/ICSI
is appropriate.

What “Special Treatment” Means at Saira Health Care

It does **not** mean:

“Every infertile couple receives the same medicines.”

It means asking:

Is there really infertility?

Is ovulation occurring?

Are the tubes open?

Is the uterus suitable?

Is sperm production adequate?

Is ejaculation occurring properly?



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Is intercourse actually taking place effectively?

Is time becoming critical because of age?

Is there a structural problem that medicine cannot reverse?

Once these questions are answered, treatment becomes:

individualized.

Saira Health Care's Contribution to Sexual Disorders & Infertility

The contribution of Saira Health Care in this field is particularly focused on integrating:

sexual medicine + male infertility + female infertility + Unani supportive care.

Many infertility clinics focus primarily on:

the woman,

laboratory investigations,

IVF.

But some couples need attention to:

erectile dysfunction,

painful intercourse,

ejaculation disorders,

male fertility,

relationship-related sexual anxiety

before or alongside assisted reproduction.

Our approach aims to identify:

the simplest effective path that remains medically appropriate.

Current Medical Understanding — 2026 Update

The fertility-care landscape has evolved significantly.

WHO published its **first global guideline for infertility in November 2025**, creating an evidence-based framework covering prevention, diagnosis and treatment of:

ovulatory infertility,



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tubal disease,

uterine-cavity disorders,

male-factor infertility,

unexplained infertility.

WHO continues to estimate that approximately:

one in six people

experience infertility in their lifetime.

The traditional definition of infertility remains useful:

no pregnancy after 12 months of regular unprotected intercourse.

But modern reproductive medicine no longer interprets this as:

“Everyone must wait exactly twelve months.”

ASRM explicitly states that evaluation should begin without delay when a medical, sexual or reproductive condition already suggests impaired fertility.

Age-based timing remains central:

under 35 → approximately 12 months;

35–40 → approximately 6 months;

over 40 → prompt evaluation.

Male evaluation should occur at the same time.

The AUA/ASRM 2024 amended male-infertility guideline identifies both partners as equal participants in diagnosis and recommends reproductive history plus semen analysis as part of the initial male work-up.

Modern evidence also encourages restraint:

more tests are not always better.

ASRM does not recommend routinely performing tests such as:

diagnostic laparoscopy,

advanced sperm-function tests,

postcoital testing,

thrombophilia panels,

immune tests,



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endometrial biopsy

in every couple without a clinical indication.

This represents a fundamental principle of modern fertility care:

investigate early when necessary—but investigate intelligently.

Conclusion

When should you seek a fertility evaluation?

For a younger couple with:

no known fertility problem,

regular intercourse,

regular cycles,

the usual threshold is approximately:

12 months when the female partner is younger than 35.

When she is:

35 or older,

evaluation should usually begin after approximately:

6 months.

When she is:

over 40,

evaluation should begin:

without unnecessary delay.

But these are:

guidelines—not rigid waiting rules.

You should seek fertility evaluation earlier when there is:

irregular menstruation,

amenorrhea,

endometriosis,

previous PID,



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previous ectopic pregnancy,
known tubal disease,
uterine abnormality,
diminished ovarian reserve,
chemotherapy/radiation exposure,
known male infertility,
abnormal semen analysis,
testicular disease,
sexual dysfunction,
ejaculatory problems,
recurrent pregnancy loss.

A proper fertility evaluation should not begin by assuming:

the woman is responsible.

Both partners should be evaluated in parallel, and a semen analysis should be part of the early male assessment.

Similarly, the evaluation should not mean ordering every possible test.

Modern guidance supports a focused approach centred upon:

ovulation,

female reproductive anatomy and tubal patency,

male semen and reproductive function.

ASRM specifically discourages indiscriminate advanced testing that does not improve routine fertility diagnosis.

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

Mizaj,
nutrition,
digestion,
menstrual health,
sexual function,



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metabolic wellbeing,

male reproductive health.

CCRU and Unani institutions have conducted preliminary clinical work in infertility-related areas including:

oligospermia,

female reproductive disorders.

These traditional approaches may contribute usefully to individualized integrative care.

But:

infertility should first be correctly diagnosed.

Unani medicine cannot responsibly be presented as a universal substitute for:

tubal surgery,

management of severe genetic male infertility,

medically necessary ART,

time-sensitive fertility treatment.

At **Saira Health Care**, my approach is:

do not investigate too early without reason;

do not wait too long when a fertility risk is already present;

evaluate both partners;

treat sexual dysfunction as part of fertility;

use the least invasive appropriate tests;

identify the actual cause;

integrate Unani medicine responsibly where it can support reproductive health;

and:

move toward IUI, IVF or ICSI only when the clinical situation genuinely requires it.

My most important message to couples is:

You do not need to wait until you are desperate before seeking fertility advice.

And equally:

not conceiving in the first few months does not automatically mean you are infertile.



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The right time to seek help depends on:

**your age, your history, your sexual function and your individual reproductive risks—
not simply the number of months on a calendar.**

About the Author

Dr. Nizamuddin Qasmi

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

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health — ISRH, UNFPA

Dr. Nizamuddin Qasmi is a well-qualified physician with a **specialized clinical focus on Sexual Disorders & Infertility.**

His work at **Saira Health Care** integrates evaluation of:

male infertility,

female infertility,

erectile dysfunction,

ejaculatory disorders,

painful intercourse,

fertility-related sexual anxiety,

reproductive-tract disorders.

His fertility-care philosophy emphasizes:

diagnosis before treatment.

Depending upon the individual couple, assessment may include:

detailed reproductive and sexual history,

semen analysis,



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menstrual and ovulatory assessment,
ovarian-reserve assessment when clinically indicated,
pelvic ultrasound,
tubal assessment,
hormonal evaluation,
male reproductive evaluation,
sexual-function assessment.

Where appropriate, individualized Unani treatment may be incorporated to support:
general health,
nutrition,
digestion,
metabolism,
menstrual wellbeing,
male reproductive health,
sexual wellbeing.

At Saira Health Care, the objective is not merely to tell a couple:

“Keep trying.”

Nor is it to tell every couple:

“You need IVF.”

The objective is to determine:

Why has pregnancy not occurred?

Is treatment needed now?

Can natural conception reasonably continue?

Is reproductive time being lost?

Does either partner have a treatable sexual or fertility problem?

and:

What is the safest, most appropriate and least unnecessarily invasive path toward pregnancy?



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Medical Disclaimer

This article is intended for professional education and public awareness and does not replace individualized fertility evaluation by an appropriately qualified healthcare professional.

The commonly used 12-month and 6-month thresholds apply primarily to couples without a known medical, sexual or reproductive condition that already suggests reduced fertility.

Earlier evaluation may be appropriate when there is:

irregular or absent menstruation,

endometriosis,

known tubal or uterine disease,

previous pelvic infection,

ectopic pregnancy,

chemotherapy or radiation exposure,

known diminished ovarian reserve,

known or suspected male infertility,

erectile or ejaculatory dysfunction,

recurrent pregnancy loss.

Women over 40 should generally seek fertility advice promptly rather than automatically waiting six or twelve months.

AMH and other ovarian-reserve markers should not be interpreted as direct tests of natural fertility or egg quality.

No single semen parameter can perfectly determine male fertility except in certain extreme conditions; abnormal findings require appropriate clinical interpretation.

Unani or herbal treatment should not be used to delay clinically indicated evaluation or evidence-based treatment for conditions in which reproductive time is important.

Claims that any medicine can guarantee pregnancy, permanently restore ovarian age, reverse every blocked fallopian tube or cure every form of azoospermia are not supported by current evidence.

Couples should receive individualized, couple-based evaluation and treatment according to:

age,

diagnosis,

duration of infertility,

reproductive goals,

medical history.