Necrozoospermia (Dead Sperm): Causes, Diagnosis, Treatment, Fertility Options and the Role of Unani Medicine

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Introduction: "Doctor, My Report Says Most of My Sperm Are Dead. Can I Still Become a Father?"

When a patient brings me a semen-analysis report and says:

"Doctor, my report shows dead sperm. Does this mean I cannot become a father?"

I first explain that the term "dead sperm" needs to be understood correctly.

The proper medical term is:

Necrozoospermia

also sometimes called:

Necrospermia

Necrozoospermia means that an abnormally low proportion of sperm in the semen are **alive or viable**.

This is different from:

- low sperm count,
- poor sperm motility,
- abnormal sperm morphology,
- or complete absence of sperm.

One of the biggest misunderstandings I see is that patients are told:

“Your sperm are not moving, therefore they are dead.”

That is not necessarily true.

A sperm may be:

- alive and moving,
- alive but immotile,
- or dead and immotile.

This distinction is extremely important because:

a living but immotile sperm may still sometimes be usable for ICSI, whereas a dead sperm cannot fertilize an egg.

Current EAU guidance, based on the WHO sixth-edition semen manual, specifically recommends sperm-vitality assessment when **more than 60% of sperm are immotile**. The current WHO lower fifth-percentile reference for vitality is approximately **54% live spermatozoa**.

Therefore, when a report says:

“70% immotile sperm”

I do not automatically tell the patient:

“70% of your sperm are dead.”

I ask:

“Was sperm vitality actually tested?”

That one question can completely change the interpretation.

What Does “Dead Sperm” Actually Mean?

A living sperm cell has an intact and functioning cell membrane.

The membrane is essential for:

- maintaining the internal environment of the sperm,
- energy regulation,
- movement,
- capacitation,

- interaction with the egg,
- and fertilization.

When a sperm dies, its membrane loses normal integrity.

Laboratory vitality tests take advantage of this difference between:

- living sperm with intact membranes,
- and dead sperm with damaged membranes.

Necrozoospermia therefore refers specifically to:

reduced sperm vitality.

It should not be diagnosed merely because:

- sperm move slowly,
- sperm have abnormal shapes,
- the semen looks watery,
- or the couple has infertility.

WHO Definition and Current Reference Value

The sixth edition of the WHO Laboratory Manual for the Examination and Processing of Human Semen remains the international reference standard for semen testing.

The current lower fifth-percentile value for:

Sperm Vitality

is approximately:

54% live spermatozoa

with a reported 95% confidence interval of approximately 50–56%.

In practical terms, a sample with substantially fewer than approximately 54% viable sperm may be described as having reduced vitality or necrozoospermia.

However, like other WHO reference values:

54% is not a magical fertile-versus-infertile dividing line.

The WHO values are distributions from fertile reference populations.

The complete reproductive picture must be considered.

Why Vitality and Motility Are Different

This distinction is so important that I explain it separately.

Motility

Means:

Can the sperm move?

Vitality

Means:

Is the sperm alive?

Consider four sperm cells.

Sperm 1

Alive + actively moving forward.

Sperm 2

Alive + moving poorly.

Sperm 3

Alive + completely immotile.

Sperm 4

Dead + completely immotile.

Without vitality testing, Sperm 3 and Sperm 4 may look similar because neither is moving.

But their fertility significance is completely different.

Necrozoospermia vs Asthenozoospermia

These conditions are often confused.

Asthenozoospermia

Means:

Reduced sperm motility.

The sperm may still be alive.

Necrozoospermia

Means:

Reduced sperm vitality.

A high proportion are genuinely non-viable.

A review devoted specifically to sperm vitality emphasizes that when no motile sperm are observed, vitality testing is necessary to distinguish true necrozoospermia from live-but-immotile sperm caused by flagellar or other motility defects.

Necrozoospermia vs Abnormal Sperm Morphology

This is another important correction to older descriptions.

Sperm morphology refers to:

shape and structure

of:

- the head,
- midpiece,
- and tail.

An abnormal-looking sperm is not automatically dead.

Likewise:

a normally shaped sperm can be dead.

Therefore:

- morphology = structure,
- motility = movement,
- vitality = life/death status.

These are three separate semen parameters.

Necrozoospermia vs Azoospermia

These are very different diagnoses.

Necrozoospermia

Sperm are present, but an abnormally high proportion are dead.

Azoospermia

No sperm are found in the semen after appropriate laboratory examination.

A man with necrozoospermia may have:

- millions of sperm in the ejaculate,

while a man with azoospermia has:

- none detected.

Their evaluation and treatment are therefore different.

Necrozoospermia vs Necro-Asthenozoospermia

Many patients have a combination of:

- poor vitality,
- and poor motility.

If a large proportion of sperm are dead, overall motility will naturally be reduced because:

dead sperm cannot swim.

However, living sperm may also have impaired motility simultaneously.

The laboratory should therefore assess:

- total motility,
- progressive motility,
- vitality,

rather than assuming that all immobility has one cause.

How Common Is Necrozoospermia?

Necrozoospermia is considered much less common than:

- oligozoospermia,
- asthenozoospermia,
- or teratozoospermia.

Published estimates vary substantially depending on:

- the population studied,
- laboratory methodology,
- and the vitality threshold used.

A recent large retrospective cohort described necrozoospermia as a relatively uncommon male-infertility finding and cited earlier estimates in the range of approximately **0.2–0.4%**, while other infertility-clinic populations have reported higher rates.

Because vitality is not measured routinely in every semen sample, true prevalence remains less well characterized than many other semen abnormalities.

Partial vs Absolute Necrozoospermia

Necrozoospermia exists on a spectrum.

Partial Necrozoospermia

Some live sperm remain in the ejaculate.

For example:

- 20% viable,
- 30% viable,
- 40% viable.

Treatment may focus on:

- finding the cause,
- improving the sperm environment,
- and using viable sperm for fertility treatment when necessary.

Absolute Necrozoospermia

This is the most severe situation.

It means:

no viable sperm can be identified in repeated ejaculated samples.

Absolute necrozoospermia has very different fertility implications.

If confirmed, published reproductive literature supports consideration of:

testicular sperm retrieval

because live sperm may sometimes be recovered directly from the testes even when ejaculated sperm are all non-viable.

Proposed Severity Categories

Some recent literature has proposed describing necrozoospermia as:

Mild

Vitality approximately 40–54%.

Moderate

Approximately 20–40%.

Severe

Less than approximately 20%.

These are useful research descriptions but should not be confused with formal universal WHO disease grades.

The clinically important questions remain:

- how many sperm are alive,
- how many are motile,
- what is the total sperm number,
- and what is the couple's overall fertility situation?

Does Necrozoospermia Cause Symptoms?

Usually:

No physical symptom is felt.

A man cannot feel that:

- 20%,
- 40%,
- or 70%

of his sperm are dead.

Most patients discover the problem during:

infertility evaluation.

Does Necrozoospermia Cause Erectile Dysfunction?

Not necessarily.

A patient may have:

- normal libido,
- excellent erections,
- normal intercourse,
- normal orgasm,
- normal ejaculation,

while sperm vitality is severely reduced.

Infertility and sexual performance are different physiological functions.

At Saira Health Care, because my focused work includes both **sexual disorders and infertility**, I consider this distinction very important.

Can Semen Look Completely Normal?

Yes.

Dead sperm cannot be identified by looking at semen.

A sample may appear:

- white,
- thick,
- normal in volume,
- completely ordinary,

while laboratory testing shows poor sperm vitality.

Conversely, watery-looking semen does not prove necrozoospermia.

Causes of Necrozoospermia

There is no one universal cause.

Necrozoospermia may result from:

- testicular factors,
- post-testicular factors,
- infections,

- environmental conditions,
- lifestyle factors,
- systemic disease,
- or remain unexplained.

A recent large clinical series described the condition as having:

- testicular,
- post-testicular,
- and mixed etiological patterns.

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1. Genital-Tract Infection and Inflammation

Infection is one of the important potentially reversible causes that should be considered.

Possible conditions include:

- epididymitis,
- prostatitis,
- urethritis,
- sexually transmitted infection,
- other genital inflammation.

Inflammation may expose sperm to:

- reactive oxygen species,
- inflammatory mediators,
- toxic changes in seminal plasma,

which may reduce sperm survival.

However:

a low-vitality semen report does not prove infection.

Testing and treatment should be based on:

- symptoms,
- physical findings,
- urine/STI testing,

- semen findings,
- or culture where appropriate.

Antibiotics should not simply be given because sperm vitality is low.

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2. Epididymal Dysfunction and Prolonged Sperm Storage

Sperm are produced in the testis but spend time maturing and being stored in the:

epididymis.

Excessively prolonged storage can reduce sperm survival in some men.

Research on necrozoospermia has reported that in selected patients with prolonged abstinence or excessive epididymal storage:

shorter ejaculation intervals or repeated ejaculations

may improve the proportion of viable sperm.

This does not mean every necrozoospermia patient should ejaculate repeatedly.

It means that:

abstinence duration matters and should be reviewed.

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3. Varicocele

Varicocele is an enlargement of veins around the testicle.

Potential mechanisms include:

- increased scrotal temperature,
- oxidative stress,
- impaired venous circulation,
- altered testicular environment.

Varicocele and testicular hyperthermia are among the clinical factors reported in necrozoospermia cohorts.

A patient with:

- clinical varicocele,
- infertility,
- abnormal semen

should therefore receive appropriate reproductive-urology assessment.

But:

an ultrasound-only small varicocele should not automatically be blamed for every dead sperm.

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4. Excessive Heat

Sperm survive best when the testes remain cooler than core body temperature.

Potential excessive exposures include:

- frequent very hot baths,
- prolonged hot tubs,
- repeated high-temperature sauna use,
- occupational exposure to furnaces or high heat,
- prolonged scrotal overheating.

Recent clinical research into necrozoospermia has specifically reported heat-related exposure among possible causes.

The aim should be:

reasonable avoidance of unnecessary chronic heat

rather than extreme cooling practices.

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5. Recent Fever

A significant febrile illness can temporarily impair:

- sperm production,
- motility,
- morphology,
- vitality.

Because sperm production takes weeks, semen abnormalities may persist for some time after the patient feels fully recovered.

When a semen report changes suddenly, I ask:

“Did you have a high fever during the last two or three months?”

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6. Oxidative Stress

Oxidative stress is an important biological mechanism in male infertility.

Reactive oxygen species can damage:

- sperm membranes,
- mitochondria,
- DNA,
- proteins.

Loss of membrane integrity is particularly relevant to:

sperm death.

Current EAU guidance recognizes oxidative stress as an important mechanism affecting sperm quality and DNA integrity, although routine clinical ROS testing remains insufficiently standardized.

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7. Smoking and Tobacco

Smoking can expose sperm to:

- nicotine,
- oxidative stress,
- toxic chemicals,
- inflammatory effects.

Stopping tobacco is one of the most sensible reproductive-health measures for any man trying to achieve pregnancy.

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8. Excessive Alcohol and Recreational Drugs

Heavy alcohol use and recreational drug exposure may negatively affect:

- hormones,
- testicular function,
- oxidative balance,
- semen quality.

The exact contribution to necrozoospermia may vary between individuals.

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9. Environmental and Occupational Toxins

Potential concerns include:

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

A clear cause-and-effect relationship can be difficult to prove in an individual patient, but occupational history remains important.

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10. Systemic and Endocrine Disease

Some systemic or endocrine disorders have been reported in association with reduced sperm vitality.

Examples described in necrozoospermia literature include certain:

- thyroid disorders,
- metabolic disease,
- systemic illnesses.

Treatment should be directed at an actual diagnosed condition rather than assuming every vitality problem is hormonal.

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11. Testicular Disease

Conditions damaging testicular function may affect:

- sperm production,
- quality,
- vitality.

Examples include:

- cryptorchidism,

- severe testicular infection,
- torsion,
- trauma,
- chemotherapy,
- radiotherapy.

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12. Spinal Cord Injury and Severe Neurological Conditions

Men with major neurological injury can sometimes have very poor semen quality, including reduced vitality.

Possible mechanisms include:

- abnormal ejaculation,
- prolonged sperm storage,
- infection,
- inflammatory changes,
- altered accessory-gland function.

These cases generally require specialist reproductive management.

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13. Medication and Toxic Exposure

Certain medicines and toxins can affect sperm health.

Every patient with persistent necrozoospermia should review:

- prescription medicines,
- testosterone,
- anabolic steroids,
- recreational drugs,
- occupational exposures

with the treating clinician.

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14. Improper Sample Handling

Before diagnosing a man's body as the problem, the laboratory process must be considered.

Sperm can lose viability if a sample is:

- excessively delayed before examination,
- exposed to inappropriate temperatures,
- contaminated,
- collected using toxic lubricants,
- handled improperly.

WHO emphasizes standardized semen collection and laboratory methodology because reliable technique is critical to accurate fertility assessment.

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15. Long Abstinence Period

Long periods without ejaculation can result in older sperm remaining in the reproductive tract.

In selected necrozoospermia patients, prolonged abstinence may contribute to reduced vitality.

This is one reason I review:

abstinence duration

before interpreting semen reports.

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16. Idiopathic Necrozoospermia

In some men:

- examination is normal,
- no infection is found,
- hormones are acceptable,
- no significant varicocele exists,
- no obvious heat or toxin exposure is identified.

The cause remains unexplained.

This is described as:

Idiopathic Necrozoospermia.

It does not mean the abnormality is imaginary.

It means routine testing has not identified its cause.

Why Dead Sperm May Have More DNA Damage

Recent research suggests necrozoospermia can be associated with increased:

Sperm DNA Fragmentation

A recent clinical study reported that men with necrozoospermia had significantly greater sperm-DNA fragmentation and slightly poorer fertilization outcomes with ICSI compared with men without necrozoospermia.

This does not mean every patient requires sperm-DNA testing.

But it highlights that sperm vitality reflects more than movement alone.

Diagnosis of Necrozoospermia

The diagnostic process should answer:

1. Is sperm vitality truly low?
2. Is the abnormality persistent?
3. Are immotile sperm alive?
4. Is an infection present?
5. Is there varicocele?
6. Is there excessive heat exposure?
7. Are other sperm parameters abnormal?
8. Is the condition partial or absolute?
9. What is the couple's fertility situation?

Step 1: Semen Analysis

A properly performed semen analysis assesses:

- semen volume,
- sperm concentration,
- total sperm number,

- progressive motility,
- total motility,
- morphology,
- and selected additional parameters.

Vitality is especially important when most sperm are immotile.

Current EAU/WHO guidance states that vitality does not need to be measured in every sample but should be assessed when:

more than 60% of sperm are immotile.

Step 2: Repeat the Test

Semen can fluctuate.

A diagnosis with major reproductive implications should generally be confirmed rather than based on a single questionable specimen.

The sample should be collected and transported according to standardized laboratory instructions.

Step 3: Eosin-Nigrosin Vitality Test

One widely used vitality test is:

Eosin-Nigrosin Staining

The principle is based on sperm-membrane integrity.

Live sperm

Maintain an intact membrane and exclude eosin.

Dead sperm

Have damaged membranes that allow the dye to enter.

The sperm head then stains.

WHO's sixth edition recognizes eosin-nigrosin as an important diagnostic vitality method.

Step 4: Hypo-Osmotic Swelling Test – HOS/HOST

Another method is:

Hypo-Osmotic Swelling Test

A living sperm has a functionally intact membrane.

When placed in a hypo-osmotic solution, water enters the cell and produces characteristic swelling or tail changes.

Dead sperm do not respond normally.

The HOS test can therefore help distinguish:

- live but immotile sperm,
- dead sperm.

Unlike diagnostic staining methods that damage sperm, HOS testing may also help embryologists identify viable immotile sperm for potential ICSI.

Why Eosin-Nigrosin and HOS Serve Different Purposes

Eosin-nigrosin is useful for:

diagnosis.

However, sperm exposed to the dye cannot subsequently be injected into an egg.

Therefore, when an embryologist needs to choose a living immotile sperm for ICSI, non-destructive techniques such as:

- HOS testing,
- or other specialized viability-selection methods

may be used.

Step 5: Evaluate the Entire Semen Profile

I do not look at vitality alone.

I also assess:

- sperm concentration,
- total sperm number,
- motility,
- morphology,
- semen volume,

- liquefaction,
- viscosity,
- white blood cells when relevant.

For example:

Patient A

50 million sperm/mL with 40% live sperm.

Patient B

1 million sperm/mL with 20% live sperm.

These are very different fertility situations.

Step 6: Clinical Examination

A male fertility examination may assess:

- testicular size,
- consistency,
- epididymis,
- vas deferens,
- clinical varicocele,
- reproductive anatomy.

Saira Health Care's current physician profile specifically includes **Necrospermia** among the male-infertility conditions addressed in Dr. Nizamuddin Qasmi's focused practice.

Step 7: Infection Assessment

When appropriate, testing may include:

- urinalysis,
- STI testing,
- semen culture,
- other microbiological investigation.

This should be driven by clinical findings.

Step 8: Hormonal Testing

Tests may include:

- FSH,
- LH,
- morning testosterone,
- prolactin,
- thyroid testing

when clinically justified.

Not every necrozoospermia patient needs every hormonal test.

Step 9: Doppler Ultrasound

Scrotal Doppler ultrasound may be appropriate when:

- varicocele is suspected,
- examination is uncertain,
- testicular pathology needs evaluation.

A small ultrasound-only abnormality should not automatically be labelled the cause.

Step 10: Advanced Testing in Selected Cases

Depending on the clinical picture, consideration may be given to:

- sperm DNA fragmentation,
- genetic assessment,
- advanced sperm-function testing.

These are not routine for every patient.

Treatment of Necrozoospermia

I explain to patients:

There is no single universal medicine called "dead sperm medicine."

The treatment depends on:

why the sperm are dying.

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1. Confirm the Diagnosis Before Treating

This is the first treatment principle.

A man should not receive months of medication because:

“The laboratory wrote non-motile sperm.”

First determine:

- motility,
- vitality,
- collection quality,
- repeat result.

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2. Correct the Abstinence Interval

If a patient has:

- very prolonged abstinence,
- repeated poor vitality,

a shorter ejaculation interval may sometimes improve sperm vitality.

Specialized necrozoospermia literature describes improvement in some men after repeated ejaculations at shorter intervals.

This is particularly relevant when prolonged epididymal sperm storage is suspected.

It should be individualized rather than used as a universal rule.

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3. Treat Infection or Inflammation

If a genuine genital infection exists:

- targeted antibiotic treatment,
- STI management,
- treatment of epididymitis/prostatitis

may improve the sperm environment.

Again:

Do not use antibiotics without a reason.

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4. Treat a Clinically Significant Varicocele

If a patient has:

- clinical/palpable varicocele,
- infertility,
- abnormal semen,

varicocele management should be discussed according to current fertility guidelines.

Options include:

- microsurgical varicocelectomy,
- radiological embolization

in appropriately selected patients.

Varicocele treatment should not be undertaken merely because a Doppler report mentions enlarged veins.

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5. Reduce Excessive Heat Exposure

Men with significant repeated heat exposure may be advised to reduce:

- hot baths,
- hot tubs,
- extreme sauna exposure,
- occupational overheating.

This is a reasonable fertility-support measure.

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6. Stop Smoking and Harmful Substances

This includes:

- cigarettes,

- tobacco,
- recreational drugs,
- anabolic steroids.

The reproductive system should be given the healthiest possible environment.

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7. Improve Metabolic Health

Attention should be given to:

- obesity,
- diabetes,
- poor diet,
- physical inactivity,
- sleep.

This is particularly useful when oxidative or metabolic dysfunction is suspected.

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8. Antioxidants

Because oxidative stress can damage sperm membranes, antioxidants are frequently used in male infertility.

Common supplements include:

- CoQ10,
- vitamins,
- carnitine,
- selenium,
- zinc,
- herbal antioxidant preparations.

However:

evidence does not support a guaranteed universal antioxidant treatment for necrozoospermia.

Current male-infertility guidelines remain cautious about routine supplement use because evidence for clinically important outcomes is inconsistent.

Antioxidants may be considered selectively rather than marketed as a cure.

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9. Natural Conception

Natural pregnancy may remain possible in partial necrozoospermia if:

- sufficient viable,
- progressively motile,
- functional sperm

remain.

The probability depends on:

- number of live sperm,
- motility,
- sperm concentration,
- female fertility,
- age,
- intercourse timing.

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10. IUI

Intrauterine insemination may be possible in selected mild cases if semen processing yields enough:

viable motile sperm.

When very few live motile sperm remain, the chance of success becomes lower and IVF/ICSI may be more appropriate.

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11. IVF and ICSI

For more severe male-factor infertility:

ICSI

can be particularly useful.

During ICSI:

- one selected viable sperm is injected directly into the egg.

This means sperm do not have to:

- travel through the reproductive tract,
- penetrate the egg independently.

But:

the sperm must be alive.

Injecting a dead sperm cannot produce normal fertilization.

Therefore, viability selection becomes crucial.

Selecting a Live Immotile Sperm for ICSI

In men with completely immotile sperm but some viable sperm, specialized embryology methods can identify living sperm.

These may include:

- HOS testing,
- laser-assisted viability testing,
- selected motility-stimulation techniques.

Published ART literature emphasizes that evaluating vitality is critical in severe asthenozoospermia because unselected immotile sperm produce poorer ICSI outcomes.

Absolute Necrozoospermia: What If Every Ejaculated Sperm Is Dead?

This is the most severe clinical situation.

If repeated, carefully tested ejaculates show:

no viable sperm

then treatment strategy changes.

A sperm may die during:

- epididymal storage,
- transit through the reproductive tract,
- exposure to abnormal seminal conditions,

even though living sperm may still exist inside the testis.

Therefore:

testicular sperm retrieval may be considered.

A major review of necrozoospermia management states that when absolute necrozoospermia is confirmed, **testicular sperm extraction should be considered because viable sperm may be recoverable from testicular tissue**.

Retrieved sperm can then potentially be used for:

ICSI.

Why Testicular Sperm May Be Alive When Ejaculated Sperm Are Dead

This is an important concept.

Sperm inside the testis have not yet undergone prolonged exposure to:

- epididymal storage,
- accessory-gland secretions,
- abnormal inflammatory semen environment.

In selected men, this means the testis may contain viable sperm even though ejaculated sperm die later in the reproductive pathway.

That is why absolute necrozoospermia does not necessarily mean:

“No living sperm exist anywhere.”

Does Testicular Sperm Retrieval Guarantee Pregnancy?

No.

There are several steps:

1. viable sperm must be found,
2. mature eggs must be obtained,
3. ICSI must result in fertilization,
4. embryos must develop,
5. implantation must occur,
6. pregnancy must continue,
7. live birth must occur.

Therefore:

sperm retrieval is an opportunity—not a pregnancy guarantee.

Necrozoospermia in the Unani System of Medicine

As a Unani physician with focused work in sexual disorders and infertility, I approach patients through both:

- traditional individualized assessment,
- and modern reproductive findings.

However, an academically important distinction is necessary.

Classical Unani medicine developed centuries before:

- microscopy,
- eosin-nigrosin staining,
- HOST,
- sperm vitality percentages.

Therefore:

there is no classical Unani diagnosis that should automatically be claimed as an exact equivalent of modern necrozoospermia.

Traditional male reproductive conditions can nevertheless provide a framework for supportive management.

Qillat-e-Haiwane-Manwiya and Qillat-i-Mani

Official CCRUM literature discusses conditions such as:

Qillat-i-Mani

and:

Qillat-e-Haiwane-Manwiya

in relation to reduced semen or sperm production.

Traditional descriptions consider factors such as:

- weakness,
- poor nutrition,
- reproductive-organ Mizaj,

- environmental influences,
- general health.

However:

oligospermia is not necrozoospermia.

A medicine studied in low sperm count cannot automatically be assumed to restore sperm vitality.

Mizaj and Individualized Treatment

One valuable principle of Unani medicine is:

individualization according to Mizaj.

When I evaluate a male-infertility patient, I consider:

- body constitution,
- digestion,
- appetite,
- sleep,
- physical activity,
- general weakness,
- sexual function,
- metabolic health,
- reproductive history.

Modern information is assessed simultaneously:

- semen concentration,
- motility,
- morphology,
- vitality,
- hormones,
- varicocele,
- infection.

This allows treatment to be more individualized than simply:

“Dead sperm = same prescription for everybody.”

Akhlat – The Traditional Humoral Framework

Unani medicine traditionally describes four humors:

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

These concepts form part of classical Unani physiology.

However, I do not equate them directly with:

- sperm viability,
- ROS,
- FSH,
- testosterone,
- sperm DNA.

Traditional concepts and modern laboratory mechanisms should be kept intellectually distinct.

Asbab-e-Sitta Zarooriya

The Unani system places considerable importance on the six essential factors affecting health.

These broadly include:

- environment,
- food and drink,
- physical activity and rest,
- psychological state,
- sleep,
- elimination and retention.

These concepts can be highly relevant to male reproductive health.

For example:

Environment

May involve:

- occupational heat,
- toxins,
- smoking.

Food

May affect:

- nutrition,
- obesity,
- diabetes,
- oxidative balance.

Activity

May affect:

- metabolic health,
- circulation,
- weight.

Sleep

Influences:

- endocrine,
- psychological,
- metabolic health.

Therefore, Unani lifestyle management can contribute meaningfully to supportive fertility care.

Major Treatment Modes in Unani Medicine

Traditional Unani medicine includes:

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bit-Tadbir

Regimenal therapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical treatment

This is a useful principle in integrative infertility care.

It shows that Unani medicine need not be presented as:

“herbs instead of every procedure.”

When ART or sperm retrieval is appropriate, referral is compatible with responsible care.

Ilaj-bil-Ghiza in Necrozoospermia

Dietotherapy cannot bring a dead sperm back to life.

The aim is instead to improve:

the biological environment in which future sperm are produced and survive.

I may advise:

- vegetables,
- fruits,
- adequate protein,
- pulses,
- nuts,
- seeds,
- whole grains,
- healthy fats,
- appropriate hydration.

I discourage:

- smoking,
- heavy alcohol,
- excessive processed food,
- repeated fried foods,
- uncontrolled sugar intake.

The exact diet is individualized.

Ilaj-bit-Tadbir

Regimenal management may include:

- regular appropriate physical activity,
- good sleep,
- healthy body weight,
- stress management,
- reducing excessive heat,
- improving daily routine.

These measures can complement modern fertility treatment.

Ilaj-bid-Dawa

Selected traditional formulations may be used to support:

- general reproductive health,
- semen quality,
- nutrition,
- testicular function,
- associated sexual-health concerns.

At Saira Health Care, treatment is selected according to the patient's:

- vitality percentage,
- sperm count,
- motility,

- morphology,
- overall fertility diagnosis.

Spermogenic Powder

A formulation frequently used within Saira Health Care's male-fertility programme is:

Dr. Qasmi's Spermogenic Powder

The current Saira Health Care Pharmacy listing describes it for male reproductive-health concerns including:

- low sperm count,
- reduced sperm motility,
- abnormal sperm morphology,
- and broader semen-quality concerns.

The published formulation lists traditional ingredients including:

- Asgand Nagori,
- Kaunch Beej,
- Maror Phali,
- Khulanjan,
- Salab preparations,
- Satawar,
- Musli Safed,
- Darchini,

among others.

Does Spermogenic Specifically Cure Necrozoospermia?

I want to present this accurately.

The current product page describes Spermogenic as:

- researched,
- and used for male-fertility support.

However:

I have not identified a high-quality peer-reviewed controlled clinical trial specifically demonstrating that Spermogenic reliably normalizes sperm vitality in confirmed necrozoospermia or improves live-birth rates.

Therefore, I do not believe it should be advertised as:

"a scientifically proven universal cure for dead sperm."

Its appropriate role is:

individualized supportive Unani therapy within a complete fertility plan.

Dr. Qasmi's Nuskha No. 129 – Vitasem Max

Another formulation used within Saira Health Care's male-fertility practice is:

Dr. Qasmi's Nuskha No. 129 – Vitasem Max

It is used primarily as a traditional Unani supportive formulation for:

- vitality,
- general weakness,
- and semen-quality support.

As with Spermogenic:

it should be selected according to the patient rather than automatically prescribed for every necrozoospermia case.

What Does Published Unani Research Show?

CCRUM-associated research has evaluated Unani formulations in:

Oligospermia

rather than specifically confirmed necrozoospermia.

A retrospective study of **126 men with idiopathic oligospermia** reported improvements in different semen parameters across treatment groups, including improvement in sperm motility in one group.

An observational study from the National Institute of Unani Medicine also evaluated a classical compound formulation for oligospermia.

These studies are useful because they show that traditional Unani approaches to male infertility deserve scientific investigation.

But they do not prove that:

necrotic sperm vitality will normalize in every patient.

Why Unani Medicine Can Still Be Useful

The absence of a large necrozoospermia-specific randomized trial does not mean that:

- nutrition,
- lifestyle,
- traditional pharmacotherapy,
- individualized supportive care

have no value.

Their role is strongest where they address:

- general reproductive health,
- nutritional weakness,
- poor lifestyle,
- metabolic dysfunction,
- idiopathic semen-quality abnormalities,
- oxidative-health factors.

But in conditions such as:

- absolute necrozoospermia,
- severe infection,
- significant varicocele,
- major testicular disease,

traditional care should be integrated with appropriate modern reproductive treatment.

Dr. Nizamuddin Qasmi's Special Individualized Approach to Necrozoospermia

When a patient comes to me with a report saying:

“Dead sperm”

my approach is not simply to prescribe a fertility powder.

I prefer a structured assessment.

Step 1: Confirm What the Report Actually Means

I ask:

“Does the report show immotility—or did the laboratory actually perform a vitality test?”

This is the most important first step.

Step 2: Review Motility and Vitality Separately

I look at:

- progressive motility,
- non-progressive motility,
- immotile sperm,
- live sperm percentage.

This helps differentiate:

- asthenozoospermia,
- necrozoospermia,
- or a combination.

Step 3: Repeat the Semen Analysis

If the result is unexpected or severe, I prefer confirmation in an experienced laboratory.

The patient should follow correct:

- abstinence,
- collection,
- transport,
- timing

instructions.

Step 4: Determine Whether the Condition Is Partial or Absolute

This has major fertility implications.

If:

- viable sperm remain,

ejaculated sperm may potentially be used.

If:

- no viable ejaculated sperm remain,

testicular sperm retrieval may eventually need discussion.

Step 5: Evaluate Other Semen Parameters

I review:

- sperm concentration,
- total sperm number,
- motility,
- morphology,
- semen volume,
- viscosity,
- liquefaction,
- pus cells where relevant.

Step 6: Look for Infection

I ask about:

- burning urination,
- discharge,
- pelvic discomfort,
- painful ejaculation,
- epididymal pain,

- previous STI.

Appropriate tests are ordered where indicated.

Step 7: Look for Varicocele

The testes are examined for:

- palpable varicocele,
- testicular size,
- other scrotal abnormalities.

Doppler ultrasound is used when clinically appropriate.

Step 8: Review Heat Exposure

I specifically ask about:

- frequent hot baths,
- sauna,
- industrial heat,
- prolonged high-temperature exposure.

Step 9: Review Lifestyle

I discuss:

- smoking,
- alcohol,
- diet,
- body weight,
- diabetes,
- sleep,
- activity.

Step 10: Review Hormones and Medical Conditions

Where indicated:

- FSH,
- LH,
- testosterone,
- prolactin,
- thyroid function

may be evaluated.

Step 11: Use Individualized Unani Treatment

When clinically appropriate, I may incorporate:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Spermogenic,
- Nuskha No. 129,
- or another selected traditional formulation

according to the patient's condition.

The objective is to support:

future sperm production and sperm survival

rather than claiming we can revive sperm that are already dead.

Step 12: Monitor With Objective Semen Testing

Treatment success should be demonstrated by:

- improved vitality,
- improved motility,
- improved total viable sperm number,
- or improved reproductive outcome.

Feeling:

- stronger,

- more energetic,
- more sexually active

does not automatically prove that dead sperm have decreased.

Step 13: Protect Reproductive Time

This is especially important when the female partner:

- is older,
- has low ovarian reserve,
- has tubal disease,
- or has another time-sensitive fertility condition.

A couple should not wait indefinitely for a semen report to improve when ART offers a more realistic chance.

Step 14: Discuss ICSI When Needed

When the number of live sperm is very low but viable sperm remain, ICSI may bypass many natural fertilization barriers.

Step 15: Discuss Testicular Sperm Retrieval for Confirmed Absolute Necrozoospermia

If repeated semen testing shows:

no viable ejaculated sperm

I believe the patient should be informed about reproductive-urology options, including possible:

- testicular sperm extraction,
- followed by ICSI.

This is an established fertility strategy described in necrozoospermia literature.

Can Dead Sperm Become Alive Again?

No.

Once an individual sperm cell is dead:

that particular sperm cannot be revived.

Treatment works differently.

The goal is to:

- improve the environment,
- remove damaging causes,
- and allow future sperm to survive better.

Therefore, when a treatment improves vitality from:

- 20%
- to 50%

it does not mean the old dead sperm came back to life.

It means:

a larger proportion of newly ejaculated sperm are surviving.

This is a medically important distinction.

How Long Does Improvement Take?

This depends on the cause.

Some post-testicular factors such as:

- abstinence interval

may influence semen relatively quickly.

But when treatment aims to improve sperm production and testicular health:

several months may be required.

Spermatogenesis itself takes weeks, followed by epididymal maturation.

Therefore, fertility treatment should generally be assessed over appropriate biological time rather than after only a few days.

Can Necrozoospermia Be Completely Cured?

Sometimes significant improvement is possible.

For example, if the major contributor is:

- infection,
- heat,
- prolonged storage,
- reversible lifestyle factor,

vitality may improve.

However:

a universal cure cannot be guaranteed.

The outcome depends on the cause and severity.

Can a Man With Necrozoospermia Become a Father Naturally?

Yes, in some partial cases.

If sufficient:

- live,
- progressively motile,
- functionally competent sperm

remain, natural conception may still occur.

Can a Man With Severe Necrozoospermia Become a Biological Father?

In selected cases:

yes.

Even when natural conception is unrealistic:

- IVF/ICSI,
- viable sperm selection,
- or testicular sperm retrieval

may provide reproductive options.

Does Necrozoospermia Guarantee ICSI Failure?

No.

If living sperm can be identified, ICSI may be successful.

However, viability must be carefully assessed.

A recent clinical study found somewhat lower fertilization in men with necrozoospermia compared with controls, but ART remained possible.

Does Sperm DNA Fragmentation Need to Be Tested in Every Patient?

No.

It may be considered in selected situations such as:

- recurrent pregnancy loss,
- repeated ART failure,
- unexplained infertility,
- selected severe semen abnormalities.

It should not replace basic semen and vitality evaluation.

Psychological Impact of "Dead Sperm" Diagnosis

The phrase:

"dead sperm"

can be emotionally devastating.

Patients may interpret it as:

"My reproductive system is dead."

That is not correct.

A semen report does not define:

- masculinity,
- sexual ability,
- self-worth,
- possibility of treatment.

I often tell patients:

Necrozoospermia is a laboratory finding that requires investigation—not a judgment about you as a man.

Common Myths About Dead Sperm

Myth 1: Immotile sperm are always dead.

Fact: A sperm can be alive but completely immotile.

Myth 2: Abnormally shaped sperm are dead sperm.

Fact: Morphology and vitality are different measurements.

Myth 3: Dead sperm means azoospermia.

Fact: Necrozoospermia means sperm are present but many are non-viable; azoospermia means sperm are absent.

Myth 4: Watery semen means sperm are dead.

Fact: Semen appearance cannot diagnose vitality.

Myth 5: Thick semen means sperm are alive.

Fact: Only laboratory vitality testing can assess whether sperm are living.

Myth 6: Low motility automatically equals necrozoospermia.

Fact: Low motility may involve living but poorly moving sperm.

Myth 7: A single semen report is enough.

Fact: Severe or unexpected abnormalities should generally be confirmed.

Myth 8: Antibiotics improve every dead-sperm problem.

Fact: Antibiotics help only when a relevant infection exists.

Myth 9: Every patient needs antioxidants.

Fact: Antioxidant evidence is inconsistent and treatment should be individualized.

Myth 10: One herbal medicine can revive dead sperm.

Fact: An already dead sperm cannot be brought back to life. Treatment aims to improve survival of subsequently produced sperm.

Myth 11: Spermogenic is proven to cure all necrozoospermia.

Fact: It is used within Saira Health Care's male-fertility programme, but high-quality product-specific clinical evidence establishing a universal necrozoospermia cure is not currently available.

Myth 12: If every ejaculated sperm is dead, biological fatherhood is impossible.

Fact: In confirmed absolute necrozoospermia, viable testicular sperm may sometimes be recovered for ICSI.

Frequently Asked Questions

What is the medical name for dead sperm?

The correct term is:

Necrozoospermia

or necrospermia.

What percentage of sperm should be alive?

The WHO sixth-edition lower fifth-percentile reference value is approximately:

54% live sperm.

When should vitality be tested?

Current EAU/WHO guidance recommends vitality assessment particularly when:

more than 60% of sperm are immotile.

What is the difference between vitality and motility?

Motility asks:

Does the sperm move?

Vitality asks:

Is the sperm alive?

Can immotile sperm be alive?

Yes.

This is one of the main reasons vitality testing exists.

How are dead sperm identified?

Common laboratory tests include:

- eosin-nigrosin staining,
- hypo-osmotic swelling testing.

What happens in eosin-nigrosin testing?

Dead sperm with damaged membranes take up eosin dye.

Living sperm exclude the dye.

Can eosin-stained sperm be used for ICSI?

No.

The staining is diagnostic and damages the sperm.

Can HOS-selected sperm be used for ICSI?

In specialized laboratories, HOS responses can help identify living immotile sperm for ART.

Can varicocele cause reduced sperm vitality?

It may contribute in selected men through:

- heat,
- oxidative stress,
- altered testicular environment.

Can infection cause dead sperm?

Yes, genital infection or inflammation can contribute in some men.

But an infection should be diagnosed rather than assumed.

Can heat reduce sperm vitality?

Repeated excessive scrotal heat has been associated with reduced sperm survival.

Can smoking cause necrozoospermia?

Smoking can worsen the oxidative environment and semen quality.

It may contribute to poor sperm survival in susceptible men.

Can long abstinence increase dead sperm?

It may in some patients because sperm remain stored for longer periods.

Selected studies suggest shorter ejaculation intervals can improve vitality in certain cases.

Can frequent ejaculation help?

In selected men with prolonged epididymal storage, yes.

It is not a universal treatment for every cause.

Can antioxidants improve vitality?

They may be considered in selected patients, particularly where oxidative stress is suspected.

However, no antioxidant regimen is proven to cure every necrozoospermia case.

Can Unani medicine help?

Unani medicine can support male reproductive health through:

- individualized Mizaj assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised Ilaj-bid-Dawa,
- lifestyle and nutritional optimization.

Its use is most responsible when integrated with objective semen-vitality testing and modern infertility evaluation.

What is the role of Spermogenic?

Spermogenic is a Dr. Qasmi herbal formulation currently used by Saira Health Care within male-fertility programmes for several semen-quality concerns.

It may be used as part of individualized supportive care.

Does Spermogenic guarantee pregnancy?

No.

No medicine can guarantee:

- sperm normalization,
- fertilization,
- pregnancy,
- live birth.

Can Nuskha No. 129 be used?

Dr. Qasmi's Nuskha No. 129 may form part of an individualized Unani reproductive-health programme according to:

- general health,
- semen profile,
- associated weakness,

- clinical assessment.

It is not a replacement for vitality testing or ART when indicated.

Can IUI work in necrozoospermia?

It may be considered if sufficient:

- live,
- motile sperm

remain after semen preparation.

Severe cases are generally less suitable.

Can ICSI work?

Yes, provided:

viable sperm can be identified.

What if no living sperm are found in semen?

In confirmed absolute necrozoospermia, testicular sperm retrieval may be considered because viable sperm may remain inside the testes.

Does testicular sperm extraction guarantee live sperm?

No.

It provides an opportunity but cannot guarantee retrieval.

Latest Scientific Perspective: 2025–2026

Necrozoospermia remains less extensively researched than:

- azoospermia,
- oligospermia,
- asthenozoospermia.

However, several important concepts are now clearer.

WHO Vitality Standard Remains 54%

Current EAU guidance based on WHO 2021 semen standards lists:

54% live sperm

as the lower fifth-percentile vitality reference.

This remains the key standardized benchmark in 2026.

Vitality Should Be Tested Selectively

WHO/EAU methodology does not require vitality testing in every semen sample.

It is particularly indicated when:

more than 60% of sperm are immotile.

This prevents unnecessary testing while ensuring severe motility abnormalities are interpreted correctly.

Recent Large Cohort Research

A recent study involving more than **300 men with necrozoospermia** reinforced several important observations:

- necrozoospermia is relatively uncommon,
- causes can be testicular, post-testicular or mixed,
- varicocele and testicular heat can be relevant,
- vitality evaluation remains important for diagnosis.

Recent Fertility-Outcome Research

Another study evaluating infertile men with reduced vitality found an association between necrozoospermia and:

- increased sperm DNA fragmentation,
- slightly reduced normal fertilization rate after ICSI.

Importantly, pregnancy through ART was still possible.

Absolute Necrozoospermia Remains a Special ART Problem

In men with confirmed absolute necrozoospermia, modern ART strategy increasingly focuses on:

- obtaining viable sperm before they undergo post-testicular death,
- selecting viable testicular sperm,
- using ICSI.

This remains far more evidence-based than repeatedly injecting dead ejaculated sperm or relying indefinitely on empirical supplements.

Dr. Nizamuddin Qasmi and Saira Health Care

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

Sexual Disorders & 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 current public physician profile lists:

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

and specifically identifies clinical work in conditions including:

- azoospermia,

- oligospermia,
- teratospermia,
- **necrospermia**,
- asthenospermia,
- varicocele,
- other male and female infertility disorders.

Saira Health Care's more recent professional educational material additionally lists:

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

within my current professional profile.

Saira Health Care's Contribution to Sexual Disorders & Infertility

Saira Health Care focuses specifically on:

Sexual Disorders & Infertility

and presents its care model as:

- patient-centered,
- individualized,
- combining traditional Unani understanding,
- lifestyle guidance,
- and appropriate contemporary medical information.

For conditions such as necrozoospermia, this integrated approach is especially important.

Why?

Because a patient may need:

Unani lifestyle and nutritional support

for overall reproductive health.

Modern semen vitality testing

to determine whether sperm are truly alive or dead.

Antibiotic treatment

if a genuine infection is present.

Varicocele assessment

if clinically relevant.

Hormonal evaluation

if endocrine disease is suspected.

IVF/ICSI

if viable sperm are too few for natural conception.

Testicular sperm retrieval

if absolute necrozoospermia persists.

A responsible fertility clinic should remain open to all of these options.

One of the Most Important Contributions: Correcting Misinformation

Patients frequently receive incorrect statements such as:

“Immotile sperm are dead sperm.”

“Abnormal morphology means dead sperm.”

“Dead sperm can be brought back to life by medicine.”

“Thick semen proves sperm are healthy.”

“If semen contains only dead sperm, no biological child is possible.”

Modern reproductive medicine shows that all of these statements can be misleading.

Education is therefore an important part of infertility treatment.

My Integrative Treatment Philosophy

I do not believe the patient should be forced to choose between:

Unani medicine

and:

modern infertility care.

The appropriate role of each depends on the diagnosis.

If poor diet and lifestyle are contributing

Unani dietotherapy and regimenal treatment can be valuable.

If infection is present

it should be appropriately treated.

If there is significant varicocele

reproductive-urology management may be needed.

If some living ejaculated sperm remain

they may potentially be used for natural conception, IUI or ICSI depending on the complete fertility picture.

If ejaculated sperm are alive but immotile

specialized viability selection may allow ICSI.

If absolute necrozoospermia persists

testicular sperm retrieval with ICSI may need to be discussed.

If traditional medicines are prescribed

they should support—not replace—objective follow-up testing.

This is what I consider:

responsible integrative male-fertility care.

My Final Message to Patients

If your report says:

“Dead sperm”

do not immediately assume:

“I cannot become a father.”

Instead ask:

Was sperm vitality actually tested?

Are my sperm dead or only immotile?

What percentage are alive?

Was eosin-nigrosin or HOS testing performed?

Should the semen test be repeated?

What is my sperm count?

What is my progressive motility?

What is my morphology?

Do I have varicocele?

Could there be an infection?

Do I have excessive heat exposure?

Was my abstinence period too long?

Do I smoke or use harmful substances?

Do I need hormonal assessment?

How is my wife's fertility?

Could individualized Unani treatment support my reproductive health?

Would IUI be appropriate?

Do we need IVF/ICSI?

If no living sperm are present in repeated ejaculates, could viable sperm be retrieved from the testis?

These questions lead to a rational fertility plan.

Conclusion

“Dead sperm” is the common-language description of:

Necrozoospermia

a condition characterized by abnormally reduced sperm vitality.

It should not be confused with:

- low sperm motility,
- abnormal sperm morphology,
- low sperm count,
- or azoospermia.

According to current WHO-based reference distributions:

approximately 54% live sperm

represents the lower fifth-percentile vitality value in fertile reference populations.

Current EAU/WHO methodology recommends measuring sperm vitality particularly when:

more than 60% of sperm are immotile.

This distinction is essential because:

immotile sperm may still be alive.

Common vitality assessments include:

- eosin-nigrosin staining,
- hypo-osmotic swelling testing.

Possible contributing factors include:

- genital infection or inflammation,
- varicocele,
- excessive heat,
- prolonged sperm storage,
- smoking,
- oxidative stress,
- toxins,
- systemic disease,
- testicular disease,
- sample-handling problems,
- or unexplained causes.

Treatment depends on the cause.

It may include:

- correcting semen-collection factors,
- adjusting abstinence in selected patients,
- treating infection,
- reducing excessive heat,
- stopping smoking,
- improving metabolic health,

- treating clinically important varicocele,
- individualized reproductive-health support,
- ART.

For severe cases:

ICSI

can allow fertilization when viable sperm are available.

For:

confirmed absolute necrozoospermia

published evidence supports considering:

testicular sperm extraction with ICSI

because viable sperm may sometimes still be found inside the testis.

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

- Mizaj-based individualized assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- nutrition,
- lifestyle correction,
- general reproductive-health support.

CCRUM research has shown encouraging semen-parameter changes with selected Unani formulations in conditions such as oligospermia, but these studies do not specifically prove a cure for necrozoospermia.

At **Saira Health Care**, formulations such as:

- **Spermogenic Powder**
- **Dr. Qasmi's Nuskha No. 129 – Vitasem Max**

may be used as part of an individualized male-fertility programme according to the patient's complete diagnosis.

Spermogenic is currently listed by Saira Health Care Pharmacy for several male-fertility and semen-quality concerns, including reduced motility and abnormal sperm parameters.

However:

no traditional or modern medicine should be advertised as capable of bringing an already dead sperm cell back to life.

Treatment works by creating better conditions for:

future sperm to be produced, mature and survive.

My approach at Saira Health Care can therefore be summarized as:

Confirm whether sperm are actually dead.

Distinguish vitality from motility and morphology.

Repeat severe abnormalities when necessary.

Use appropriate vitality testing.

Look for infection, varicocele, heat and lifestyle causes.

Treat reversible problems.

Use Unani medicine rationally and individually.

Monitor sperm vitality objectively.

Evaluate the female partner at the same time.

Use IUI, IVF or ICSI when appropriate.

Discuss testicular sperm retrieval when absolute necrozoospermia persists.

And never replace realistic fertility counselling with guaranteed claims.

For every man who asks me:

“Doctor, my sperm are dead. Is there still hope?”

my answer is:

There may still be meaningful fertility options. The first step is not to panic—it is to find out exactly how many sperm are alive, why vitality is reduced, and which treatment pathway is scientifically appropriate for you and your partner.

About the Author

Dr. Nizamuddin Qasmi

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Focused Practice in Sexual Disorders & Infertility

Professional Education & Training

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

Saira Health Care's official professional profile includes **Necrospermia** among the male-infertility conditions addressed in Dr. Nizamuddin Qasmi's focused practice.

His clinical approach combines:

- traditional Unani principles,
- male-infertility assessment,
- semen analysis,
- reproductive-health counselling,
- lifestyle management,
- and referral for appropriate modern fertility treatment when necessary.

Medical Disclaimer

This article is intended for general medical education and reproductive-health awareness.

It is not a substitute for:

- medical consultation,
- standardized semen analysis,
- sperm-vitality testing,
- physical examination,
- hormone testing,
- microbiological investigation,
- Doppler ultrasound,

- reproductive-urology evaluation,
- embryology assessment,
- or personalized infertility treatment.

Do not assume that:

- non-motile sperm are dead,
- abnormally shaped sperm are dead,
- watery semen means dead sperm,
- thick semen proves healthy sperm.

A properly performed sperm-vitality test is necessary when necrozoospermia is suspected.

Do not independently start:

- antibiotics,
- testosterone,
- fertility hormones,
- antioxidants,
- herbal products,
- Unani medicines,
- mineral preparations,
- or other treatments

without appropriate professional guidance.

Dr. Qasmi's Spermogenic Powder, Nuskha No. 129 or other fertility formulations should not be interpreted as guaranteed cures for necrozoospermia.

Men with confirmed absolute necrozoospermia should receive appropriate fertility counselling regarding:

- viable sperm selection,
- IVF/ICSI,
- and possible testicular sperm retrieval.

No treatment can guarantee:

- sperm recovery,
- fertilization,

- pregnancy,
- or live birth.