

Low AMH and Diminished Ovarian Reserve: Causes, Diagnosis, Fertility Treatment and the Role of Unani Medicine

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Introduction: “Doctor, My AMH Is Low. Does This Mean I Cannot Become Pregnant?”

One of the most anxious fertility consultations I see is a woman who comes to me holding an AMH report and says:

“Doctor, my AMH is low. Someone told me that my eggs are almost finished. Can I still become pregnant?”

Another woman may say:

“My AMH was 0.6. Does that mean IVF will fail?”

Someone else asks:

“Can medicine increase my AMH?”

And very often I hear:

“If my AMH becomes normal, will my fertility become normal again?”

These are very important questions because Anti-Müllerian Hormone—commonly known as:

AMH

is one of the most widely used and also one of the most misunderstood fertility tests.

The first thing I explain to my patients is:



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Low AMH is not the same as infertility.

AMH is primarily a marker of:

ovarian reserve

which means the approximate quantity of recruitable follicles remaining in the ovaries.

It gives us useful information about how the ovaries may respond to:

- fertility stimulation,
- IVF medicines,
- egg retrieval.

But AMH cannot, by itself, tell us:

- whether a woman will conceive naturally this month,
- whether her fallopian tubes are open,
- whether she is ovulating normally,
- whether her husband's sperm are healthy,
- whether an embryo will be genetically normal,
- whether pregnancy will definitely occur.

The American Society for Reproductive Medicine emphasizes that AMH and antral follicle count are good predictors of **egg quantity and ovarian response**, but are much weaker independent predictors of pregnancy or live birth. Female age is substantially more important when assessing overall reproductive potential.

This is why I tell women:

“Please do not let one AMH number decide your entire future.”

At the same time, low AMH should not simply be ignored.

When ovarian reserve is genuinely reduced, particularly in a woman who wishes to become pregnant, time can become important.

The correct approach is:

understand why AMH is low, interpret it according to age and ultrasound findings, evaluate both partners, and choose the fertility plan without unnecessary delay.

What Is Anti-Müllerian Hormone – AMH?



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AMH is a glycoprotein hormone.

In women, it is produced mainly by the:

granulosa cells

of small developing ovarian follicles.

These include:

- primary follicles,
- pre-antral follicles,
- small antral follicles.

As the number of these follicles decreases, circulating AMH generally declines.

Therefore, AMH has become one of the most useful laboratory markers of:

ovarian reserve.

ASRM currently describes AMH and antral follicle count as among the simplest and most sensitive ovarian-reserve markers.

What Is Ovarian Reserve?

Ovarian reserve means:

the remaining quantity of oocytes or egg-containing follicles in the ovaries.

It is important to distinguish:

Egg Quantity

How many potentially recruitable follicles remain.

from:

Egg Quality

How likely an egg is to:

- fertilize normally,
- produce a chromosomally normal embryo,
- ultimately result in live birth.

These are related but different concepts.



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AMH Mainly Reflects Quantity, Not Egg Quality

This is one of the most important messages in this article.

A woman may have:

low AMH but relatively good egg quality

particularly when she is younger.

Another woman may have:

a higher AMH but poorer average egg quality

because she is older.

Therefore:

AMH does not directly measure the genetic quality of eggs.

Female age remains much more strongly related to age-associated oocyte chromosomal abnormalities and reproductive prognosis. ASRM specifically emphasizes that ovarian-reserve tests primarily measure quantity rather than quality and that age is a stronger predictor of reproductive success.

Where Do a Woman's Eggs Come From?

Unlike sperm production in men, the conventional biological understanding is that women begin life with a finite pool of oocytes.

The number declines progressively through:

- natural follicular loss,
- ovulation,
- aging.

There is substantial individual variation.

Two women of the same age may therefore have very different:

- AMH,
 - antral follicle count,
 - ovarian response.
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Does Low AMH Mean That All Eggs Are Finished?



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No.

If follicles remain and the woman continues ovulating:

eggs remain present.

A low AMH value does not mean:

“zero eggs.”

Even extremely low values should not automatically be used to deny fertility treatment.

ASRM explicitly advises that even very low AMH should be used for realistic counselling regarding expected ovarian response—not as a reason to refuse IVF.

Low AMH and Diminished Ovarian Reserve Are Related but Not Exactly the Same Sentence

The term:

Diminished Ovarian Reserve – DOR

usually refers to a reduction in the remaining ovarian follicular pool or reduced expected ovarian responsiveness compared with what may be expected.

AMH can be one marker of DOR.

Other information includes:

- antral follicle count,
- age,
- previous response to IVF stimulation,
- sometimes FSH and estradiol.

Therefore:

one AMH test should be interpreted within the full clinical picture.

Is There One Normal AMH Level for Every Woman?

No.

There is no single AMH value that can be interpreted identically in:

- a 22-year-old woman,
- a 32-year-old woman,
- a 41-year-old woman.



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AMH naturally declines with age.

Laboratories also use:

- different assays,
- reference ranges,
- reporting methods.

The updated **ESHRE Ovarian Stimulation Guideline 2025** recommends using either AMH or antral follicle count to predict low or high ovarian response, but notes that differences among assays and study ranges make it inappropriate to derive one universal cut-off that works everywhere.

For this reason:

AMH should preferably be interpreted against age, laboratory method, ultrasound and fertility history rather than an internet chart alone.

What Does an AMH of Less Than 1 ng/mL Mean?

Many clinical studies use values around:

<1 ng/mL

to describe lower ovarian reserve.

But this is not a universal biological border.

For example:

- AMH 0.9 does not mean infertile,
- AMH 1.1 does not mean fertile,
- AMH 3 does not guarantee pregnancy.

The number is continuous rather than a simple:

pass/fail fertility test.

Can AMH Be Tested on Any Day of the Cycle?

One practical advantage of AMH is that it is relatively stable across the menstrual cycle compared with FSH.

It can generally be measured without restricting testing strictly to cycle day 2 or 3.



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However, clinical context remains important.

ASRM notes that AMH is relatively stable within and between cycles compared with several traditional ovarian-reserve hormones.

Factors That Can Temporarily Influence AMH Measurement

A low result does not always mean irreversible egg loss.

Several conditions can affect interpretation.

Hormonal Contraception

Women currently using:

- combined oral contraceptive pills,
- some other hormonal contraceptives

may show lower AMH and AFC measurements.

ASRM specifically recommends caution when interpreting AMH in women using hormonal contraception.

A systematic review found that AMH, AFC and ovarian volume can be lower during long-term hormonal contraceptive use and that AMH may recover after discontinuation.

Therefore:

a lower AMH while using contraception does not necessarily mean the same number will persist permanently.

Never stop prescribed contraception solely to change an AMH number without discussing the reason for testing with your clinician.

Hypothalamic Amenorrhoea

A particularly interesting 2026 update concerns women with:

- significant calorie deficiency,
- excessive exercise,
- low body weight,
- prolonged hypothalamic suppression.



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A 2026 systematic review found that AMH and AFC can sometimes underestimate true ovarian reserve in prolonged hypothalamic anovulation.

Therefore these tests should be interpreted cautiously in this population.

Low AMH Does Not Automatically Mean Premature Ovarian Insufficiency

This distinction is extremely important.

Diminished Ovarian Reserve

A woman may still have:

- regular menstruation,
- spontaneous ovulation,
- pregnancy potential,

but a reduced follicular pool or reduced ovarian response.

Premature Ovarian Insufficiency – POI

Is a more significant disorder involving impaired ovarian function before age 40.

It may involve:

- irregular or absent periods,
- biochemical evidence of ovarian insufficiency,
- symptoms of estrogen deficiency.

The international POI guideline published in 2025 states that diagnosis relies primarily on the clinical menstrual pattern and elevated FSH; AMH may support diagnosis when uncertainty remains but is not the sole diagnostic test.

Therefore:

low AMH alone does not diagnose POI.

Can a Woman With Very Low AMH Still Ovulate?

Yes.

Many women with low AMH continue having:

- regular menstrual cycles,
- spontaneous ovulation.

This explains why natural pregnancy can still occur.

AMH mainly reflects how many small follicles remain—not whether one particular egg can ovulate this month.

Can a Woman With Low AMH Conceive Naturally?

Yes.

This is one of the most important answers I give.

Older large prospective studies summarized by ASRM found that ovarian-reserve tests were poor predictors of natural conception on their own.

More recent evidence adds nuance.

A 2024 prospective cohort of **3,150 women** found that AMH below 1 ng/mL was associated with a modestly lower chance of natural conception compared with normal AMH, but pregnancy remained clearly possible in the low-AMH group.

So the most accurate interpretation in 2026 is:

Low AMH may reduce reproductive opportunity in some women, but it does not determine natural fertility by itself.

Pregnancy still depends on:

- age,
 - ovulation,
 - sperm,
 - fallopian tubes,
 - intercourse timing,
 - endometriosis,
 - uterine health,
 - many additional biological factors.
-

Can Low AMH Cause Infertility?

I prefer not to say:

“low AMH caused infertility.”



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AMH is primarily a:

marker.

A reduced ovarian follicle pool may contribute to fertility difficulty because:

- fewer recruitable follicles remain,
- reproductive time may be shorter,
- fewer eggs may be obtained during IVF.

But AMH itself is not simply a harmful substance causing infertility.

It reflects ovarian biology.

Why Does AMH Decline?

The most important causes and associations include the following.

1. Increasing Female Age

This is the commonest reason.

The follicular pool naturally declines throughout reproductive life.

Therefore AMH generally falls with age.

This is normal ovarian aging.

2. Individual Biological Variation

Women of the same age may have dramatically different ovarian reserves.

One healthy 30-year-old may have:

- relatively high AMH.

Another healthy 30-year-old may have:

- low AMH.

Sometimes no specific disease is found.

3. Genetic Factors

Certain women inherit a tendency toward:



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- earlier ovarian depletion,
- premature ovarian insufficiency.

A family history of:

- early menopause,
- POI

may therefore be relevant.

Selected genetic causes of ovarian insufficiency include:

- chromosomal abnormalities,
- X-chromosome disorders,
- FMR1 premutation,
- additional emerging genetic conditions.

Genetic testing is particularly relevant when genuine POI is suspected rather than for every isolated low-AMH result.

4. Ovarian Surgery

Surgery can reduce ovarian reserve when healthy ovarian tissue is inadvertently lost or damaged.

This is particularly important with:

- repeated ovarian operations,
- bilateral ovarian surgery,
- endometrioma cystectomy.

A systematic review found a sustained AMH decline after endometrioma cystectomy, particularly following bilateral surgery.

Therefore ovarian surgery should always balance:

treatment benefit against potential ovarian-reserve loss.

5. Endometriosis

Endometriosis and especially:

- ovarian endometriomas,



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- surgery for endometriomas

may be associated with reduced ovarian reserve.

A 2026 review of endometriosis-associated infertility emphasizes that women with:

- low AMH/AFC,
- age 35 or older,
- prolonged infertility

may often benefit from earlier consideration of ART rather than repeated delays.

6. Chemotherapy

Certain chemotherapy medicines can damage ovarian follicles.

The effect depends on:

- drug,
- dose,
- age,
- treatment duration.

Women facing gonadotoxic cancer treatment should receive fertility-preservation counselling whenever possible before therapy.

7. Pelvic Radiation

Radiation involving the ovaries can significantly reduce ovarian reserve.

The degree depends on:

- radiation field,
 - dose,
 - age.
-

8. Removal of an Ovary

A woman with one remaining healthy ovary may still conceive naturally.

However, total follicular reserve is generally lower than when two functioning ovaries are present.



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9. Autoimmune Ovarian Disease

Selected autoimmune conditions can contribute to:

premature ovarian insufficiency.

This should be evaluated according to the POI clinical picture rather than assumed simply because AMH is low.

10. Smoking

Smoking is associated with accelerated reproductive aging and poorer reproductive health.

Stopping smoking is one of the most appropriate fertility-health interventions.

WHO's current infertility guideline emphasizes tobacco cessation and healthy lifestyle as part of reproductive care.

11. Severe Systemic or Metabolic Health Problems

Overall health can influence reproductive physiology.

However, a single low AMH number should not automatically be blamed on:

- stress,
- vitamin deficiency,
- diet

without evidence.

12. Unexplained Diminished Ovarian Reserve

Many young women with low AMH have no obvious:

- surgery,
- chemotherapy,
- genetic diagnosis,
- major disease.

The condition may remain:

idiopathic.



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Does Stress Cause Low AMH?

Chronic stress can affect:

- sleep,
- hypothalamic reproductive function,
- sexual activity,
- metabolic health.

But it should not be presented as a proven universal cause of diminished ovarian reserve.

I do not tell a patient:

“Your eggs reduced because you were stressed.”

That statement is too simplistic.

Does Poor Diet Cause Low AMH?

Severe malnutrition can disrupt reproductive hormone function.

A balanced diet supports overall fertility.

But there is no evidence that eating one particular food will:

replenish the ovarian egg pool.

Does PCOS Cause Low AMH?

Usually:

No.

Women with PCOS frequently have:

- a large number of small follicles,
- relatively high AMH.

Therefore high rather than low AMH is commonly associated with PCOS.

A high AMH in PCOS does not mean exceptionally high fertility because ovulation may still be irregular.

AMH is also **not recommended as a stand-alone diagnostic test for PCOS.**



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Symptoms of Low AMH

Low AMH itself generally produces:

no specific symptom.

A woman cannot feel whether her AMH is:

- 3,
- 1,
- 0.5.

Many women discover low AMH only during fertility testing.

Can Periods Be Completely Normal?

Yes.

A woman may have:

- regular monthly periods,
- normal ovulation,
- low AMH.

This is particularly common in diminished ovarian reserve.

When Symptoms Suggest Something More Than DOR

If a younger woman develops:

- increasingly irregular periods,
- several months without menstruation,
- hot flushes,
- vaginal dryness,
- symptoms of estrogen deficiency,

evaluation for:

premature ovarian insufficiency

may be appropriate.



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How Is Low AMH Diagnosed Properly?

The process should involve more than ordering one blood test.

Step 1: Age

AMH must be interpreted in relation to:

the woman's age.

An identical AMH value can have different implications at:

- 24,
 - 34,
 -
- 41.
-

Step 2: Fertility History

I ask:

- How long have you been trying?
 - Have you conceived previously?
 - Have there been miscarriages?
 - Is pregnancy desired immediately?
 - Have you undergone IVF before?
-

Step 3: Menstrual History

I ask:

- Are periods regular?
- Have cycles become shorter?
- Are periods being missed?
- Is there amenorrhoea?



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This helps distinguish:

- DOR,
 - POI,
 - hypothalamic dysfunction,
 - other reproductive disorders.
-

Step 4: AMH Blood Test

AMH helps estimate:

the recruitable follicular pool.

But the test should not be interpreted alone.

Step 5: Antral Follicle Count – AFC

Transvaginal ultrasound can count the small visible follicles in the ovaries.

This is called:

Antral Follicle Count.

ESHRE 2025 strongly recommends either:

- AMH,
- or AFC

for predicting low and high ovarian response during IVF stimulation.

AMH and AFC Can Occasionally Disagree

A woman may have:

- relatively low AMH,
- but a better-than-expected AFC.

Or the reverse.

ASRM notes that discordance between AMH and AFC can occur.

Therefore:

one test should not always overrule the complete clinical picture.



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Step 6: FSH and Estradiol

In selected patients, particularly with very low AMH or suspected ovarian insufficiency, clinicians may evaluate:

- FSH,
- estradiol.

FSH has more cycle-to-cycle variability than AMH.

A normal FSH therefore does not guarantee normal ovarian reserve.

Step 7: Evaluate Ovulation

A low-AMH woman may still ovulate normally.

Ovulation assessment depends on:

- menstrual history,
 - ultrasound,
 - progesterone testing where necessary.
-

Step 8: Check Fallopian Tubes When Indicated

Low AMH does not tell us whether tubes are:

- open,
- blocked.

A woman with low AMH and bilateral tubal obstruction needs a very different treatment plan from a woman with low AMH and normal tubes.

Step 9: Evaluate the Uterus

Ultrasound and selected additional imaging can identify:

- fibroids,
- polyps,
- adhesions,
- adenomyosis,



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- congenital abnormalities.

Step 10: Evaluate the Male Partner

This is essential.

I do not want a woman with low AMH to spend valuable reproductive time receiving repeated treatment while her husband has:

- severe oligozoospermia,
- azoospermia,
- another major fertility factor.

Male and female evaluation should occur together whenever possible.

WHO's 2025 guideline reinforces evidence-based evaluation of infertility as a couple-level reproductive problem.

AMH and Natural Pregnancy: What Does the Science Really Say?

This subject has changed over time.

Older prospective studies showed relatively weak predictive ability.

ASRM therefore continues to caution:

AMH is not a stand-alone natural fertility test.

Newer research involving more than 3,000 women found that low AMH below 1 ng/mL was associated with a modestly lower probability of natural conception.

But natural pregnancies still occurred in the low-AMH group.

So I explain the modern position as:

AMH matters, but age and the entire reproductive picture matter more than the AMH number alone.

AMH and IVF

This is where AMH is particularly useful.

AMH predicts:

how strongly the ovaries are likely to respond to stimulation.



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A woman with low AMH may:

- recruit fewer follicles,
- produce fewer eggs per cycle,
- have a higher chance of cycle cancellation.

This information helps fertility specialists:

- counsel patients,
- select stimulation strategies,
- discuss realistic egg yield.

Current ESHRE 2025 guidance strongly supports AMH or AFC for predicting ovarian response category.

Does Low AMH Mean IVF Will Fail?

No.

It often means:

fewer eggs may be obtained.

But IVF success also depends on:

- female age,
- egg competence,
- sperm quality,
- fertilization,
- embryo development,
- uterine factors,
- laboratory quality.

ASRM specifically states that AMH is only weakly predictive of pregnancy/live birth when considered independently.

Very low AMH should therefore not be used to refuse IVF.

Which Is More Important: Age or AMH?

For overall reproductive prognosis:



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Age is generally more important.

AMH mainly helps estimate:

- ovarian response,
- available egg quantity.

Age is more strongly related to:

- chromosomal egg quality,
- embryo euploidy,
- miscarriage,
- live-birth probability.

Can AMH Be Increased?

This question needs careful wording.

A laboratory AMH value can sometimes:

- fluctuate,
- temporarily rise,
- fall,
- change with hormonal conditions.

Certain interventions have produced changes in AMH in studies.

But the clinically important question is not simply:

“Can we make the AMH number higher?”

The important questions are:

- Has the number of usable eggs truly improved?
- Is ovarian response better?
- Is pregnancy probability improved?
- Is live birth improved?

A medicine that changes AMH slightly is not automatically:

an ovarian-reserve cure.



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Can Lost Eggs Be Regenerated With Medicine?

There is currently no established conventional, Unani, Ayurvedic or supplement therapy proven to:

recreate a depleted normal ovarian egg pool in routine clinical care.

This is an essential scientific limitation.

Treatments should aim to:

- optimize remaining reproductive potential,
- address reversible factors,
- avoid unnecessary delay,
- use ART when indicated.

Modern Treatment of Low AMH and Diminished Ovarian Reserve

There is no one standard medicine for every patient.

Treatment depends on:

- age,
- AMH/AFC,
- menstrual function,
- cause,
- duration of infertility,
- previous pregnancy,
- male fertility,
- tubal status,
- pregnancy goal.

1. Do Not Treat the Number Alone

A woman who is:

- 25,
- AMH 0.8,



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- regular ovulation,
- open tubes,
- fertile male partner

has a different situation from:

- 41,
- AMH 0.8,
- long infertility,
- poor semen parameters.

The laboratory value is identical.

The treatment should not be.

2. Do Not Waste Reproductive Time

This is one of my strongest messages.

A low-AMH woman who wants pregnancy should not necessarily spend:

- one year,
- two years

trying supplement after supplement simply to increase the laboratory number.

The real objective is:

pregnancy and family building.

3. Natural Conception May Still Be Reasonable

In younger women with:

- regular ovulation,
- adequate sperm,
- open tubes,
- short infertility duration,

natural conception may still be realistic.

Treatment does not always mean immediate IVF.



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4. Treat Other Fertility Problems

Examples include:

- thyroid disease,
- hyperprolactinemia,
- PCOS,
- tubal disease,
- endometriosis,
- male infertility.

Correcting these may be more important than attempting to increase AMH.

5. Ovulation Induction

If the woman is not ovulating normally, appropriate ovulation-induction treatment may be used.

The drug is selected according to:

- underlying diagnosis.

Low AMH alone does not automatically mean ovulation medicine is required.

6. IUI

IUI may be considered in selected women when:

- at least one fallopian tube is functional,
- usable sperm are available,
- ovulation can occur.

However, low ovarian reserve plus:

- increasing age,
- long infertility duration

may favor moving to IVF sooner.



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7. IVF

IVF is particularly useful because it allows fertility teams to:

- stimulate available follicles,
- retrieve eggs,
- fertilize them,
- assess embryo development.

A current 2026 review emphasizes highly individualized IVF planning in women with DOR because ovarian response and prognosis vary substantially.

Can More IVF Medicine Create Unlimited Eggs?

No.

Increasing gonadotropin doses cannot force the ovary to produce an unlimited number of follicles if the recruitable follicular pool is small.

The stimulation strategy should therefore be individualized rather than assuming:

“more injections always mean more eggs.”

Add-On Treatments in Diminished Ovarian Reserve

Many add-on treatments are offered to women with low AMH.

These include:

- DHEA,
- testosterone pretreatment,
- growth hormone,
- CoQ10,
- PRP,
- antioxidants.

The evidence is mixed.

DHEA and Testosterone



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A 2025 systematic review of randomized trials reported signals of benefit for some androgen pretreatments in selected DOR patients, including a possible association between testosterone pretreatment and live birth.

However, these findings are not strong enough to justify unsupervised routine use.

The ESHRE 2025 ovarian-stimulation guideline remains cautious regarding several adjuvant therapies for predicted low responders.

These should therefore be considered:

specialist IVF decisions—not over-the-counter fertility tonics.

Growth Hormone

Despite some studies suggesting potential benefits in selected low responders, the **ESHRE 2025 guideline states that adjunct growth hormone is probably not recommended routinely for low responders** because evidence quality is insufficient and safety information remains limited.

Coenzyme Q10

A 2024 meta-analysis of six randomized trials reported improvements in several IVF outcomes with CoQ10 pretreatment among women with DOR.

However, the authors also noted limitations in:

- study quality,
- methodology,
- sample size.

Therefore CoQ10 may be discussed selectively, but it should not be presented as:

proven ovarian rejuvenation.

Ovarian PRP – “Ovarian Rejuvenation”

This treatment receives enormous online attention.

Platelet-rich plasma is injected into the ovaries with the aim of improving ovarian function.

Early uncontrolled studies appeared encouraging.

But stronger trials have been much less convincing.



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The randomized **PROVA trial** found no significant improvement in:

- mature oocytes,
- blastocysts,
- euploid blastocysts,
- sustained implantation,
- post-treatment AMH or AFC

with ovarian PRP.

A newer 2026 systematic review found that uncontrolled studies often report improvements in AMH/AFC, but controlled studies and randomized trials have **not demonstrated consistent improvements in pregnancy or live birth**.

Therefore:

ovarian PRP should still be regarded as an unproven or investigational fertility add-on rather than an established cure for low AMH.

Stem Cells and “New Egg Formation”

Stem-cell approaches and ovarian regeneration are active research fields.

They are not established routine treatment for diminished ovarian reserve in 2026.

Patients should be cautious of clinics advertising:

“We create new eggs.”

Such claims go beyond established clinical evidence.

Fertility Preservation

A woman diagnosed with diminished ovarian reserve who does not currently wish to conceive may need an individualized discussion about:

- reproductive plans,
- egg freezing,
- embryo freezing.

However, the number of eggs that can be frozen may be limited when ovarian reserve is already substantially reduced.



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ASRM emphasizes that age and reproductive plans are central to fertility-preservation counselling; AMH should not be used as a simplistic fertility test.

Low AMH and Premature Ovarian Insufficiency

When low AMH is associated with:

- menstrual irregularity,
- amenorrhoea,
- high FSH,
- estrogen-deficiency symptoms

before age 40, POI should be considered.

The updated international POI guideline published in 2025 changed diagnostic guidance, including use of FSH above 25 IU/L in the appropriate clinical setting and reserving AMH as an additional test where diagnostic uncertainty exists.

Can Women With POI Ever Ovulate?

Ovarian activity can occasionally occur intermittently in spontaneous POI.

But fertility is substantially reduced.

Management also includes protecting:

- bone health,
- cardiovascular health,
- estrogen-dependent tissues,

not merely attempting pregnancy.

POI should therefore not be treated as simply:

“very low AMH.”

The Unani Concept of Low AMH and Diminished Ovarian Reserve

Classical Unani physicians did not have:

- AMH assays,
- ultrasound follicle counting,



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- IVF,
- modern ovarian endocrinology.

Therefore:

there is no classical Unani diagnosis that is an exact equivalent of a modern low-AMH laboratory result.

This distinction is important.

Classical Unani medicine does, however, contain a detailed framework for:

- female infertility,
- menstrual health,
- reproductive-organ function,
- constitutional health.

The recognized Unani term:

‘Uqr

is used for female infertility.

CCRU's **Standard Unani Treatment Guidelines for Common Diseases** describe ‘Uqr as a condition in which a woman is unable to conceive and discuss traditional causes involving different states of the uterus and general constitution.

What Unani Medicine Traditionally Considers

The Unani approach assesses the whole patient rather than a laboratory number alone.

Traditional assessment may include:

- Mizaj,
- menstrual health,
- nutrition,
- digestion,
- body weight,
- activity,
- sleep,
- general reproductive health,



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- uterine health.

I believe this whole-person perspective can be very useful when it is combined responsibly with:

- AMH,
 - AFC,
 - hormones,
 - ultrasound,
 - tubal testing,
 - male-partner evaluation.
-

Mizaj – Individualized Constitutional Assessment

Two women with AMH 0.7 may differ completely.

Woman A

- age 27,
- regular periods,
- normal BMI,
- no surgery.

Woman B

- age 37,
- previous bilateral endometrioma surgery,
- infertility for four years.

Their laboratory AMH may be similar.

Their reproductive prognosis is not.

Unani medicine's emphasis on individualized:

Mizaj

is therefore philosophically compatible with personalized care—as long as modern biological information is not ignored.

Akhlat and AMH Are Not the Same Thing



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Classical Unani physiology refers to:

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

These traditional concepts should not be presented as if:

- AMH represents one humour,
- low AMH means one particular humour is deficient.

AMH is a measurable hormone produced by granulosa cells.

Akhlat represents a historical physiological framework.

Keeping these concepts distinct makes integrative medicine more academically credible.

Usul-i-Ilaj in Unani Female Infertility

CCRUM's standard guidance for '**Uqr**' describes traditional principles including:

- correction of the predominant constitutional state,
- individualized warming/cooling/moistening approaches,
- weight reduction where obesity contributes,
- nutritional restoration where the woman is underweight,
- **Taqwiyat-i-Rahim** – support/toning of uterine function.

These principles are useful as traditional supportive concepts.

But they should not be interpreted as proven methods of:

creating new ovarian follicles.

Ilaj-bil-Ghiza – Dietotherapy

This is one of the areas where Unani fertility care can be especially useful.

Diet may support:

- metabolic health,
- protein intake,



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- micronutrient sufficiency,
- healthy body weight,
- menstrual health,
- overall fertility.

Depending on the patient, I may recommend:

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

The goal is:

reproductive health—not a miracle AMH diet.

Can Any Food Increase AMH?

No food has been proven to:

rebuild the ovarian follicle pool.

A healthy diet supports the body and may help correct:

- undernutrition,
- obesity,
- insulin resistance,
- micronutrient deficiencies.

But statements such as:

“Eat this seed and your AMH will become normal”

are not scientifically justified.



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Ilaj-bit-Tadbir – Regimenal Care

Unani regimenal principles can support:

- appropriate exercise,
- healthy weight,
- adequate sleep,
- stress management,
- general health.

These measures align with contemporary reproductive-health recommendations.

Stress Management

Low AMH often creates enormous anxiety.

Some women begin testing AMH:

- every month,
- every few weeks.

This can increase fear without improving treatment.

I counsel patients that:

our target is fertility—not continuously chasing a hormone number.

Ilaj-bid-Dawa – Unani Pharmacotherapy

Traditional Unani medicines may be prescribed according to:

- Mizaj,
- menstrual pattern,
- general weakness,
- metabolic health,
- associated reproductive diagnosis.

However, any treatment advertised specifically as:

“AMH increasing medicine”



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should be judged by whether good clinical evidence exists.

What Evidence Exists Specifically for Unani Medicine and Low AMH?

At present, published high-quality evidence is:

limited.

I have not identified a large, independently replicated randomized clinical trial demonstrating that a specific Unani formulation:

- permanently restores depleted ovarian reserve,
- reliably normalizes AMH,
- produces new eggs,
- improves live birth specifically because AMH increased.

This limitation must be acknowledged.

A Very Important 2026 Development in Unani Research

A small prospective study has been registered in 2026 to investigate:

Satawar – *Asparagus racemosus*

in women with diminished ovarian reserve and low AMH.

This is relevant because it shows that traditional approaches are beginning to be evaluated specifically with:

- modern AMH outcomes.

However, the registered study is small and was listed without completed efficacy results.

Therefore:

it cannot currently be cited as proof that Satawar increases AMH or fertility.

This is exactly why continued clinical research is important.

Ashwagandha, Shatavari and Maca: Important Correction

The supplied material mentions:

- Ashwagandha,
- Shatavari,



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- Maca

as herbs believed to improve AMH.

They should not be grouped together as though all are classical Unani drugs with proven AMH-raising efficacy.

Ashwagandha – *Withania somnifera*

is used in more than one traditional medical system, including Unani and Ayurveda, but convincing clinical evidence that it restores diminished ovarian reserve in women is insufficient.

Shatavari/Satawar – *Asparagus racemosus*

is traditionally used for female reproductive support and is now being studied more directly in diminished ovarian reserve, but definitive clinical evidence is not yet available.

Maca – *Lepidium meyenii*

is a South American traditional botanical, not a classical Unani drug.

Therefore:

traditional use and scientific proof should not be confused.

Why Unani Treatment Can Still Be Valuable

A therapy does not have to claim:

“I make new eggs”

to be useful.

Unani treatment may help support:

- nutrition,
- menstrual health,
- metabolic health,
- healthy body weight,
- sleep,
- stress,
- general reproductive wellbeing,
- associated PCOS or cycle-related problems.



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These are clinically meaningful objectives.

Where Unani Medicine May Be Particularly Helpful

I consider supportive Unani management especially relevant when a woman with low AMH also has:

- poor nutritional status,
 - unhealthy lifestyle,
 - obesity,
 - underweight,
 - sleep disturbance,
 - menstrual irregularity,
 - general weakness,
 - metabolic dysfunction,
 - sexual-health issues,
 - stress related to infertility.
-

Where Unani Treatment Should Not Create Delay

This is equally important.

A woman should not spend prolonged periods attempting to raise AMH with traditional treatment alone when she has:

Advanced reproductive age

because egg quality declines with time.

Very low ovarian reserve

because reproductive opportunity may be limited.

Severe bilateral tubal damage

because the problem is not AMH alone.

Hydrosalpinx

which may require surgical treatment before IVF.

Severe male-factor infertility



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where ICSI may be required.

Previous repeated poor IVF response

where specialist reproductive planning is necessary.

Premature ovarian insufficiency

which requires broader medical and fertility management.

Can Unani Treatment Be Used Alongside IVF?

In selected patients, supportive:

- diet,
- lifestyle,
- properly supervised traditional care

may be integrated alongside modern fertility planning.

But it is essential to inform the IVF specialist about:

- every herbal medicine,
- supplement,
- mineral formulation

being taken.

Potential:

- drug interactions,
- liver effects,
- quality-control concerns

must not be ignored.

Dr. Nizamuddin Qasmi's Individualized Approach to Low AMH

When a woman comes to me at Saira Health Care saying:

“Doctor, please increase my AMH,”

I do not begin by chasing the laboratory number.

My approach is broader.



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Step 1: Ask the Woman's Age

This is fundamental.

The same AMH means different things at different ages.

Step 2: Confirm Why AMH Was Tested

Was it because of:

- infertility?
- irregular periods?
- IVF planning?
- previous ovarian surgery?
- fertility preservation?
- anxiety after an internet test?

Ovarian-reserve testing should answer a clinical question.

Step 3: Review the Actual AMH Laboratory Report

I consider:

- value,
 - units,
 - laboratory reference,
 - assay,
 - previous values.
-

Step 4: Ask About Hormonal Contraception

If the patient is taking hormonal contraception, AMH can sometimes be underestimated and should be interpreted cautiously.

Step 5: Review Menstrual Cycles



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I ask:

- Are periods regular?
- Have cycles become shorter?
- Are periods missing?
- Are there hot flushes?

This helps determine whether we are dealing with:

- isolated DOR,
- POI,
- another hormonal disorder.

Step 6: Assess Antral Follicle Count

AMH should ideally be interpreted alongside:

AFC

where clinically appropriate.

ESHRE considers both AMH and AFC good predictors of ovarian response.

Step 7: Review FSH and Estradiol Where Appropriate

Especially when AMH is extremely low or POI is suspected.

Step 8: Evaluate Ovulation

A woman with low AMH may ovulate every month.

This changes natural-conception counselling.

Step 9: Check Fallopian Tubes

If the couple is trying naturally, tubal status can be essential.

There is little value in spending a year attempting to raise AMH when both tubes are severely damaged.



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Step 10: Evaluate the Male Partner

I want semen analysis performed when appropriate.

Fertility is a couple's issue.

Step 11: Look for Endometriosis and Previous Ovarian Surgery

I specifically ask about:

- endometriomas,
- cyst surgery,
- repeated laparoscopy,
- removal of ovarian tissue.

These may be highly relevant to ovarian reserve.

Step 12: Assess Metabolic and General Health

I review:

- weight,
 - nutrition,
 - smoking,
 - diabetes,
 - thyroid function when clinically relevant,
 - sleep,
 - physical activity.
-

Step 13: Assess Mizaj and Add Appropriate Unani Support

When suitable, I may integrate:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- individualized traditional medicines.

But I explain clearly:



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the aim is to support the woman and her remaining reproductive potential—not claim that lost eggs are being regenerated.

Step 14: Decide How Much Time Is Reasonable

This may be one of the most important clinical decisions.

A 25-year-old and a 40-year-old should not necessarily be advised to wait for the same length of time.

Step 15: Refer for IUI or IVF When Appropriate

Supportive traditional care should not become a barrier to effective reproductive technology.

Step 16: Measure Success Correctly

Success is not simply:

AMH increased from 0.6 to 0.9.

Clinically meaningful outcomes include:

- regular ovulation,
 - adequate follicular response,
 - successful egg retrieval,
 - viable embryo,
 - pregnancy,
 - live birth.
-

Can AMH Increase After Treatment Without New Eggs Being Created?

Yes.

This is an important scientific point.

Measured AMH can change because of:

- biological variation,
- hormonal state,



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- assay variation,
- changes in small follicle activity.

Therefore:

a rise in AMH does not automatically prove that a woman created new eggs.

This is particularly important when evaluating claims made after:

- supplements,
- PRP,
- herbal treatments.

Is a Higher AMH Always Better?

No.

Women with PCOS may have very high AMH.

This may accompany:

- many follicles,
- irregular ovulation,
- increased risk of excessive IVF stimulation response.

Therefore:

fertility is not a competition to achieve the highest AMH number.

How Often Should AMH Be Repeated?

There is no need to repeat AMH constantly.

Repeat testing may be useful when:

- an earlier result was unexpected,
- clinical circumstances changed,
- treatment planning requires updated reserve information,
- temporary suppression may have affected the measurement.

Repeating every few weeks usually creates more anxiety than useful information.



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Low AMH and Egg Freezing

Egg freezing may be considered depending on:

- age,
- current ovarian reserve,
- reproductive plans.

But low AMH often means:

- fewer eggs may be obtained per stimulation cycle.

Therefore:

earlier fertility-preservation counselling is generally more useful than waiting until reserve becomes extremely low.

Low AMH and Recurrent Miscarriage

Low AMH and miscarriage are not identical conditions.

Age-related decline can simultaneously contribute to:

- lower ovarian reserve,
- greater chromosomal embryo risk.

But AMH alone is not a miscarriage diagnosis.

A woman with recurrent pregnancy loss needs the appropriate miscarriage evaluation rather than only AMH treatment.

Emotional Impact of Low AMH

Few laboratory tests create as much fear as AMH.

A patient may receive one result and immediately think:

“My motherhood is over.”

This can cause:

- anxiety,
- depression,
- sleep problems,
- pressure to undergo unnecessary treatment,



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- financial stress.

I tell patients:

AMH is information—not a verdict.

It helps us plan.

It should not define:

- your femininity,
- your worth,
- your entire chance of motherhood.

Common Myths About Low AMH

Myth 1: Low AMH means infertility.

Fact: Low AMH indicates reduced ovarian reserve or expected response; natural pregnancy may still occur.

Myth 2: AMH measures egg quality.

Fact: It mainly reflects follicle quantity. Age is more informative regarding average egg quality.

Myth 3: AMH 0.5 means no eggs remain.

Fact: Women with very low AMH may still ovulate and produce oocytes.

Myth 4: Very low AMH means IVF cannot work.

Fact: Response may be low, but ASRM states that extremely low AMH should not be used to refuse IVF.

Myth 5: Normal AMH guarantees natural pregnancy.

Fact: Pregnancy also requires ovulation, sperm, tubal function and many other factors.

Myth 6: High AMH always means excellent fertility.



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Fact: High AMH commonly occurs in PCOS, where ovulation may be irregular.

Myth 7: One AMH test perfectly predicts menopause.

Fact: AMH provides ovarian-reserve information but cannot accurately predict an individual woman's exact menopause date.

Myth 8: AMH below 1 is a universal infertility cut-off.

Fact: Laboratory assays, age and clinical context matter; ESHRE does not endorse one universal response cut-off for all assays.

Myth 9: Low AMH automatically means POI.

Fact: POI has a distinct clinical and biochemical diagnosis.

Myth 10: Hormonal contraception permanently destroys AMH.

Fact: AMH may be temporarily suppressed during long-term hormonal contraception and can recover after stopping.

Myth 11: One herb can regenerate the ovarian reserve.

Fact: No traditional or conventional oral medicine has been proven to regenerate a depleted human egg pool in routine clinical practice.

Myth 12: Raising AMH proves fertility has improved.

Fact: Pregnancy and live birth—not the AMH number alone—are the clinically meaningful outcomes.

Myth 13: Ovarian PRP is a proven cure for low AMH.

Fact: Randomized trials have not demonstrated consistent fertility or live-birth benefit.

Myth 14: Every woman with low AMH should immediately use donor eggs.



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Fact: Treatment depends on age, follicular response, fertility diagnosis and patient preferences.

Myth 15: Unani medicine has no role.

Fact: Unani medicine may provide meaningful individualized support through nutrition, lifestyle, menstrual-health management and general reproductive care.

Myth 16: Unani medicine can guarantee normal AMH.

Fact: Current clinical evidence does not support such a universal guarantee.

Frequently Asked Questions

What is AMH?

AMH is Anti-Müllerian Hormone produced mainly by granulosa cells of small ovarian follicles.

What does AMH tell us?

It mainly provides information about:

ovarian reserve and expected ovarian response.

Does AMH tell how many eggs I have exactly?

No.

It is an indirect marker.

It cannot count every remaining egg.

What is diminished ovarian reserve?

It refers to reduced ovarian follicular reserve or expected ovarian response.

What AMH level is considered low?



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Many studies use values around 1 ng/mL or lower, but there is no single universal threshold applicable to every:

- age,
 - laboratory,
 - assay.
-

Can I conceive naturally with AMH below 1?

Yes.

A recent large cohort found somewhat reduced average fecundability at AMH below 1 ng/mL, but natural pregnancies clearly still occurred.

Can I conceive with AMH below 0.5?

Pregnancy can still be possible.

The probability depends heavily on:

- age,
 - ovulation,
 - tubes,
 - sperm,
 - remaining follicles.
-

What is more important—AMH or age?

For overall fertility and egg-quality prognosis:

age is usually more important.

For predicting ovarian stimulation response:

AMH is very useful.

Can low AMH become normal?

The measured number can change.



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But a numerical rise should not automatically be interpreted as restoration of the original egg pool.

Can contraception lower AMH?

Yes, especially with prolonged hormonal contraception in some women.

Interpretation should be cautious.

Does low AMH stop ovulation?

Not necessarily.

Many low-AMH women ovulate normally.

Does low AMH mean menopause is near?

Lower reserve may indicate a reduced reproductive follicle pool, but one AMH result cannot tell exactly when menopause will occur.

Is AMH testing useful before IVF?

Yes.

It is among the strongest markers for predicting ovarian response and approximate oocyte yield.

Can IUI work with low AMH?

Yes, in selected women.

Age, tubal status, ovulation and semen quality matter.

Can IVF work with low AMH?

Yes.

Egg yield may be lower, but low AMH does not equal zero IVF chance.

Should I take DHEA myself?



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No.

Hormonal and androgen supplements should not be self-prescribed because:

- evidence is mixed,
 - side effects are possible,
 - appropriate dosing and patient selection matter.
-

Does growth hormone improve low-AMH IVF?

Evidence remains insufficient for routine use.

ESHRE 2025 probably recommends against routine adjunct growth hormone in low responders.

Does CoQ10 help?

Some clinical trials and meta-analyses suggest possible benefits in selected DOR patients undergoing IVF, but the evidence remains limited and it is not a cure for depleted reserve.

Does ovarian PRP work?

Current randomized evidence does not show a consistent pregnancy/live-birth benefit, so it remains investigational rather than established therapy.

Can Unani medicine help low AMH?

Unani care may be useful for:

- individualized nutrition,
- menstrual-health support,
- metabolic optimization,
- lifestyle management,
- general reproductive wellbeing.

Its role should complement appropriate fertility evaluation.

Can Unani medicine recreate eggs?



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There is no high-quality clinical evidence proving that any Unani treatment recreates a depleted normal egg pool.

Is Satawar useful?

Satawar/Shatavari has traditional use in female reproductive health and is being studied specifically in DOR, but completed high-quality clinical evidence showing reliable improvement in pregnancy/live birth is not yet sufficient.

Can I use Unani treatment before IVF?

Selected supportive treatment may be reasonable, but when IVF is time-sensitive it should not create unnecessary delay.

All herbs and formulations should be disclosed to the fertility team.

Low AMH Treatment at Saira Health Care

Saira Health Care's current public website lists:

Infertility in Low AMH

among its female-infertility services.

Its physician profile also specifically includes:

Decreased AMH level

among the reproductive-health problems addressed in Dr. Nizamuddin Qasmi's infertility-focused practice.

At Saira Health Care, my approach to low AMH is not:

“Give one medicine to every woman until the number rises.”

I prefer to determine:

- age,
- AMH,
- AFC,
- menstrual function,
- ovulation,



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- tubal status,
- endometriosis,
- ovarian surgery history,
- male-partner fertility,
- reproductive timeline.

Only then do I develop the treatment plan.

The Special Role of Saira Health Care

Saira Health Care focuses clinically on:

Sexual Disorders & Infertility

and provides care for both:

- male,
- female reproductive problems.

This is particularly relevant in low-AMH infertility because the woman should never automatically carry the entire burden of diagnosis and treatment.

A couple may have:

- low AMH in the woman,
- and low sperm motility in the man.

Or:

- low AMH,
- bilateral tubal damage.

Or:

- low AMH,
- normal tubes,
- excellent semen,
- younger female age.

Each requires a different strategy.



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Dr. Nizamuddin Qasmi's Clinical Philosophy

When a woman asks me:

“Doctor, can you increase my AMH?”

I prefer to answer:

“My first aim is not simply to increase a laboratory number. My aim is to understand how much reproductive potential remains, protect the time you have, improve every reversible health factor, and help you choose the most appropriate route to pregnancy.”

That route may involve:

- natural conception,
- lifestyle modification,
- Unani supportive treatment,
- ovulation therapy,
- IUI,
- IVF.

Success Stories and Low AMH

Women with low AMH can and do become pregnant.

But success stories should be presented responsibly.

A meaningful low-AMH fertility case should ideally include:

1. woman's age,
2. baseline AMH,
3. AFC,
4. menstrual/ovulation status,
5. infertility duration,
6. tubal status,
7. male semen analysis,
8. treatment given,
9. post-treatment findings,
10. natural/IUI/IVF conception,



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11. pregnancy/live-birth outcome,
12. patient consent.

A statement such as:

“AMH went from 0.4 to 1.2”

does not, by itself, prove:

- egg regeneration,
- infertility cure.

What Should Count as Success?

For one woman:

Success may mean spontaneous pregnancy.

For another:

obtaining more usable follicles during treatment.

For another:

retrieving eggs before ovarian reserve declines further.

For another:

achieving an embryo and live birth through IVF.

For another:

identifying POI early and receiving appropriate health and fertility counselling.

Good fertility medicine is ultimately about:

the patient and reproductive outcome—not only the AMH result.

Latest Scientific Perspective: 2025–2026

Several important developments shape how low AMH should now be discussed.

WHO's First Global Infertility Guideline – 2025

WHO published its first comprehensive evidence-based infertility guideline on:

28 November 2025.



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It provides recommendations for:

- infertility diagnosis,
- ovulation problems,
- tubal disease,
- uterine disease,
- male infertility,
- unexplained infertility,
- assisted reproduction.

This reinforces the importance of:

treating the complete fertility diagnosis—not one laboratory biomarker.

ESHRE Ovarian Stimulation Guideline – 2025

ESHRE's updated IVF/ICSI stimulation guideline strongly recommends:

AMH or AFC

for predicting low and high ovarian response.

It also emphasizes that:

- different assays,
- different study ranges

prevent one universal AMH cut-off from being applied across all clinical settings.

DOR Treatment Research Is Increasing

A 2025 meta-analysis of randomized studies investigated multiple DOR interventions including:

- DHEA,
- testosterone,
- gonadotropin doses,
- letrozole,
- growth hormone,



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- other stimulation strategies.

Some possible benefits were observed for selected treatments, but results remain heterogeneous and require individualized specialist interpretation.

PRP Evidence Has Become More Cautious

Earlier observational studies generated enthusiasm for:

ovarian PRP.

However, randomized trials have not reproduced dramatic improvements consistently.

The PROVA randomized trial found no significant improvement in key reproductive outcomes.

A 2026 meta-analysis similarly concluded that controlled evidence does not yet demonstrate consistent pregnancy or live-birth benefit.

Therefore:

AMH improvement alone should not be used to validate an experimental ovarian-rejuvenation treatment.

POI Guidance Has Also Changed

The international evidence-based POI guideline updated in 2025 provides clearer guidance regarding:

- FSH,
- AMH,
- genetics,
- fertility preservation,
- hormone therapy,
- lifestyle.

It also states that women considering:

- herbal,
- nutritional complementary treatments

should be informed that evidence supporting these approaches in POI remains insufficient.



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This is especially important because:

POI and ordinary low AMH should not be confused.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

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

Professional Education & Additional Training

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

Saira Health Care's public physician profile describes Dr. Nizamuddin Qasmi as a **sexologist and infertility specialist** and specifically lists clinical work involving:

- PCOD/PCOS,
- irregular menses,
- decreased AMH,
- male and female infertility.

Saira Health Care's current professional educational pages also list:

- Certificate in Urology – London, UK,
- Masters in Male Infertility – MasterHealthPro,
- Integrated Sexual and Reproductive Health – ISRH, UNFPA

within Dr. Qasmi's published professional byline.

Why Male-Infertility Training Is Relevant Even in a Low-AMH Article

Some patients may wonder:



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“Why does male infertility expertise matter when AMH belongs to the woman?”

Because infertility belongs to:

the couple.

A woman with reduced ovarian reserve may have limited reproductive time.

If the male partner also has:

- severe oligozoospermia,
- low motility,
- azoospermia,
- another major sperm problem,

that must be identified early.

Months should not be lost treating only one partner.

This is why an infertility-focused practice should understand:

- female reproductive reserve,
- male reproductive factors,
- sexual-health barriers,
- ART options.

My Final Message to Women With Low AMH

If your AMH report is low:

do not panic.

But also:

do not ignore it.

Ask the right questions:

How old am I?

Is this AMH low for my age?

What is my antral follicle count?

Are my periods regular?

Am I ovulating?



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Am I taking hormonal contraception that may affect the result?

Could I have premature ovarian insufficiency?

Have I had endometrioma or ovarian surgery?

Are my fallopian tubes open?

Do I have endometriosis?

Has my husband had a semen analysis?

How long have we been trying?

Can we reasonably try naturally?

Would IUI help?

Should I consider IVF sooner?

Would fertility preservation be appropriate?

Can individualized Unani care support my nutrition, menstrual health and overall reproductive wellbeing?

Am I wasting valuable fertility time trying only to increase an AMH number?

These are the questions that create a rational treatment plan.

Conclusion

Anti-Müllerian Hormone:

AMH

is one of the most useful modern markers of:

ovarian reserve.

It is produced mainly by granulosa cells of small developing ovarian follicles.

As the follicular pool declines:

AMH generally decreases.

But low AMH should not be misunderstood.

It does **not** automatically mean:

- infertility,
- no eggs,



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- no ovulation,
- poor egg quality,
- IVF failure,
- premature menopause.

AMH is most useful for predicting:

ovarian response and likely egg yield during fertility stimulation.

ASRM emphasizes that AMH and AFC are much better at predicting **quantity** than:

- egg quality,
- natural pregnancy,
- live birth.

Female age remains a more powerful determinant of overall reproductive potential.

Current ESHRE guidance recommends AMH or AFC for predicting:

- low,
- high ovarian response

but does not support one universal AMH cut-off across every assay and patient.

Low AMH may result from or be associated with:

- normal ovarian aging,
- individual/genetic variation,
- ovarian surgery,
- endometrioma surgery,
- chemotherapy,
- radiation,
- ovarian insufficiency,
- smoking,
- unexplained causes.

Interpretation can sometimes be affected by:

- hormonal contraception,
- hypothalamic suppression.



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Natural pregnancy remains possible in women with low AMH.

Recent evidence suggests lower AMH may be associated with a modest reduction in natural fecundability, but it remains far from a yes/no fertility test.

Treatment should therefore focus on:

female age,

remaining follicular reserve,

ovulation,

fallopian tubes,

uterine health,

male-partner fertility,

time available for conception.

Modern fertility options may include:

- natural attempts,
- correction of associated endocrine problems,
- IUI,
- individualized IVF.

Add-on treatments such as:

- DHEA,
- testosterone,
- CoQ10,
- growth hormone,
- ovarian PRP

have varying and often uncertain levels of evidence and should not be used as unsupervised universal AMH treatments. Current randomized evidence does not establish ovarian PRP as a reliable fertility or live-birth treatment.

The **Unani system of medicine** can provide useful individualized reproductive support through:

- Mizaj assessment,
- Ilaj-bil-Ghiza,



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- Ilaj-bit-Tadbir,
- supervised Ilaj-bid-Dawa,
- nutritional optimization,
- menstrual-health support,
- healthy weight,
- general reproductive wellbeing.

CCRUM's standard Unani guidelines describe female infertility as:

‘Uqr

and emphasize individualized treatment according to traditional constitutional and uterine-health concepts.

However:

there is currently insufficient high-quality evidence to claim that Unani medicines reliably regenerate lost human eggs, permanently restore diminished ovarian reserve or guarantee normalization of AMH.

At **Saira Health Care**, low AMH and female infertility form part of the clinic's publicly listed reproductive-health practice.

My approach as Dr. Nizamuddin Qasmi is therefore:

Do not treat AMH as a fertility verdict.

Interpret AMH according to age.

Confirm ovarian reserve with the complete clinical picture and AFC when appropriate.

Distinguish DOR from POI.

Consider temporary factors affecting AMH.

Evaluate ovulation.

Assess the fallopian tubes when indicated.

Evaluate the uterus and endometriosis.

Evaluate the male partner early.

Correct smoking, nutrition, weight and general-health factors.

Use individualized Unani supportive care responsibly.

Do not promise new egg formation.



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Do not chase an AMH number while reproductive time is being lost.

Use IUI or IVF when that offers the better chance of pregnancy.

For every woman who asks:

“Doctor, my AMH is low. Is there still hope?”

my answer is:

Yes. Low AMH does not mean your chance of motherhood has ended. It tells us that we should understand your ovarian reserve carefully and use your reproductive time wisely. The right treatment is not simply the medicine that makes the AMH report look better; it is the treatment plan that gives you the most realistic and medically appropriate opportunity to achieve pregnancy.

Selected Medical References

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6. **Conforti et al.** Therapeutic management in women with diminished ovarian reserve: systematic review and meta-analysis of randomized trials. *Fertility and Sterility.* 2025.
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8. **PROVA Randomized Controlled Trial.** Intraovarian PRP and IVF outcomes in poor ovarian response.
9. **2026 systematic review of intraovarian PRP in DOR.** Controlled studies did not demonstrate consistent pregnancy/live-birth benefit.
10. **CCRU, Ministry of AYUSH.** Standard Unani Treatment Guidelines – ‘Uqr (female infertility).



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Medical Disclaimer

This article is intended for:

- general education,
- fertility awareness,
- patient information.

It does not replace:

- gynecological consultation,
- reproductive-endocrinology assessment,
- AMH testing,
- ultrasound/AFC,
- hormone evaluation,
- tubal testing,
- semen analysis,
- fertility-preservation counselling,
- IUI/IVF consultation.

Do not begin or discontinue:

- hormonal contraception,
- DHEA,
- testosterone,
- growth hormone,
- fertility injections,
- ovulation medicines,
- supplements,
- Unani medicines,
- Ayurvedic medicines,
- herbal formulations

without appropriate professional advice.



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A low AMH result should not be used alone to:

- diagnose infertility,
- diagnose POI,
- predict exact menopause age,
- deny IVF,
- recommend donor eggs,
- guarantee treatment failure.

Likewise, an increase in AMH after:

- supplements,
- herbal treatment,
- PRP,
- other interventions

does not by itself prove:

- new eggs were created,
- ovarian reserve was permanently regenerated,
- pregnancy chances increased.

Women with:

- markedly reduced ovarian reserve,
- age 35 or above,
- suspected POI,
- previous ovarian surgery,
- endometriosis,
- chemotherapy/radiation history,
- prolonged infertility

should receive timely specialist fertility assessment.

Traditional Unani medicine may provide valuable individualized:

- diet,
- lifestyle,



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- menstrual-health,
- general reproductive support,

but should not delay fertility preservation, IVF or other medically indicated treatment when reproductive time is limited.

No modern medicine, Unani formulation, herbal therapy, supplement, PRP procedure, IUI or IVF cycle can ethically guarantee:

- AMH normalization,
- egg regeneration,
- pregnancy,
- live birth.

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