

Diminished Ovarian Reserve (DOR) and Fertility

Understanding Low AMH, Low Antral Follicle Count, Egg Reserve, Fertility, IVF, Fertility Preservation and an Integrative Unani Approach

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When a woman comes to me carrying an AMH report showing:

0.8 ng/mL

or:

0.4 ng/mL

or sometimes an even lower value,

the first thing I usually notice is not the laboratory number.

I notice the fear on her face.

She may ask me:

“Doctor, are my eggs finished?”

“Does low AMH mean I can never become pregnant?”

“Does it mean my eggs are poor quality?”

“Will my periods stop soon?”

“Can medicine increase my ovarian reserve?”

“Should I immediately go for IVF?”

These questions are completely understandable because the phrase “**diminished ovarian reserve**” can sound much more final than it actually is.

My first message to patients is therefore:

Low ovarian reserve does not mean zero fertility.

Diminished ovarian reserve—commonly shortened to **DOR**—generally means that the ovaries contain a lower remaining pool of recruitable follicles than expected or are likely to produce fewer eggs during ovarian stimulation.

It is mainly a problem of:

Egg Quantity



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rather than a direct laboratory measurement of:

Egg Quality.

Current ASRM guidance defines ovarian reserve principally in terms of the **quantity of remaining oocytes** and emphasizes that tests such as AMH and antral follicle count are good predictors of how many eggs the ovaries may produce during fertility treatment, but they are much poorer independent predictors of natural pregnancy or live birth.

The updated **2025 ESHRE ovarian-stimulation guideline** reaches a similar conclusion: **AMH and antral follicle count are recommended for predicting low or high response to IVF stimulation, but neither AMH nor AFC should be used by itself to predict pregnancy or live birth. Female age remains an important predictor of those outcomes.**

This distinction is one of the most important things a woman with low AMH should understand.

What Is Ovarian Reserve?

Every woman is born with a finite population of immature eggs contained inside structures called:

follicles.

Unlike sperm production in men, women do not continuously produce large numbers of new mature eggs throughout adult life.

The ovarian follicle pool gradually declines.

This begins long before menopause.

With increasing age:

- fewer follicles remain,
- AMH generally falls,
- antral follicle count declines,
- ovarian response to stimulation becomes lower.

Eventually, the remaining follicle population becomes insufficient to sustain normal reproductive cycles and menopause occurs.

Ovarian reserve therefore refers primarily to:

how much remaining follicular or egg-producing capacity is present in the ovaries.



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What Is Diminished Ovarian Reserve?

The American Society for Reproductive Medicine describes diminished ovarian reserve as a situation in which a reproductive-aged woman—often still having regular menstrual cycles—has a lower-than-expected response to ovarian stimulation compared with other women of similar age.

In practical fertility medicine, DOR may be suspected when one or more of the following are present:

- low AMH,
- low antral follicle count,
- elevated early-cycle FSH in some women,
- unexpectedly low number of developing follicles during IVF stimulation,
- unexpectedly low number of retrieved oocytes.

However:

there is no single universal AMH number that defines DOR in every woman.

Different laboratories use:

- different assays,
- different units,
- different reference ranges.

Research studies also use different cut-offs.

For example, some studies define DOR using AMH below approximately:

1.0–1.2 ng/mL

while others use:

0.7 ng/mL

or incorporate AFC and previous ovarian response.

Therefore, I do not advise patients to diagnose themselves from one internet cut-off.

Diminished Ovarian Reserve Is Not the Same as Menopause

This is extremely important.



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A woman with DOR may still:

- menstruate every month,
- ovulate regularly,
- produce an egg,
- conceive naturally.

Menopause means permanent cessation of menstruation because ovarian follicular activity has reached a very advanced stage of depletion.

DOR may precede menopause by many years.

A 32-year-old woman with low AMH is therefore not automatically menopausal.

DOR Is Also Not the Same as Premature Ovarian Insufficiency

Another condition frequently confused with DOR is:

Premature Ovarian Insufficiency — POI

These conditions overlap biologically but are not identical.

The current international POI guideline defines premature ovarian insufficiency as **loss of ovarian activity before age 40**, usually characterized by irregular or absent menstrual cycles together with biochemical evidence of ovarian insufficiency. Current diagnostic criteria include menstrual disturbance for at least four months and **FSH above 25 IU/L**, with repeat testing after 4–6 weeks when there is diagnostic uncertainty.

A woman with DOR may instead have:

- completely regular periods,
- normal estrogen,
- normal ovulation,
- low AMH,
- low AFC.

That is not automatically POI.

DOR Versus POI — An Easy Way to Understand the Difference

Think of ovarian reserve as a fuel tank.



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Normal reserve

The tank contains a relatively large amount of fuel.

Diminished ovarian reserve

The tank contains less fuel than expected, but the engine may still be functioning normally.

Premature ovarian insufficiency

The ovarian system has begun losing normal function before age 40, commonly producing:

- irregular or absent periods,
- high FSH,
- low estrogen in many women.

This analogy is imperfect, but it helps explain why low AMH and ovarian failure are not synonyms.

DOR Is Not the Same as Poor Egg Quality

This may be the single most important misconception surrounding AMH.

AMH mainly reflects:

egg quantity / follicle quantity.

It does **not directly test the genetic quality of the eggs.**

Egg quality is much more strongly related to:

Female Age

As women age, the proportion of eggs carrying chromosomal abnormalities increases.

Therefore:

a 29-year-old woman with AMH 0.6 ng/mL

and

a 42-year-old woman with AMH 0.6 ng/mL

do **not** have the same reproductive prognosis.

Their ovarian reserve may look similar numerically.

Their expected egg quality is very different because of age.



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Current ESHRE guidance specifically recommends AMH or AFC for predicting the number of eggs likely to respond to ovarian stimulation but does **not** recommend AMH or AFC as predictors of pregnancy or live birth. Female age remains considerably more relevant for pregnancy prognosis.

A Young Woman Can Have Low AMH but Good-Quality Eggs

Yes.

A younger woman with diminished reserve may produce only:

- one,
- two,
- three eggs

during IVF.

But those eggs can still be developmentally competent.

The challenge is primarily:

fewer opportunities per treatment cycle.

That is different from saying:

“Every egg is poor quality.”

An Older Woman Can Have Normal AMH but Still Face Age-Related Egg Quality Decline

This is the reverse misunderstanding.

A 41-year-old woman may have an AMH of 2 ng/mL.

That is encouraging regarding:

expected egg quantity.

But it does not make the eggs biologically equivalent to those of a 25-year-old woman.

AMH does not stop reproductive ageing.

Age remains one of the strongest predictors of IVF pregnancy and live birth. A 2026 systematic review of recent IVF studies likewise found female age to be the most consistent and powerful predictor of pregnancy outcomes.



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What Is AMH?

AMH stands for:

Anti-Müllerian Hormone

AMH is produced by granulosa cells surrounding:

- pre-antral follicles,
- small antral follicles.

Because the number of these developing follicles generally reflects the underlying follicular pool, AMH provides an indirect measure of ovarian reserve.

As ovarian reserve declines:

AMH generally declines.

Current ASRM guidance considers AMH one of the most sensitive and clinically useful biochemical markers of ovarian reserve.

Can AMH Be Tested on Any Day of the Cycle?

Generally, yes.

Unlike early-follicular FSH, AMH is relatively stable across the menstrual cycle.

Therefore, it does not usually need to be performed specifically on:

- Day 2,
- Day 3,
- Day 4.

However, the value still needs clinical interpretation.

Hormonal Contraceptives Can Affect AMH Interpretation

AMH may appear somewhat lower while a woman is using some hormonal contraceptives.

ASRM specifically advises that AMH results should be interpreted cautiously in women currently using hormonal contraception.

Therefore, a low AMH value obtained while taking hormonal contraception should not automatically create panic.



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The complete reproductive history and clinical situation matter.

Does AMH Tell Me How Many Eggs I Have?

Not literally.

No blood test can count every primordial follicle remaining inside the ovaries.

AMH is an indirect biomarker.

It helps estimate ovarian reserve and predict:

response to ovarian stimulation.

It cannot tell a woman:

“You have exactly 8,452 eggs remaining.”

Such precision is biologically impossible.

What Is Antral Follicle Count — AFC?

Antral follicle count is measured using:

Transvaginal Ultrasound

The clinician counts small developing follicles—usually approximately 2–10 mm—in both ovaries during the early part of the menstrual cycle.

The total number is called:

AFC.

Like AMH, AFC reflects the population of follicles currently available for recruitment.

Current ASRM and ESHRE guidance considers both:

AMH and AFC

the best available predictors of ovarian response.

Is AMH Better Than AFC?

Not necessarily.

Both have clinical value.



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The 2025 ESHRE guideline recommends **either AFC or AMH** for predicting high or low ovarian response and notes that both have good accuracy for this purpose. Combining them does not necessarily improve prediction enough to be required routinely.

In practice, I prefer to interpret them together when both are available because they help provide a fuller clinical picture.

But one should not treat one number as absolute truth.

What About FSH?

FSH stands for:

Follicle-Stimulating Hormone.

FSH is produced by the pituitary gland.

As ovarian reserve declines, the ovary produces less inhibitory feedback.

The pituitary may respond by producing more FSH.

Therefore:

high early-cycle FSH can indicate diminished ovarian reserve.

However, FSH has important limitations.

Its value can fluctuate substantially from one menstrual cycle to another.

A normal FSH does not exclude diminished reserve.

ASRM describes elevated basal FSH as a relatively specific but **not sensitive** marker of DOR.

Why Can FSH Be Normal When AMH Is Low?

AMH often begins declining earlier.

FSH may not rise significantly until ovarian reserve has declined further.

Therefore, a woman can have:

- low AMH,
- low AFC,
- normal Day-3 FSH.

That is not contradictory.



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AMH and AFC are generally more sensitive indicators of ovarian response.

Estradiol — E2

Early-cycle estradiol can help interpret FSH.

If estradiol rises unusually early, it may suppress FSH and make an FSH value appear deceptively normal.

Therefore, when basal FSH is being used, clinicians sometimes measure:

FSH + estradiol

together.

Estradiol alone should not be used as an ovarian-reserve test.

Tests That Are No Longer Particularly Useful

Older fertility testing sometimes used:

- inhibin B,
- clomiphene citrate challenge testing.

Modern ASRM guidance does not recommend these routinely because they provide little useful information beyond modern ovarian-reserve markers such as AMH and AFC.

Can a Woman Have Regular Periods With Very Low AMH?

Yes.

This is one of the characteristic features of DOR.

The ovaries may still recruit and ovulate one follicle every month.

Therefore:

regular menstruation does not prove that ovarian reserve is normal.

And the reverse is also true:

low AMH does not mean periods must stop.

Does Low AMH Mean I Cannot Conceive Naturally?

No.



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This deserves special emphasis.

Studies following women attempting pregnancy naturally have repeatedly shown that low AMH is a poor predictor of whether an individual woman will conceive naturally in the short term.

ASRM cites prospective studies in which women with AMH below approximately:

0.7–1.0 ng/mL

had cumulative natural pregnancy rates similar to women with more typical AMH concentrations after adjustment for age and other factors.

Therefore:

AMH is not a natural-fertility test.

It is much better at predicting how many eggs may respond during ovarian stimulation.

What Does Low AMH Actually Tell Us?

Low AMH tells me mainly:

“If I stimulate these ovaries with fertility medicines, I may obtain fewer growing follicles and fewer eggs than I would expect in someone with higher reserve.”

It does not directly tell me:

- whether ovulation occurs this month,
- whether the present egg can fertilize,
- whether an embryo will implant,
- whether natural pregnancy is impossible.

That distinction protects patients from unnecessary fear.

Can a Woman With AMH Below 0.5 Become Pregnant?

Yes.

Pregnancy is possible.

The probability depends upon many factors including:

- age,
- ovulation,



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- fallopian tubes,
- sperm quality,
- duration of infertility,
- endometriosis,
- uterine factors.

Even extremely low AMH should not automatically be used to refuse IVF treatment.

ASRM specifically states that very low AMH predicts fewer retrieved eggs and greater cancellation risk but should **not be used to deny fertility treatment**.

Can AMH Become Zero?

AMH can become:

- extremely low,
- below the assay's measurable threshold.

This indicates very advanced reduction in recruitable follicular activity.

But laboratory “undetectable AMH” and biological “absolutely no eggs anywhere in either ovary” are not necessarily identical statements.

Clinical interpretation should also consider:

- menstruation,
 - FSH,
 - AFC,
 - previous treatment response.
-

Why Does Ovarian Reserve Decline?

The most important cause is:

Age.

All women experience progressive follicular depletion.

However, some women lose ovarian reserve more rapidly than others.

Age-Related Diminished Ovarian Reserve



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Female reproductive ageing is natural.

Ovarian reserve gradually declines through:

- twenties,
- thirties,
- later reproductive years.

The rate accelerates as women approach the later reproductive period.

Importantly, reproductive ageing involves two separate processes:

1. fewer eggs remain,
2. the average chromosomal quality of remaining eggs declines.

AMH mainly reflects the first.

Age provides much more information about the second.

DOR at a Young Age

When a woman in her twenties or early thirties has unexpectedly low ovarian reserve, I look more carefully for possible causes.

However, many cases remain:

Idiopathic

meaning no definite cause can be found.

A 2025 review of DOR identifies spontaneous, genetic and treatment-related causes but also emphasizes that unexplained cases are common.

Family History

Some women appear genetically predisposed to earlier ovarian ageing.

A family history of:

- early menopause,
- premature ovarian insufficiency

can therefore be clinically relevant.

This does not mean every daughter will experience the same timing.

But it is worth asking.



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Genetic Causes

When ovarian reserve is severely diminished at a very young age—especially if menstrual cycles are becoming irregular—the possibility of an underlying genetic condition becomes more important.

Genetic investigation is particularly relevant once the clinical situation approaches or fulfils criteria for:

premature ovarian insufficiency.

The POI guideline includes evaluation for chromosomal and selected genetic causes in appropriate patients.

DOR alone does not mean every patient requires extensive genetic testing.

Chemotherapy

Certain chemotherapy medicines can destroy ovarian follicles.

The risk depends on:

- drug class,
- cumulative dose,
- age at treatment.

Alkylating chemotherapy is particularly gonadotoxic.

A 2025 review identifies chemotherapy as one of the major causes of treatment-related diminished ovarian reserve.

This is why fertility preservation should ideally be discussed before gonadotoxic cancer treatment.

Pelvic Radiotherapy

Radiation can also damage ovarian follicles.

Risk depends upon:

- radiation dose,
- treatment field,
- age,



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- whether the ovaries can be moved outside the radiation field in selected circumstances.

Women receiving potentially gonadotoxic radiation should receive fertility-preservation counselling whenever medically feasible.

Ovarian Surgery

Ovarian surgery can reduce reserve because healthy ovarian tissue may be removed or damaged along with the abnormal tissue.

This is particularly important in surgery for:

Ovarian Endometrioma.

A 2025 review of DOR identifies ovarian surgery as a major iatrogenic cause, and contemporary studies continue to demonstrate measurable reduction in ovarian reserve after endometrioma surgery.

Therefore, repeated ovarian surgery should never be considered trivial in a woman who wants future fertility.

Endometriosis and Ovarian Reserve

Endometriosis itself—particularly ovarian endometrioma—can be associated with diminished ovarian reserve.

Surgery can sometimes reduce reserve further.

A 2025 review of endometriosis surgery found that ovarian endometriomas are associated with lower AMH and that surgical treatment can produce a further decline.

The decision between:

- surgery,
- fertility treatment,
- fertility preservation

should therefore be individualized.

Smoking

Smoking is another potentially modifiable factor.



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ASRM's 2024 committee opinion reports evidence associating cigarette smoking with:

- accelerated follicular depletion,
- lower AMH,
- earlier menopause.

The effect appears dose-related in several studies.

For a woman with already reduced ovarian reserve, smoking cessation is particularly sensible.

However:

stopping smoking cannot recreate follicles that have already been lost.

Its purpose is to reduce further avoidable reproductive harm.

Autoimmune and Medical Conditions

Some autoimmune and systemic conditions may affect ovarian function.

However, not every woman with low AMH needs an extensive autoimmune panel.

Testing should be based on:

- age,
 - menstrual pattern,
 - symptoms,
 - degree of ovarian dysfunction,
 - whether POI is suspected.
-

Can Stress Cause Diminished Ovarian Reserve?

Ordinary psychological stress has not been established as a cause of major permanent follicular depletion.

Severe stress can affect:

- menstrual timing,
- sexual activity,
- sleep,
- general wellbeing.



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But a woman should not be told:

“Your AMH is low because you worry too much.”

That oversimplifies ovarian biology and can create unnecessary guilt.

Can Poor Diet Cause Low AMH?

Nutrition affects general health and reproductive function.

Severe malnutrition can disturb ovulation and menstruation.

But there is no evidence that an ordinary nutritional deficiency alone explains every case of DOR.

Improving nutrition is good reproductive medicine.

It should not be promoted as a guaranteed method of rebuilding the primordial follicle pool.

Symptoms of Diminished Ovarian Reserve

Many women have:

no symptoms.

They continue having:

- regular periods,
- normal libido,
- normal intercourse,
- normal daily life.

The condition may only be discovered because:

- infertility investigation is performed,
 - AMH is measured,
 - AFC is unexpectedly low,
 - IVF produces unexpectedly few eggs.
-

Shorter Menstrual Cycles



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As ovarian ageing progresses, some women notice that menstrual cycles become somewhat shorter.

This can occur because hormonal changes cause follicles to begin developing earlier.

However:

short cycles alone do not diagnose DOR.

Irregular Periods Are More Concerning for POI

If a woman under 40 develops:

- increasingly irregular periods,
- missed periods,
- hot flushes,
- vaginal dryness,

the evaluation needs to consider:

premature ovarian insufficiency, not just uncomplicated DOR.

The international POI guideline specifically recommends considering POI in women under 40 with irregular or absent cycles or symptoms of estrogen deficiency.

Does DOR Cause Hot Flushes?

Typical DOR with regular ovulation generally does not.

Hot flushes, night sweats and vaginal dryness suggest more significant estrogen deficiency.

This deserves further hormonal evaluation.

DOR and Infertility

DOR becomes particularly important in infertility because reproductive time and the number of remaining treatment opportunities may be reduced.

A woman can still conceive naturally.

However, if she is already infertile, I am less comfortable recommending prolonged delay when reserve is clearly reduced.



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This is particularly true when:

- age is above 35,
- AMH/AFC are substantially reduced,
- infertility has already lasted a long time.

The **2025 WHO infertility guideline** emphasizes timely, evidence-based, progressively appropriate infertility care rather than prolonged dependence on unproven treatments.

Female Age Changes the Urgency

Consider two women with AMH 0.6.

Woman A

Age 27.

She has been trying for pregnancy for four months.

Woman B

Age 39.

She has been trying for three years.

Their AMH is identical.

Their clinical situation is not.

For the younger woman, there may be substantially more reproductive time.

For the 39-year-old, delaying fertility treatment for many months while trying to “increase AMH” may cost valuable reproductive time.

This is why I never treat AMH independently of age.

How Is DOR Diagnosed Properly?

The diagnosis should be made from the **whole clinical picture**.

Useful information includes:

- age,
- menstrual history,
- reproductive history,
- previous ovarian surgery,



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- cancer-treatment history,
- family history,
- AMH,
- AFC,
- basal FSH/estradiol where appropriate,
- previous ovarian-stimulation response.

No single test should be interpreted without context.

AMH and AFC Are the Best Predictors of IVF Response

The **2025 ESHRE guideline** strongly recommends either:

AMH

or:

Antral Follicle Count

for predicting whether a woman is likely to have:

- low ovarian response,
- high ovarian response

during stimulation.

This helps choose a rational IVF stimulation plan.

AMH Should Not Predict Pregnancy or Live Birth by Itself

The same ESHRE guideline specifically states that:

- AMH,
- AFC,
- basal FSH,
- basal LH,
- estradiol,
- progesterone,
- inhibin B



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should not be used as standalone predictors of pregnancy or live birth after IVF.

That is because an egg must pass through several steps:

egg retrieval → fertilization → embryo development → implantation → ongoing pregnancy.

Reserve primarily influences how many opportunities enter that pathway.

Latest 2025 Evidence on IVF Outcomes in DOR

A 2025 multicentre study of 606 women with DOR found an important pattern:

pregnancy and ongoing pregnancy/live birth per embryo-transfer cycle were related strongly to age rather than AMH concentration.

Higher AMH did increase cumulative opportunity at the patient level because women with more reserve were more likely to generate more usable embryos.

This illustrates the principle beautifully:

AMH influences quantity of opportunities; age influences the biological potential of each opportunity much more strongly.

Does DOR Increase Miscarriage Risk?

The relationship is not straightforward.

Age itself strongly increases miscarriage risk because embryo chromosomal abnormalities increase with age.

Research attempting to determine whether low ovarian reserve adds miscarriage risk independently of age has produced inconsistent findings.

The **2026 ASRM recurrent-pregnancy-loss opinion** therefore does not recommend ovarian-reserve testing routinely as part of recurrent miscarriage evaluation because the association remains uncertain and there is no proven DOR-specific therapy that prevents miscarriage.

Can DOR Cause Poor IVF Response?

Yes.

This is where ovarian-reserve testing has its clearest value.

A woman with DOR may produce:



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- fewer follicles,
- fewer mature eggs,
- fewer embryos

during an IVF cycle.

This does not mean IVF is useless.

It means expectations and treatment strategy should be realistic.

What Is Poor Ovarian Response?

Poor ovarian response means that relatively few follicles or eggs develop despite ovarian-stimulation medication.

It may be predicted by:

- low AMH,
- low AFC,

or discovered during a previous stimulation cycle.

DOR and poor ovarian response overlap substantially but are not exactly identical terms.

DOR describes reserve.

Poor response describes what actually happens during stimulation.

Can Giving Much Higher Doses of FSH Force the Ovary to Make Many More Eggs?

Usually not.

This is another common misunderstanding.

If only a limited number of recruitable follicles are available in that cycle, simply giving extremely high doses of fertility medicine cannot create a large new follicle population.

The updated **2025 ESHRE guideline states that gonadotropin doses above 300 IU per day are not recommended for predicted low responders**, because doses above that level have not demonstrated meaningful improvement in reproductive outcomes.

This is important because “more medicine” does not necessarily mean “more eggs.”



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IVF Treatment in DOR

There is no one universally superior IVF protocol for every woman with DOR.

Treatment may involve an individualized stimulation strategy based on:

- age,
- AMH,
- AFC,
- previous response,
- previous egg maturity,
- previous embryo development.

Current ESHRE guidance recognizes that low responders are heterogeneous.

In women with exceptionally low reserve, modified natural-cycle approaches can sometimes be considered, although conventional stimulation remains appropriate for many.

What Is the Goal of IVF in DOR?

The objective is not:

“Make AMH normal.”

The objective is:

obtain the best possible usable eggs from the follicles that are available.

Sometimes that means only:

- one,
- two,
- three eggs.

A single good-quality embryo can still result in a healthy pregnancy.

However, fewer eggs generally mean fewer opportunities to create embryos.

Can Multiple IVF Cycles Be Needed?

Yes.



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When each stimulation produces only a small number of eggs, some couples may consider more than one retrieval cycle.

In selected cases, embryos or eggs may be accumulated across cycles.

The benefit depends heavily upon:

- age,
- previous embryo development,
- financial and emotional burden,
- treatment goals.

This should be individualized rather than sold as a guaranteed strategy.

Can IVF “Cure” Diminished Ovarian Reserve?

No.

IVF does not increase the underlying primordial follicle population.

It uses hormonal stimulation to recruit follicles that are available in that treatment cycle.

IVF is therefore a way of **using remaining reproductive potential efficiently**, not a cure for reduced ovarian reserve.

Natural Conception With DOR

If a younger woman:

- ovulates regularly,
- has open tubes,
- has no major male-factor infertility,
- has not been trying for very long,

natural conception may still occur.

Low AMH should not automatically send every woman directly to IVF.

But treatment should not be delayed unnecessarily when:

- age is advanced,
- infertility duration is long,



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- reserve is markedly reduced,
 - additional infertility factors exist.
-

Timed Intercourse

For women attempting natural conception, intercourse should be concentrated around the fertile window.

However, repeatedly spending many cycles on timed intercourse becomes less attractive when reproductive time is limited.

A treatment plan should consider:

- age,
 - duration of infertility,
 - ovarian reserve,
 - tubal status,
 - semen analysis.
-

IUI and DOR

Low AMH alone does not automatically make IUI impossible.

ASRM notes that ovarian-reserve tests have not consistently predicted pregnancy following ovarian stimulation/IUI in unexplained infertility.

Whether IUI is appropriate depends more broadly upon:

- age,
- tubal patency,
- semen quality,
- infertility duration,
- available time.

In an older patient with very low reserve, proceeding directly to IVF may sometimes be more efficient.

DHEA — Does It Improve Ovarian Reserve?



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DHEA supplements are heavily promoted to women with low AMH.

However, current evidence does not support routine use.

The latest **ESHRE ovarian-stimulation guideline states that DHEA before or during stimulation is not recommended for low responders.**

Therefore, DHEA should not be taken automatically because:

“AMH is low.”

It is an androgen hormone and can produce side effects.

Testosterone Pretreatment

Testosterone has also been investigated as an IVF add-on for poor responders.

Some studies suggested benefit.

Others did not.

The updated **2025 ESHRE guideline concludes that testosterone pretreatment is probably not recommended for low responders because evidence is inconsistent and dosage and safety remain uncertain.**

Growth Hormone

Growth hormone is another expensive add-on sometimes offered to women with poor ovarian response.

The 2025 ESHRE guideline concludes that adjunct growth hormone is **probably not recommended for low responders**, because existing evidence is not strong enough to establish a reliable benefit and long-term safety information remains limited.

Patients deserve to know this before paying for costly adjunct therapies.

Aspirin, Sildenafil and Myo-Inositol

These have also been proposed as fertility add-ons.

Current ESHRE guidance does **not recommend routine aspirin or sildenafil for low responders** and does not recommend myo-inositol as an ovarian-stimulation add-on in low responders.

More treatment is not automatically better treatment.



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Coenzyme Q10

CoQ10 is different because some randomized trials have produced encouraging results.

A 2024 meta-analysis of six randomized trials involving 1,529 women with DOR reported improvements in:

- numbers of retrieved oocytes,
- selected embryo outcomes,
- clinical pregnancy rates.

However, the authors emphasized limitations in sample size and study methodology and called for better-quality trials.

Therefore, I would describe CoQ10 as:

promising but not proven to restore ovarian reserve.

It should not be presented as a method for creating new eggs.

Can Vitamins Increase AMH?

There is no vitamin with established evidence showing that it can reliably rebuild ovarian follicle number.

Correcting genuine deficiencies—for example nutritional deficiency—can improve general health.

But changing an AMH number is not the same as producing meaningful additional reproductive lifespan or live birth.

Patients should be cautious about programmes promising:

“AMH 0.3 to AMH 3.0 guaranteed.”

Ovarian PRP — “Ovarian Rejuvenation”

Platelet-rich plasma—PRP—is increasingly marketed as:

ovarian rejuvenation.

PRP is injected into ovarian tissue in an attempt to stimulate biological activity.

Research has reported possible changes in:

- AMH,
- AFC,
- retrieved oocytes.

A 2024 systematic review involving 2,256 women found improvements in several ovarian-reserve and IVF parameters after PRP, but the evidence consisted predominantly of observational studies, and the authors specifically concluded that larger randomized trials are needed.

Therefore:

ovarian PRP should still be regarded as experimental.

It should not be marketed as a proven method of producing new eggs.

Stem Cells and Ovarian Regeneration

Stem-cell approaches are also being studied.

A 2025 review of DOR describes:

- stem-cell strategies,
- ovarian tissue activation,
- PRP

as emerging experimental approaches with promising early findings but insufficient evidence for widespread routine clinical use.

Patients should be especially cautious when experimental treatments are marketed with:

- guaranteed AMH increase,
- guaranteed pregnancy,
- “reversal of ovarian ageing.”

These claims go far beyond current evidence.

Can We Reverse Ovarian Ageing?

At present, no established treatment can reliably turn a 40-year-old ovary biologically into a 25-year-old ovary.

We can:



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- optimize health,
- stimulate remaining follicles,
- retrieve eggs,
- freeze eggs,
- create embryos,
- use assisted reproduction.

But we cannot currently guarantee regeneration of the original primordial follicle pool.

This distinction is fundamental.

Fertility Preservation

For some women with reduced ovarian reserve who are not yet ready for pregnancy, fertility-preservation counselling may be relevant.

Options can include:

Oocyte Cryopreservation — Egg Freezing

or, when appropriate:

Embryo Cryopreservation.

However, the decision needs careful counselling.

A woman with DOR may retrieve fewer eggs per cycle and may need more than one stimulation to obtain the desired number.

Age at Egg Freezing Matters More Than the AMH Number Alone

Egg freezing works by preserving eggs at their current biological age.

Therefore:

eggs frozen at 28

generally have better reproductive potential than:

eggs frozen at 39.

AMH mainly predicts how many eggs might be retrieved.

Age influences the likelihood that those eggs will eventually produce a chromosomally competent embryo.

Current ASRM guidance specifically cautions against using ovarian-reserve markers alone to promote elective egg freezing in otherwise fertile women; reproductive plans and age are more important.

Fertility Preservation Before Ovarian Surgery

This is particularly relevant to women with:

- bilateral endometriomas,
- recurrent endometrioma,
- only one functioning ovary,
- already low reserve before planned ovarian surgery.

Recent evidence emphasizes that endometrioma surgery can further reduce ovarian reserve, making preoperative fertility-preservation discussion important in selected patients.

Fertility Preservation Before Chemotherapy or Radiotherapy

Women scheduled to receive gonadotoxic cancer treatment should ideally receive fertility-preservation counselling **before therapy begins** whenever clinically feasible.

Depending upon circumstances, options may include:

- egg freezing,
- embryo freezing,
- ovarian tissue cryopreservation.

The appropriate strategy requires coordination with:

- oncology,
- reproductive medicine.

Cancer treatment should not be unsafely delayed.

Donor Eggs

For some women with extremely advanced ovarian depletion or repeated unsuccessful IVF attempts, donor-oocyte IVF may eventually provide a much higher chance of pregnancy.



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This can be emotionally difficult to discuss.

I do not introduce donor eggs simply because one AMH number is low.

The decision depends upon:

- age,
- previous response,
- whether viable embryos have been produced,
- reproductive goals.

But patients deserve to know that donor-oocyte treatment exists when their own-oocyte prognosis becomes extremely poor.

Donor Eggs Do Not Mean the Woman Cannot Carry a Pregnancy

A woman may have very few remaining eggs while still having:

- a normal uterus,
- ability to carry pregnancy.

With donor-oocyte IVF, the embryo is created using a donor egg but transferred into the intended mother's uterus.

The pregnancy then develops in her body.

This is a different issue from ovarian reserve itself.

Lifestyle and DOR

Lifestyle cannot recreate lost follicles.

However, optimizing general health remains worthwhile.

I encourage attention to:

- smoking cessation,
- healthy weight,
- regular physical activity,
- balanced nutrition,
- adequate sleep,
- appropriate management of diabetes or thyroid disease,



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- avoiding unnecessary reproductive delay when fertility is desired.

The purpose is to protect overall reproductive and pregnancy health—not promise that AMH will become normal.

Smoking Cessation

Among all lifestyle interventions, smoking cessation has particularly strong biological justification.

ASRM reports evidence that cigarette smoking can accelerate ovarian follicular depletion and is associated with lower AMH and earlier menopause.

A woman with low ovarian reserve has even more reason to avoid additional avoidable ovarian toxicity.

Weight

Very low or high body weight can affect:

- ovulation,
- pregnancy,
- metabolic health,
- fertility-treatment outcomes.

However, weight loss should not become an excuse to delay fertility care indefinitely in an older woman with significant DOR.

Treatment and metabolic optimization can often proceed together.

The Unani Perspective on Diminished Ovarian Reserve

As a physician trained in **Unani medicine** and working with patients affected by sexual and reproductive disorders, I believe infertility should never be reduced to one laboratory value.

Traditional Unani medicine evaluates reproductive health in the context of:

- **Mizaj** or constitutional temperament,
- menstrual function,
- uterine and ovarian health,



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- nutrition,
- digestion,
- sleep,
- physical wellbeing,
- metabolic health,
- psychological wellbeing,
- sexual health.

These areas can be relevant for a woman who is trying to conceive.

However, diminished ovarian reserve requires an important scientific distinction:

supportive reproductive treatment is not the same as regenerating lost follicles.

How Unani Medicine May Be Useful in DOR

An individualized Unani approach may be useful for supporting:

- nutritional wellbeing,
- digestion,
- healthy body weight,
- menstrual health,
- sleep,
- stress management,
- sexual wellbeing,
- general preconception health.

Some traditional approaches and herbal medicines have also been investigated for:

- follicular development,
- ovulatory infertility,
- female reproductive function.

These areas justify further scientific research.

What Does Published Unani Research Show?



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One randomized study from the National Institute of Unani Medicine investigated **Asparagus racemosus—Satavar/Shatavari—in women with anovulatory infertility.**

The study assessed follicular growth and ovulation.

However, importantly, women with **primary ovarian failure were excluded**, and pregnancy outcomes did not demonstrate superiority of the herbal intervention.

This distinction is crucial.

Evidence concerning ovulation in women with available ovarian follicles cannot automatically be translated into evidence that a treatment:

- increases ovarian reserve,
- rebuilds the primordial follicle pool,
- reverses advanced DOR.

Direct Evidence for Unani Treatment of DOR Is Currently Limited

At present, I would not tell a patient:

“Unani medicine has been scientifically proven to restore diminished ovarian reserve.”

That statement would be stronger than the evidence.

There is currently insufficient high-quality clinical research showing that Unani medicines can reliably:

- increase the true ovarian follicle pool,
- reverse age-related ovarian depletion,
- normalize severely reduced reserve,
- improve live birth specifically in women with confirmed DOR.

The responsible role is:

supportive and integrative.

Why Unani Support Can Still Matter

A woman with DOR may also have:

- PCOS,
- obesity,



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- digestive problems,
- disturbed sleep,
- anxiety,
- sexual difficulties,
- menstrual complaints.

These factors deserve treatment.

Treating the woman as a whole person can improve:

- health,
- quality of life,
- treatment readiness,
- sexual relationship,
- preconception wellbeing.

But the woman should simultaneously receive appropriate fertility counselling.

Time Is Particularly Important in DOR

This is where I am most cautious about prolonged empirical treatment.

If a 39-year-old woman has:

- AMH 0.3,
- infertility for four years,

I would not advise her to spend another twelve months simply trying to raise AMH through supplements or herbs before seeing a reproductive specialist.

Age continues progressing while she waits.

For some patients, the most appropriate integrative strategy is:

support general health while fertility treatment proceeds.

These approaches do not have to compete with one another.

“Special Treatment” by Dr. Nizamuddin Qasmi — What It Means

When I use the phrase **individualized or special fertility treatment**, I do not mean that every woman with low AMH receives one fixed formula.



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My focused clinical work in **Sexual Disorders & Infertility** begins by understanding why ovarian reserve is reduced and how urgently fertility needs to be addressed.

I ask:

How old is the patient?

Are periods regular?

What is the AMH?

What is the AFC?

What is the FSH?

Has she had ovarian surgery?

Is endometriosis present?

Has she received chemotherapy or radiotherapy?

How long has she been trying for pregnancy?

Are the fallopian tubes open?

Is ovulation occurring?

What does the male partner's semen analysis show?

Has IVF already been attempted?

These questions are much more important than simply asking:

“What medicine increases AMH?”

My Approach at Saira Health Care

At **Saira Health Care**, I approach DOR through several objectives.

First:

confirm that diminished reserve is actually present.

Then:

understand whether the woman is currently infertile.

Next:

identify additional fertility factors.

After that:



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estimate how much reproductive time is realistically available.

Then we can decide whether the most appropriate path involves:

- natural attempts for a limited period,
- ovulation management,
- IUI in selected couples,
- IVF/ICSI,
- egg or embryo freezing,
- specialist reproductive endocrinology referral.

Individualized Unani supportive care can be incorporated alongside this plan where medically appropriate.

Examples of Different DOR Patients

The same AMH does not mean the same treatment.

Patient One

Age 26.

AMH 0.8 ng/mL.

Regular cycles.

Not infertile.

No immediate plan for pregnancy.

She needs:

- proper counselling,
- reproductive-life planning,
- individualized discussion of fertility preservation.

She does not need to be told:

“You are infertile.”

Patient Two

Age 29.



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AMH 0.6.

Trying for six months.

Open tubes.

Normal semen analysis.

Regular ovulation.

Natural pregnancy may still occur.

Treatment urgency is different from an older patient.

Patient Three

Age 37.

AMH 0.6.

Three years of infertility.

Here time is much more important.

Prolonged empirical treatment is difficult to justify.

Early reproductive-medicine planning may be appropriate.

Patient Four

Age 32.

AMH 0.7.

Large bilateral endometriomas.

No children yet.

Before repeated ovarian surgery, the potential effect on ovarian reserve and possible fertility preservation deserve careful discussion.

Patient Five

Age 36.

AMH 0.4.

Husband has severe oligospermia.



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Her fertility problem cannot be treated as DOR alone.

The couple may need IVF/ICSI because of:

female ovarian reserve + male-factor infertility.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At **Saira Health Care**, our aim is to help patients move beyond fear created by isolated test results.

Women are often told:

“AMH is low, pregnancy is impossible.”

That is medically inaccurate.

Others are told:

“Take this medicine and AMH will definitely become normal.”

That is also not supported by current evidence.

Our approach is to explain:

- what ovarian reserve really means,
- what AMH can predict,
- what AMH cannot predict,
- how age changes the prognosis,
- when reproductive treatment should be accelerated,
- where supportive Unani medicine may be integrated responsibly.

This allows the patient to make rational decisions without either:

- unnecessary hopelessness,
- false reassurance.

DOR and Sexual Health

Infertility can also affect sexual wellbeing.

Couples may turn intercourse into:

“a fertility task.”



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This can produce:

- performance pressure,
- reduced desire,
- anxiety,
- relationship tension.

At Saira Health Care, I consider these sexual-health concerns separately from ovarian reserve.

A woman should not feel that her femininity or sexual identity is defined by her AMH result.

Diminished Ovarian Reserve Does Not Define Femininity

AMH does not measure:

- femininity,
- sexual attractiveness,
- ability to experience desire,
- ability to have orgasm,
- personal worth.

It is a reproductive biomarker.

That is all.

A laboratory number should not become an identity.

Frequently Asked Questions

What is diminished ovarian reserve?

Diminished ovarian reserve means that the ovaries contain a reduced remaining pool of recruitable follicles or are expected to produce fewer eggs during ovarian stimulation than women with greater reserve.

Is DOR a disease?

Not always.



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Age-related decline in ovarian reserve is normal biology.

DOR becomes clinically important when reserve appears lower than expected for age or influences:

- infertility,
- fertility treatment,
- fertility preservation.

What is the best test for ovarian reserve?

Current evidence supports:

AMH

and:

antral follicle count

as the most useful markers for predicting ovarian response.

Is AMH an egg-quality test?

No.

AMH primarily reflects egg quantity or follicle quantity.

Female age is much more informative regarding average egg quality.

Does low AMH mean my eggs are abnormal?

No.

Low AMH does not directly measure chromosome abnormalities.

Can I conceive naturally with low AMH?

Yes.

Low AMH does not automatically prevent natural conception.

Prospective studies have shown similar short-term cumulative natural pregnancy rates in some women with low versus normal AMH after accounting for other factors.

Can I conceive with AMH below 1?

Yes.

Pregnancy is possible.

Your overall chance depends more broadly upon:

- age,
 - tubes,
 - ovulation,
 - sperm,
 - duration of infertility,
 - other reproductive conditions.
-

Can I conceive with AMH below 0.5?

Yes, it remains possible.

However, ovarian response to IVF is more likely to be low, and fertility planning becomes particularly important.

Does very low AMH mean IVF should be refused?

No.

ASRM specifically advises that extremely low AMH can be used for realistic counselling but should **not be used to deny IVF treatment**.

Can low AMH become normal?

AMH can fluctuate.

Different assays and clinical circumstances can produce somewhat different results.

However, true age-related loss of ovarian follicles is not normally reversed simply because a later AMH measurement rises.

Treat the patient rather than chasing the laboratory number.

Should I repeat AMH every month?



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Usually no.

Repeated monthly testing rarely adds meaningful clinical value.

Testing should answer a clinical question.

Does normal FSH mean my ovarian reserve is normal?

Not necessarily.

AMH often declines before FSH rises.

What does high FSH mean?

High basal FSH can indicate more advanced diminished ovarian reserve.

However, FSH fluctuates between cycles and should not be interpreted alone.

What is AFC?

AFC means:

Antral Follicle Count.

Small developing follicles in both ovaries are counted using transvaginal ultrasound.

Is low AFC serious?

A low AFC predicts that fewer follicles may respond during ovarian stimulation.

Its significance still depends strongly upon:

- age,
 - clinical history,
 - previous treatment.
-

Does DOR mean early menopause?

Not necessarily.

DOR may indicate reduced reserve but does not reliably predict the exact age at which menopause will occur for an individual woman.

Is DOR the same as POI?

No.

POI involves loss of ovarian activity before age 40 and typically includes:

- irregular or absent cycles,
- elevated FSH.

DOR patients may continue to have completely regular cycles.

Can ovarian surgery lower AMH?

Yes.

This is particularly well documented after surgery involving ovarian endometriomas.

Can endometriosis reduce ovarian reserve?

Ovarian endometrioma has been associated with lower AMH, and surgery may further reduce reserve.

Can chemotherapy cause DOR?

Yes.

Some chemotherapy agents, particularly alkylating agents, can destroy ovarian follicles.

Can radiation cause DOR?

Yes.

Pelvic or ovarian radiation can damage follicles.

Can smoking lower ovarian reserve?

Evidence indicates cigarette smoking can accelerate follicular depletion and is associated with lower AMH and earlier menopause.

Can stress lower AMH?

Ordinary psychological stress has not been established as a major cause of irreversible ovarian follicle depletion.

Stress management remains important for general wellbeing.

Can diet restore ovarian reserve?

Healthy nutrition supports reproductive and pregnancy health.

However, no diet has been proven to reliably regenerate lost primordial follicles.

Does IVF increase ovarian ageing by “using up” all my eggs?

IVF stimulates a cohort of follicles that would largely have undergone natural atresia during that cycle.

Current fertility treatment is not generally considered to consume years of ovarian reserve in a single cycle.

Can high-dose injections overcome low reserve?

Only to a limited extent.

ESHRE recommends against gonadotropin doses above **300 IU/day** for predicted low responders because higher doses have not demonstrated meaningful additional benefit.

Does DHEA increase egg reserve?

Current ESHRE guidance does not recommend DHEA before or during IVF stimulation for low responders.

Does growth hormone improve IVF in DOR?

Evidence remains uncertain.

The updated ESHRE guideline states that growth hormone is probably not recommended routinely for low responders.

Does testosterone pretreatment help?

Current evidence is inconsistent, and ESHRE states that testosterone pretreatment is probably not recommended routinely for low responders.

Does CoQ10 help?

Some randomized studies and a 2024 meta-analysis reported improvements in selected IVF outcomes among women with DOR.

However, trial quality and methodology remain limited, and larger studies are needed.

It should not be described as proven ovarian regeneration.

Does ovarian PRP restore egg reserve?

PRP remains experimental.

Research is promising but is dominated by observational studies, and high-quality randomized evidence is still insufficient.

Can stem cells make new eggs?

This remains a research area.

Stem-cell and ovarian-regeneration strategies are not established routine fertility treatments for DOR.

Should I freeze my eggs if AMH is low?

Possibly, depending upon:

- age,
- reproductive plans,
- AFC,
- expected egg yield.

But AMH alone should not determine the decision.

Younger age at freezing is an important advantage.

Can IUI work with DOR?

Yes, in selected women.

Low ovarian reserve alone does not eliminate IUI pregnancy potential.

Treatment choice should account for:

- age,
- tubal status,
- sperm,
- duration of infertility.

Is IVF better than IUI for every woman with low AMH?

No.

Treatment should be individualized.

An older woman with prolonged infertility may benefit from moving to IVF more quickly.

A younger woman with shorter-duration infertility and otherwise favourable factors may have other reasonable options.

Can Unani medicine increase AMH?

There is currently insufficient high-quality evidence showing that Unani medicines reliably increase the true ovarian follicle pool or reverse established DOR.

An AMH increase alone would also not prove that new eggs were created.

Is Unani medicine useful for DOR?

It can have a **supportive integrative role** in appropriately selected patients by addressing:

- nutrition,
- digestion,
- metabolic health,
- sleep,
- menstrual wellbeing,
- stress,



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- general reproductive and sexual health.

But it should not replace time-sensitive fertility treatment when ovarian reserve is significantly reduced.

Can Unani treatment improve ovulation?

Some traditional treatments have been studied for ovulatory infertility.

However, ovulation treatment and diminished ovarian reserve treatment are not the same thing.

A woman may ovulate normally while still having low ovarian reserve.

Does Shatavari increase ovarian reserve?

A small trial investigated *Asparagus racemosus* in **anovulatory infertility**, not established DOR, and women with ovarian failure were excluded. It therefore does not prove restoration of ovarian reserve.

Should I spend six months trying medicines to raise AMH before IVF?

This depends very heavily upon age and reproductive history.

In an older woman with long-standing infertility and very low reserve, prolonged delay solely to raise an AMH number may reduce valuable reproductive time.

Treatment should target:

pregnancy potential,

not simply:

the AMH report.

A Message From Dr. Nizamuddin Qasmi

When a woman sits in front of me and says:

“Doctor, my AMH is only 0.5. Have I lost my chance to become a mother?”

I do not answer by looking only at the AMH report.

I ask:



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How old are you?

Because age matters enormously.

Then:

Are your periods regular?

How many antral follicles are present?

What is your FSH?

How long have you been trying?

Have you had ovarian surgery?

Do you have endometriosis?

Are your fallopian tubes open?

What does your husband's semen analysis show?

That is how low AMH becomes clinically meaningful.

What I Tell My Younger Patients

If a 27-year-old woman has low AMH, I do not want her to believe that her fertility has ended.

Her young age can still be an important reproductive advantage.

But I also do not want her to ignore the finding completely.

If she wishes to delay motherhood for many years, fertility-preservation counselling may be sensible.

The goal is:

informed planning, not fear.

What I Tell My Older Patients

For a woman in her late thirties or early forties with significant DOR, I focus strongly on time.

I explain:

“AMH is important, but age is even more important.”



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Waiting a year for a supplement to raise the laboratory AMH number may not improve egg quality.

Meanwhile, another year of reproductive ageing has passed.

Therefore, supportive treatment and evidence-based fertility treatment can often proceed **together**.

What I Tell Patients About “Increasing AMH”

I explain:

AMH is a marker—not the disease itself.

Our purpose should not simply be:

“Make AMH go from 0.5 to 1.2.”

The meaningful questions are:

- Can we obtain usable eggs?
- Can fertilization occur?
- Can an embryo develop?
- Can pregnancy occur?
- Can we achieve a healthy live birth?

Those outcomes matter more than the laboratory number.

My Integrative Clinical Philosophy

My approach is:

Measure accurately → interpret with age → identify the cause → assess the whole couple → avoid unnecessary delay → optimize general reproductive health → use fertility technology when clinically appropriate.

Unani medicine can fit responsibly within this pathway.

It should not compete against:

- reproductive endocrinology,
- IVF,
- fertility preservation.



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It should complement the patient's broader reproductive care where suitable.

Latest Medical Understanding — 2026 Update

Several points are particularly important from the most recent evidence.

1. AMH and AFC predict ovarian response—not pregnancy

The **2025 ESHRE guideline** strongly recommends AMH or AFC for predicting low or high ovarian response.

It specifically does **not** recommend them as standalone predictors of pregnancy or live birth.

2. Age remains more important for pregnancy prognosis

Age has a major effect on:

- egg chromosomal competence,
- embryo quality,
- miscarriage,
- live birth.

Low AMH and young age are therefore different from low AMH and advanced reproductive age.

3. Low AMH does not mean no natural pregnancy

Ovarian-reserve biomarkers perform poorly as tests of short-term natural fecundity.

Women with low AMH can still conceive naturally.

4. DOR is different from POI

POI requires evidence of actual ovarian dysfunction before age 40, typically including persistent irregular or absent periods and elevated FSH.

DOR may occur while cycles remain normal.

5. Extremely low AMH should not be used to refuse IVF



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A very low value predicts fewer eggs and higher cancellation risk but does not equal zero chance of treatment success.

6. Giving ever-higher stimulation doses is not the answer

ESHRE recommends against gonadotropin doses above **300 IU/day** in predicted low responders.

7. Popular IVF add-ons remain poorly supported

Current ESHRE guidance does not recommend routine:

- DHEA,
- aspirin,
- sildenafil,

for low responders and is cautious against routine:

- testosterone,
 - growth hormone.
-

8. CoQ10 remains promising but unproven

Randomized evidence suggests potential benefit in selected DOR patients, but stronger trials are needed before firm conclusions about live-birth improvement can be made.

9. “Ovarian rejuvenation” is still experimental

PRP, stem cells and other regenerative approaches remain areas of active research.

Current evidence does not justify guaranteed claims that these techniques rebuild the ovarian follicular pool.

10. Global fertility care is increasingly emphasizing timely evidence-based treatment

The **2025 WHO infertility guideline** warns against patients being pushed toward expensive or unproven fertility interventions and emphasizes accessible, evidence-based, person-centred infertility care.

This is particularly relevant in DOR because unnecessary delay can itself become important.

Conclusion

Diminished Ovarian Reserve is a reduction in the remaining ovarian follicle pool or expected ovarian response relative to reproductive age.

It is commonly identified through:

- low AMH,
- low antral follicle count,
- elevated FSH in some women,
- poor response during ovarian stimulation.

But DOR must be understood correctly.

Low AMH does not mean no eggs.

Low AMH does not directly mean poor egg quality.

Low AMH does not automatically mean infertility.

Low AMH does not automatically mean premature ovarian failure.

Current evidence shows that **AMH and AFC are most useful for predicting how strongly the ovaries will respond to IVF stimulation and approximately how many eggs may be obtained.**

They are much less useful for predicting:

- natural conception,
- embryo quality,
- pregnancy,
- live birth.

Female age remains one of the most important predictors of reproductive success.

DOR should also be distinguished from:

Premature Ovarian Insufficiency

in which ovarian function is disrupted before age 40 and women commonly develop persistent:



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- irregular menstruation,
- amenorrhea,
- elevated FSH.

Possible causes of reduced ovarian reserve include:

- natural reproductive ageing,
- genetic predisposition,
- ovarian surgery,
- endometriosis/endometrioma,
- chemotherapy,
- pelvic radiotherapy,
- smoking,
- unexplained or idiopathic causes.

Treatment must therefore be individualized.

Some women can continue attempting natural conception.

Some may be suitable for IUI.

Others should move more quickly toward:

- IVF,
- ICSI,
- egg freezing,
- embryo preservation.

Extremely low AMH should be used for realistic counselling—not to deny treatment.

At the same time, patients should be cautious about treatments marketed as guaranteed ways to “increase eggs.”

The **2025 ESHRE guideline** does not recommend DHEA for low responders and remains cautious about testosterone and growth hormone. Extremely high gonadotropin doses also do not solve the limited number of follicles available for recruitment.

Newer approaches such as:

- ovarian PRP,
- stem-cell therapy,



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- ovarian activation

remain experimental.

From the **Unani perspective**, reproductive health can be approached through a whole-person framework involving:

- Mizaj,
- nutrition,
- digestion,
- menstrual wellbeing,
- metabolic health,
- sleep,
- physical activity,
- psychological wellbeing,
- sexual health.

These are meaningful areas for individualized supportive care.

However:

there is currently insufficient evidence that Unani medicine can regenerate a depleted primordial follicle pool or reliably reverse established DOR.

Therefore, at **Saira Health Care**, my approach is integrative but firmly evidence-based:

confirm the ovarian-reserve finding, interpret AMH and AFC according to age, distinguish DOR from POI, identify reversible or treatment-related contributors, evaluate the complete fertility status of both partners, avoid unnecessary reproductive delay, use fertility-preservation or assisted-reproductive technology when appropriate, and integrate individualized Unani supportive care for the woman's broader reproductive, metabolic, nutritional and sexual wellbeing.

My most important message to women with low AMH is:

Do not allow one AMH result to decide your entire reproductive future.

AMH tells us something very useful about:

egg quantity and expected ovarian response.

It does not tell us everything about:

egg quality, natural conception or motherhood.



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But because ovarian reserve continues to decline with time, the result should also not be ignored.

The correct response is neither panic nor false reassurance.

It is:

informed, timely and individualized fertility planning.

About the Author

Dr. Nizamuddin Qasmi

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

Qualifications & Professional Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health (ISRH) — UNFPA

Dr. Nizamuddin Qasmi is a well-qualified physician whose clinical work at **Saira Health Care** has a focused emphasis on sexual disorders, male and female reproductive health and infertility.

His approach to diminished ovarian reserve emphasizes that AMH should never be interpreted alone.

Depending upon the patient, evaluation may include:

- detailed menstrual and reproductive history,
- AMH,
- antral follicle count,
- appropriate hormonal assessment,
- ovarian ultrasound,
- evaluation for endometriosis or previous ovarian surgery,
- fallopian-tube assessment,



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- ovulation evaluation,
- male-partner semen analysis,
- review of previous fertility-treatment response,
- timely coordination with IVF/reproductive-medicine specialists when indicated.

Where clinically appropriate, individualized principles of Unani medicine may be incorporated to support general reproductive, nutritional, metabolic, menstrual and sexual wellbeing without delaying time-sensitive evidence-based fertility treatment.

Medical Disclaimer

This article is intended for health education and general public awareness. It does not establish an individual diagnosis and does not replace consultation with an appropriately qualified gynecologist, reproductive endocrinologist, infertility specialist or other healthcare professional.

AMH and AFC are primarily ovarian-reserve and ovarian-response markers. They should not be used alone to declare a woman fertile or infertile.

A low AMH result does not automatically indicate poor egg quality, premature ovarian insufficiency or inability to conceive naturally.

Women under 40 who develop persistent irregular or absent periods—particularly with elevated FSH or estrogen-deficiency symptoms—should be appropriately evaluated for premature ovarian insufficiency.

Patients should not delay time-sensitive fertility assessment while repeatedly attempting to increase AMH through unproven supplements, hormonal add-ons, herbal preparations, PRP or “ovarian rejuvenation” procedures.

DHEA, testosterone, growth hormone and other IVF add-ons should only be used when medically justified by an appropriately qualified fertility specialist; several are not recommended routinely by current international guidelines.

Ovarian PRP, stem-cell therapy and related regenerative treatments remain experimental or incompletely established and should not be represented as guaranteed methods of creating new eggs.

Any Unani, herbal or nutritional treatment should be individualized and coordinated with conventional fertility care, especially when IVF, pregnancy, ovarian surgery or other prescription treatment is planned.