

Congenital Absence of the Vas Deferens

Understanding CBAVD, CUAVD, Obstructive Azoospermia, CFTR Mutations, Cystic Fibrosis, Sperm Retrieval, ICSI and an Integrative Unani Approach

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When a man comes to me with a semen report showing **azoospermia—no sperm detected in the ejaculate—the first important question is not simply, “How can we increase the sperm count?”**

The much more useful question is:

“Are sperm not being produced, or are sperm being produced but unable to reach the semen?”

These are completely different conditions.

In some men the testes are capable of producing sperm normally, but the tubes that should carry sperm from the testes toward the urethra never developed properly before birth.

One of the most important examples is:

Congenital Absence of the Vas Deferens

The **vas deferens** is the muscular tube that transports sperm from the epididymis toward the ejaculatory ducts.

If both vas deferens are absent from birth, the condition is called:

Congenital Bilateral Absence of the Vas Deferens — CBAVD.

If only one is absent, the condition is called:

Congenital Unilateral Absence of the Vas Deferens — CUAVD.

CBAVD is an important cause of **obstructive azoospermia**. The testicles often continue to produce sperm, but there is no normal pathway for those sperm to enter the ejaculate. Current EAU guidance estimates CBAVD in about **1% of infertile men and up to approximately 6% of men with obstructive azoospermia**.

This distinction completely changes fertility counselling.

A man with severe primary testicular failure and azoospermia may have difficulty producing sperm.



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A man with CBAVD may have sperm production that is relatively well preserved, but the sperm are trapped behind an anatomical obstruction.

That is why many affected men can potentially achieve biological fatherhood through **surgical sperm retrieval followed by IVF with ICSI.**

My message to patients is therefore:

Congenital absence of the vas deferens can prevent sperm from appearing in semen, but it does not necessarily mean that the testes have stopped producing sperm.

What Is the Vas Deferens?

The male reproductive tract works through a series of connected structures.

Sperm are produced inside the testes.

They then enter the epididymis, where they undergo further maturation.

From there, sperm normally travel through the **vas deferens.**

The vas deferens ultimately joins structures associated with the seminal vesicles and ejaculatory ducts before semen enters the urethra.

The vas is therefore essentially a **transport tube for sperm.**

If it never develops, sperm may remain inside the epididymal and testicular system even though ejaculation otherwise appears normal.

What Does “Congenital” Mean?

Congenital means:

present from birth.

A man with CBAVD did not lose the vas deferens because of sexual activity, infection during marriage, masturbation or ageing.

The reproductive ducts failed to develop normally during fetal life.

Modern embryology shows that the vas deferens, epididymis, seminal vesicles and parts of the urinary system arise from closely related developmental structures, particularly the **Wolffian or mesonephric duct.** This explains why congenital absence of the vas may sometimes occur together with abnormalities of the kidney or seminal vesicles. The AUA/ASRM guideline recommends renal ultrasonography in men with vasal agenesis for precisely this reason.

Bilateral Versus Unilateral Absence

This distinction is extremely important.

Congenital Bilateral Absence of the Vas Deferens — CBAVD

Both vas deferens are absent.

Sperm therefore cannot normally pass from either testicle into the ejaculate.

The usual semen finding is:

obstructive azoospermia.

Congenital Unilateral Absence of the Vas Deferens — CUAVD

Only one vas deferens is absent.

The opposite side may remain anatomically normal.

Some men with unilateral absence therefore retain natural fertility because sperm can travel through the normal vas on the opposite side.

However, CUAVD is important because it is much more strongly associated with abnormalities of the kidney on the same side.

Current AUA/ASRM guidance reports renal abnormalities in approximately **26–75% of men with unilateral vasal absence**, while renal anomalies occur less frequently—around 10%—in bilateral vasal agenesis.

Why Are Kidney Abnormalities Associated With an Absent Vas Deferens?

During embryonic development, the urinary and male reproductive systems develop in close relationship.

If part of the Wolffian duct does not develop properly, abnormalities can affect both: the reproductive tract and the urinary tract.

A man with unilateral absence of the vas may therefore also have:

- absence of the kidney on the same side,
- ectopic kidney,
- other developmental urinary abnormalities.



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The EAU specifically notes that CUAVD is frequently associated with **ipsilateral renal agenesis** and probably has a somewhat different developmental mechanism from typical CFTR-associated CBAVD.

Should the Kidneys Be Checked?

Yes.

There is a small difference between international guideline approaches.

The EAU particularly recommends abdominal ultrasound in vasal absence when **CFTR mutations are not identified**, because renal developmental abnormalities become more relevant in that setting.

The **2024 AUA/ASRM male-infertility guideline takes the broader approach**, recommending **renal ultrasonography for patients with vasal agenesis regardless of CFTR status** because renal anomalies can occasionally occur even in CFTR-associated cases.

In practical clinical care, renal ultrasound is a simple and useful investigation in a man found to have congenital absence of one or both vasa.

Why Is CBAVD Strongly Connected With Cystic Fibrosis?

This is one of the most important medical aspects of the condition.

The gene most strongly associated with CBAVD is:

CFTR

CFTR stands for Cystic Fibrosis Transmembrane Conductance Regulator.

The CFTR gene is located on chromosome 7 and produces a protein involved in chloride and bicarbonate transport across cell membranes.

Severe abnormalities involving both copies of CFTR can cause **cystic fibrosis**, a multisystem genetic disease affecting organs such as the lungs, pancreas and reproductive tract.

Milder combinations of CFTR variants may produce a much more limited condition in which a man is otherwise healthy but is born without both vas deferens.

This is often described as a **CFTR-related disorder**.



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Current EAU guidance emphasizes the strong association between CFTR abnormalities and CBAVD and recommends CFTR analysis when structural absence of the vas deferens is identified.

Does a Man With CBAVD Automatically Have Cystic Fibrosis?

No.

This is an important distinction.

A man may have CBAVD without having the classic lung and digestive manifestations of cystic fibrosis.

Some men have:

- no respiratory symptoms,
- normal daily life,
- no known pancreatic disease,

and discover a CFTR-related disorder only because infertility investigation shows that their vas deferens are absent.

Modern literature therefore considers isolated CBAVD one end of a broad **CFTR-related clinical spectrum**.

However, some men may report milder CF-associated features such as recurrent respiratory infections.

A complete medical history remains important.

How Strong Is the CFTR Association?

The association is substantial, although the exact frequency depends upon:

- ethnicity,
- genetic-testing method,
- which CFTR variants are included.

A major meta-analysis found at least one detectable CFTR mutation in approximately **78%** of men with CBAVD, although the distribution of individual variants differed considerably among ethnic groups.



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A review has similarly estimated that around **60–70% or more** of CBAVD cases carry detectable pathogenic or clinically relevant CFTR variants, depending on testing methodology.

Therefore, CFTR testing is not optional trivia in CBAVD.

It can directly affect reproductive genetic counselling.

CFTR Abnormalities in Indian Men With CBAVD

The CFTR mutation spectrum in Indian patients differs from that in European populations.

This matters because a limited genetic panel designed mainly around common European variants may miss abnormalities relevant to Indian patients.

An Indian study of **80 men with CBAVD** identified CFTR variants in 53 patients and found a heterogeneous range of variants. The study also identified CFTR carrier status in a notable proportion of female partners, reinforcing the importance of genetic counselling before ICSI.

Earlier Indian research also demonstrated CFTR abnormalities in men with CBAVD and renal anomalies, although the genetics of this subgroup remain more complex.

For Indian couples, therefore, testing strategy should ideally be selected by a genetics or fertility service familiar with the local mutation spectrum.

What Is the 5T Variant?

A particularly important CFTR variant in CBAVD involves the poly-T region historically called the:

5T allele.

It can reduce normal CFTR messenger-RNA processing and thereby reduce functional CFTR protein.

Its clinical effect depends partly upon nearby TG-repeat sequences.

The 5T variant is particularly enriched among men with CBAVD and has considerably greater clinical significance in this setting than an ordinary harmless polymorphism. Current EAU guidance recommends that the 5T allele be assessed in men with CBAVD.

This illustrates why comprehensive CFTR analysis may be more useful than testing only for one famous mutation such as F508del.



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What About F508del?

The **F508del** variant is one of the best-known CFTR pathogenic variants.

It is common among people with classical cystic fibrosis in many European populations.

However, CFTR variation differs substantially by ethnicity.

Indian and other Asian populations may show a different spectrum, and F508del alone is therefore not an adequate test for CBAVD.

The goal is not:

“Is F508del present?”

The better question is:

“Does this patient have a clinically important CFTR genotype relevant to CBAVD and reproductive risk?”

Other Genetic Causes of CBAVD

Not every man with CBAVD has an identifiable CFTR cause.

Research has identified other candidate genes.

An important example is:

ADGRG2

Pathogenic variants in **ADGRG2**, an X-linked gene, can cause congenital bilateral absence of the vas deferens in some CFTR-negative men.

A 2026 report and literature review described successful fertility treatment in a man with an ADGRG2 pathogenic variant and emphasized considering ADGRG2 particularly when:

- CFTR testing is negative,
- renal ultrasound is normal.

Other genes, including **SLC9A3**, have also been investigated in CBAVD, although their clinical contribution is less established than CFTR.

This is a rapidly developing area of reproductive genetics.



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Why Does Genetic Diagnosis Matter if Sperm Can Simply Be Retrieved?

This is an extremely important question.

One might think:

“The man has sperm in his testes. Just retrieve sperm and perform ICSI.”

But the genetic diagnosis matters because ICSI bypasses natural reproductive barriers.

It can allow the man's genetic material to be transmitted to the child.

If both partners carry clinically important CFTR variants, the couple may have a significant risk of having a child with:

- cystic fibrosis,
- another CFTR-related disorder,
- or CBAVD in a son.

Therefore, genetic counselling should ideally occur **before IVF/ICSI**, not after pregnancy has already occurred.

The Female Partner Should Be Tested

Current AUA/ASRM guidance recommends CFTR carrier testing in men with vasal agenesis and states that when a CFTR mutation is found in the male partner, **genetic evaluation of the female partner should also be recommended**.

Current EAU guidance similarly recommends testing the partner when CBAVD is diagnosed.

This is one of the most important practical messages for couples considering ICSI.

What Is the Risk to the Child?

The answer depends on the exact genetic findings.

Cystic fibrosis is generally an **autosomal-recessive** disorder.

This means a child usually needs to inherit a disease-causing CFTR variant from **both parents** to develop classical cystic fibrosis.

If both parents are carriers of one clinically significant CFTR mutation, each pregnancy classically has:

- 25% chance of inheriting both variants,



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- 50% chance of being a carrier,
- 25% chance of inheriting neither.

However, men with CBAVD may carry **two CFTR variants**, often a more severe variant plus a milder one such as a 5T-related allele.

If the male carries abnormalities in both CFTR copies and his female partner is a carrier, the reproductive risk profile differs and can be higher. AUA/ASRM guidance notes that the affected-child risk can be up to approximately 50% in particular parental-genotype combinations.

This is precisely why individualized **genetic counselling** is necessary rather than quoting one universal percentage.

What If the Female Partner's CFTR Test Is Negative?

That substantially lowers the risk of classical cystic fibrosis in the child.

However, no genetic test detects every possible CFTR abnormality with 100% certainty.

The EAU notes that when the female partner is negative for known variants, a small residual carrier risk from unidentified mutations remains.

The couple should therefore be counselled according to:

- the male genotype,
- the female test used,
- ancestry,
- laboratory coverage.

Can Preimplantation Genetic Testing Be Used?

For couples with an identified clinically significant genetic risk, IVF embryos may sometimes be evaluated using **preimplantation genetic testing for monogenic disease—PGT-M**.

This requires specialist reproductive genetics.

The decision depends upon:

- the exact CFTR variants,
- their known clinical consequences,



- reproductive preferences,
- local regulations.

Prenatal genetic diagnosis may also be discussed.

These decisions should be made with a clinical geneticist or genetic counsellor rather than based solely on a male infertility consultation.

How Does CBAVD Cause Azoospermia?

The mechanism is primarily obstruction.

Sperm are produced in the testicle.

They enter the epididymis.

But when the vas deferens is absent, there is no complete pathway for sperm to enter the seminal fluid.

The semen may therefore contain:

no sperm

despite ongoing sperm production.

This is called:

Obstructive Azoospermia

It is biologically very different from **non-obstructive azoospermia**, in which the testes themselves are failing to make sufficient sperm.

Obstructive Versus Non-Obstructive Azoospermia

This is one of the most important distinctions in male infertility.

Obstructive azoospermia

Sperm production is relatively preserved.

The pathway is blocked or absent.

Examples include:

- CBAVD,
- vasectomy,
- epididymal obstruction,



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- ejaculatory-duct obstruction.

Non-obstructive azoospermia

Sperm production inside the testes is severely impaired.

Examples include:

- Klinefelter syndrome,
- complete AZFa deletion,
- severe primary testicular failure,
- some cryptorchidism-related conditions.

Treatment and prognosis differ fundamentally.

What Does Semen Analysis Look Like in CBAVD?

Several features can provide clues.

Typical findings may include:

- azoospermia,
- low semen volume,
- acidic semen,
- low or absent seminal fructose.

Current EAU guidance advises clinicians to consider CBAVD particularly when an azoospermic man has **semen volume below about 1 mL and an acidic pH below 7.0**.

These findings occur because the seminal vesicles and ejaculatory ducts may also be absent, small or abnormal.

Why Is Semen Volume Low?

Most semen volume does not come from the testes.

Large amounts are contributed by:

- seminal vesicles,
- prostate.

In CBAVD, the embryological abnormality often also affects seminal-vesicle development.



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If the seminal vesicles are absent or hypoplastic, total semen volume falls.

This explains how a man can:

- have normal erections,
- experience orgasm,
- ejaculate visible fluid,

but still produce a relatively small volume containing no sperm.

Does CBAVD Cause “Dry Ejaculation”?

Usually not completely.

A man may still ejaculate prostatic fluid and other secretions.

Therefore, CBAVD is different from:

- complete anejaculation,
- classic dry orgasm after prostate removal.

The ejaculate is simply missing normal sperm transport and often has reduced seminal-vesicle contribution.

Does the Man Feel Anything Different During Sex?

Usually not.

Most men with isolated CBAVD have:

- normal sexual desire,
- normal erections,
- normal orgasm,
- apparently normal ejaculation.

Many discover the condition only after infertility investigation.

This is why absence of the vas deferens is easy to miss.

A man may have lived his entire adult life without any symptom except inability to achieve pregnancy.

Does CBAVD Cause Low Testosterone?



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Usually not by itself.

The testes are present and often have relatively normal endocrine function.

Therefore:

- testosterone may be normal,
- FSH may be normal,
- LH may be normal.

EAU guidance notes that hormone levels are generally normal in obstructive azoospermia, although overlapping testicular disorders can occasionally coexist.

This is another important clue distinguishing obstruction from severe primary testicular failure.

Testicular Size in CBAVD

Testes are often normal or near-normal in size because sperm production is preserved.

This contrasts with many non-obstructive conditions where testicular volume may be significantly reduced.

A typical clinical pattern may therefore be:

azoospermia + relatively normal testes + normal FSH + absent vas deferens

which strongly supports obstructive infertility.

Can Sperm Production Also Be Abnormal?

Usually sperm production is sufficiently preserved for fertility treatment.

However, newer research suggests that CFTR dysfunction may sometimes influence sperm function and testicular physiology beyond simply causing obstruction.

A 2026 review notes emerging evidence that CFTR is expressed not only in reproductive ducts but also in Sertoli cells, germ cells and mature sperm, raising the possibility of additional reproductive effects in some men with cystic fibrosis.

Nevertheless, the **classic infertility mechanism in CBAVD remains obstruction**, and sperm retrieval is frequently successful.

CBAVD in Men With Classical Cystic Fibrosis



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Almost all men with classical cystic fibrosis have obstruction or congenital absence affecting the vas deferens.

Historical estimates place the figure around **97–98%**.

However, fertility treatment in men with systemic cystic fibrosis can differ somewhat from treatment in otherwise healthy men who have isolated CBAVD.

A comparative study found:

- lower retrieved sperm quality,
- more difficult retrieval,
- poorer fertilization outcomes

among men with classical cystic fibrosis compared with men who had CBAVD alone.

The patient's overall CF health therefore also matters.

How Is Congenital Absence of the Vas Diagnosed?

Diagnosis begins with a careful reproductive examination.

The vas deferens can normally be felt as a firm cord-like structure within the spermatic cord.

In CBAVD, it cannot be palpated on either side.

In CUAVD, it is absent on one side.

Current EAU guidance emphasizes that clinical diagnosis can be missed unless clinicians deliberately examine the vas deferens in azoospermic men.

This simple examination can completely redirect the infertility evaluation.

Why Physical Examination Is So Important

Consider two patients whose semen reports both show zero sperm.

Patient A

Has very small testes and FSH of 30.

Patient B

Has normal-sized testes, FSH of 5, low semen volume and no palpable vas deferens.

Both have azoospermia.



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But their fertility biology is completely different.

Patient A may have severe sperm-production failure.

Patient B may have normal sperm production with absent sperm transport.

Therefore, a semen report should never be interpreted without examining the patient.

Hormonal Evaluation

In an azoospermic man I generally consider:

- FSH,
- LH,
- testosterone.

The hormone pattern can help distinguish obstructive from non-obstructive causes.

In classic CBAVD:

FSH is generally normal because spermatogenesis is relatively preserved.

However, a normal hormone result does not diagnose CBAVD.

Physical examination and reproductive anatomy are crucial.

Renal Ultrasound

Because vasal abnormalities can coexist with kidney malformations, renal ultrasonography forms an important part of the evaluation.

Particularly important findings include:

- unilateral renal agenesis,
- ectopic kidney,
- other developmental urinary abnormalities.

The AUA/ASRM currently recommends renal ultrasonography for **all men with vasal agenesis**, while EAU guidance particularly emphasizes imaging where CFTR mutations are not found.

Is Scrotal Ultrasound Necessary?

Not always for diagnosis of CBAVD itself.



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Physical examination usually determines whether the vas is present.

Scrotal ultrasound can be helpful when:

- examination is difficult,
- there is another testicular concern,
- a testicular lesion is suspected,
- epididymal anatomy needs further assessment.

Testing should answer a clinical question rather than simply be performed as part of a standard package.

What About Transrectal Ultrasound — TRUS?

TRUS can examine:

- seminal vesicles,
- prostate,
- ejaculatory ducts.

It may show absent or hypoplastic seminal vesicles in CBAVD.

However, once CBAVD is clearly established clinically, routine TRUS usually does not change treatment.

AUA/ASRM guidance specifically states that TRUS does not generally add diagnostic or treatment value in established CBAVD.

TRUS is more useful when **ejaculatory-duct obstruction** is suspected rather than congenital absence of the vasa.

CFTR Genetic Testing

This is a core part of the work-up.

Current EAU guidance states that in **any patient with unilateral or bilateral absence of the vas deferens or seminal-vesicle agenesis, CFTR testing should be performed.**

AUA/ASRM similarly recommends CFTR mutation carrier testing, including assessment of the 5T allele, in men with:

- vasal agenesis,
- idiopathic obstructive azoospermia.



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This is not simply to explain infertility.

It is primarily important for **reproductive genetic safety**.

Does the Man Need Y-Chromosome Testing?

Not simply because he has classic CBAVD.

Y-chromosome microdeletions are primarily associated with failure of sperm production.

CBAVD is usually an obstructive disorder.

If the patient's:

- testicular size,
- FSH,
- semen profile

suggest an additional non-obstructive component, genetic testing may be expanded.

But typical CBAVD does not automatically require every genetic test used for non-obstructive azoospermia.

Does the Man Need a Karyotype?

Again, not simply because the vas deferens are absent.

Karyotyping is more relevant when there is evidence of severe impaired spermatogenesis, very low sperm production or another chromosome-related clinical pattern.

The genetic test most specifically linked to CBAVD is **CFTR analysis**.

Can the Vas Deferens Be Surgically Created?

No practical operation can simply manufacture a normal missing vas deferens.

This distinguishes CBAVD from an acquired blockage where the existing vas may sometimes be surgically reconnected.

If the vas never developed, reconstructive surgery is generally not the main fertility treatment.

Instead, modern fertility care **bypasses the absent vas**.



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We retrieve sperm directly from:

- epididymis,
- testis,

and use those sperm for ICSI.

Why Natural Pregnancy Is Usually Not Possible in CBAVD

Natural conception requires sperm to enter the semen and be deposited within the female reproductive tract.

In bilateral vasal absence, there is no complete sperm-transport pathway.

Even if millions of sperm are being produced inside the testes, they cannot normally enter the ejaculate.

Therefore, natural pregnancy with complete CBAVD is generally not possible without assisted reproduction.

This is different from ordinary oligospermia, where some sperm still reach the semen.

Surgical Sperm Retrieval

The fact that the vasa are absent does not mean sperm must be absent from the testis or epididymis.

Several procedures may be used.

PESA

Percutaneous Epididymal Sperm Aspiration

A needle is used to obtain sperm from the epididymis.

MESA

Microsurgical Epididymal Sperm Aspiration

The epididymis is exposed surgically and sperm-rich fluid is collected under magnification.

TESA

Testicular Sperm Aspiration

A needle is used to retrieve testicular tissue/sperm.



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TESE

Testicular Sperm Extraction

A small amount of testicular tissue is surgically removed and processed for sperm.

Current EAU guidance recognizes MESA, PESA, TESA and TESE as fertility options for men with CBAVD.

Is Micro-TESE Necessary?

Usually not.

This is another important distinction between obstructive and non-obstructive azoospermia.

Micro-TESE is particularly designed to search for rare sperm-producing areas when sperm production itself is severely impaired.

In classic CBAVD, sperm production is usually preserved.

Therefore, simpler sperm-retrieval procedures are commonly sufficient.

Using micro-TESE routinely would often represent unnecessary surgery.

Epididymal or Testicular Sperm?

Either can potentially be used successfully.

EAU guidance states that pregnancy outcomes in obstructive azoospermia appear broadly comparable between epididymal and testicular sperm and between fresh and appropriately frozen-thawed epididymal sperm, although available studies have limitations.

The specific approach depends upon:

- anatomy,
 - surgeon experience,
 - previous procedures,
 - laboratory arrangements,
 - IVF timing.
-

Why MESA Can Be Particularly Useful



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With microsurgical epididymal sperm aspiration, a substantial quantity of sperm can sometimes be retrieved.

These sperm can often be cryopreserved in multiple portions.

That may provide enough material for more than one future ICSI attempt without repeating surgery each time.

Current EAU guidance notes that one MESA procedure can often provide material for multiple ICSI cycles.

What Is ICSI?

ICSI means:

Intracytoplasmic Sperm Injection.

During conventional natural conception, sperm must:

- reach the egg,
- attach to it,
- penetrate its outer layers,
- fertilize it.

With ICSI, an embryologist selects one sperm and injects it directly into a mature egg.

This dramatically reduces the number of sperm required.

For men with CBAVD, this means sperm retrieved from the epididymis or testis can potentially be used even though none are present in the ejaculate.

Why IVF Is Required

ICSI is performed as part of an **IVF cycle**.

The female partner undergoes:

- ovarian stimulation,
- monitoring,
- egg retrieval.

The retrieved sperm are then injected into the eggs.

Embryos that develop appropriately may be transferred to the uterus.



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Therefore, treatment of CBAVD infertility involves the couple, not only the man.

Does Sperm Retrieval Guarantee Pregnancy?

No.

This distinction is very important.

Sperm retrieval may be straightforward in obstructive azoospermia.

But successful live birth still depends upon:

- egg quality,
- female age,
- ovarian reserve,
- embryo development,
- uterine health,
- genetic factors.

Therefore, finding sperm is an important success, but it is only one stage of the reproductive process.

Female Age Matters

Suppose a man with CBAVD has excellent retrieved sperm.

If his wife is 27 with good ovarian reserve, the reproductive outlook may be very different from that of a couple where the female partner is 42 with markedly reduced ovarian reserve.

This is why current infertility care is **couple-centred**.

The 2025 WHO infertility guideline emphasizes evidence-based evaluation of both partners and progressive treatment according to biological findings and patient preferences.

Can Retrieved Sperm Be Frozen?

Yes.

Cryopreservation can be extremely useful.



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If adequate epididymal or testicular sperm are retrieved, they can often be frozen for future ICSI.

This can reduce the need for repeated surgical procedures.

Fresh versus frozen sperm decisions should be coordinated between the reproductive urologist and embryology laboratory.

Does CBAVD Affect Sperm DNA?

The primary defect is obstruction.

However, research continues to evaluate whether particular CFTR genotypes may influence sperm function in addition to reproductive-duct development.

A recent 2026 review notes emerging evidence that CFTR dysfunction may influence sperm maturation and spermatogenesis in some men, although classic CBAVD infertility remains primarily obstructive.

This should not be interpreted to mean that every CBAVD patient has abnormal sperm genetics.

Is Sperm DNA Fragmentation Testing Required?

Usually not as a routine first test simply because CBAVD exists.

The core investigations are:

- diagnosis of obstruction,
- CFTR genetics,
- partner testing,
- fertility planning.

Sperm DNA fragmentation testing may be considered in selected reproductive situations, but it should not distract from the fundamental genetic counselling required in CBAVD.

Can a Man With Unilateral Absence Conceive Naturally?

Yes, potentially.

If the opposite testis, epididymis and vas deferens are normal, sperm can travel through that side.

However, unilateral vasal absence should still trigger careful evaluation because it can be associated with:

- renal abnormalities,
- CFTR-related disease in selected cases,
- obstruction or abnormalities on the opposite side.

EAU guidance recommends CFTR testing particularly when unilateral vasal absence occurs **with normal kidneys**.

CUAVD and Kidney Agenesis

When the absent vas occurs on the same side as a congenitally absent kidney, the embryological explanation is often different from classic CFTR-associated CBAVD.

The common developmental origin of the kidney and reproductive ducts explains this association.

Therefore, the kidney finding itself provides useful information about the likely cause.

Can CBAVD Cause Erectile Dysfunction?

No, not directly.

CBAVD primarily affects sperm transport.

The man may have:

- normal testosterone,
- normal libido,
- normal erection,
- normal orgasm.

The fertility problem should not be described as “sexual weakness.”

This is medically inaccurate and can be psychologically harmful.

Can CBAVD Cause Premature Ejaculation?

No established direct causal relationship exists.



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A man may independently have premature ejaculation or another sexual disorder, but the absence of the vas deferens is primarily a fertility problem.

Can CBAVD Cause Low Libido?

Not usually.

Libido is more strongly influenced by:

- testosterone,
- psychological state,
- general health,
- relationship factors.

CBAVD generally does not interfere with androgen production.

Is CBAVD the Same as Vasectomy?

No, although the fertility effect is similar in one respect.

After vasectomy, the vas deferens developed normally but was deliberately interrupted.

In CBAVD, the vas never developed normally in the first place.

The distinction matters because:

- vasectomy may sometimes be surgically reversed,
- CBAVD generally cannot be reconstructed in the same way.

Sperm retrieval plus ICSI therefore plays a larger role in CBAVD.

Is CBAVD the Same as Ejaculatory-Duct Obstruction?

No.

In ejaculatory-duct obstruction, the vas deferens may be present, but blockage occurs further downstream.

Some ejaculatory-duct obstructions can be treated endoscopically.

In CBAVD, the vas itself is congenitally absent.

Treatment therefore differs.



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Is CBAVD the Same as Retrograde Ejaculation?

No.

In retrograde ejaculation, semen flows backward into the bladder instead of exiting through the penis.

In CBAVD, sperm cannot reach the seminal pathway in the first place.

The patient can still ejaculate prostatic/seminal fluid forward normally.

Can CBAVD Be Prevented?

Usually not.

It is a developmental/genetic condition arising before birth.

Lifestyle during adulthood does not cause it.

Smoking, alcohol, heat exposure, masturbation or sexual frequency do not cause the vas deferens to disappear.

However, identifying a CFTR-related genetic cause has value for future family planning.

Can CBAVD Be Cured?

The word “cure” requires clarification.

Can we grow new vas deferens?

No established medical or herbal therapy can regenerate a congenitally absent vas deferens.

Can the infertility be bypassed?

Yes, frequently.

If sperm production is preserved, sperm can often be surgically retrieved and used with IVF/ICSI.

Therefore, although the anatomical abnormality remains, biological fatherhood may still be possible.

What About CFTR Modulator Medicines?

Modern CFTR modulators have revolutionized treatment of many patients with cystic fibrosis.



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However, there is currently no evidence that these medicines can regenerate a vas deferens that failed to develop during fetal life.

A congenital absence is a developmental anatomical defect.

The newer 2026 CF literature is exploring whether CFTR modulators may affect broader male reproductive physiology, but they should not be viewed as a treatment that reconstructs CBAVD.

The Unani Perspective on Congenital Absence of the Vas Deferens

As a physician trained in Unani medicine and focused on sexual disorders and infertility, I believe that male reproductive health should always be considered within the patient's overall condition.

Traditional Unani medicine evaluates male reproductive health in relation to:

- **Mizaj**, or constitutional temperament,
- nutrition,
- digestive health,
- sleep,
- physical activity,
- general vitality,
- sexual function,
- semen characteristics,
- emotional wellbeing.

These principles may have a supportive role in selected male infertility patients.

But congenital absence of the vas deferens requires a particularly clear distinction:

This is an anatomical developmental abnormality.

No Unani medicine, herbal formulation, dietary therapy or sexual tonic can be expected to physically create a missing vas deferens.

Why This Distinction Is Important

Consider two men.

The first has:

- sperm count 8 million/mL,
- normal reproductive anatomy,
- no identifiable cause.

The second has:

- normal sperm production,
- bilateral absence of the vas deferens,
- azoospermia.

The first patient has a sperm-production problem.

The second primarily has a sperm-transport problem.

Giving both the same “sperm-increasing medicine” would make little physiological sense.

This is why I believe successful integrative medicine must begin with correct diagnosis.

Can Unani Medicine Increase Sperm Production in CBAVD?

If the testes are already producing sperm adequately, increasing production does not solve the missing transport pathway.

Suppose a CBAVD patient is producing millions of sperm inside the testes.

Whether that number becomes somewhat higher does not create a vas deferens.

Sperm still cannot enter the ejaculate normally.

Therefore, the decisive fertility treatment remains:

sperm retrieval + assisted reproduction.

When Could Unani Medicine Still Be Useful?

The patient may have other reproductive or general-health issues alongside CBAVD.

For example:

- obesity,
- metabolic problems,
- poor nutrition,
- digestive complaints,



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- sleep disturbance,
- sexual anxiety,
- erectile dysfunction unrelated to the absent vas,
- poor general wellbeing.

Individualized Unani care can potentially address these associated concerns.

It may also be used supportively to optimize general reproductive health before assisted reproduction, provided it is safe and does not delay indicated genetic counselling or ART.

Does Unani Research Show Treatment for CBAVD?

At present, there is **no high-quality evidence demonstrating that Unani medicine can regenerate congenitally absent vas deferens or restore normal sperm transport in CBAVD.**

Published Unani fertility research has mainly concerned conditions such as:

- idiopathic oligospermia,
- semen-quality abnormalities,
- broader male reproductive complaints.

Those conditions are not biologically equivalent to congenital absence of the vas.

Therefore, evidence from ordinary oligospermia should not be presented as evidence for anatomical correction of CBAVD.

Scientific honesty is especially important in genetic and congenital infertility.

What Unani Medicine Should Not Delay

A man with confirmed CBAVD should not spend several years trying one oral medicine after another while delaying:

- CFTR testing,
- female-partner CFTR testing,
- renal ultrasound,
- genetic counselling,
- sperm retrieval,



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- IVF/ICSI.

Age-related decline in the female partner's fertility can make such delay clinically important.

The couple's reproductive timeline matters.

My Approach at Saira Health Care

When I see an azoospermic patient, I first determine:

Is the problem sperm production or sperm transport?

If the testes are normal in size, FSH is relatively normal, semen volume is low and the vas deferens cannot be palpated, I consider obstructive infertility very seriously.

If congenital absence is identified, the next questions are:

Is one vas absent or both?

Are the kidneys normal?

Are the seminal vesicles present?

Is CFTR testing positive?

Has the female partner been tested?

Does the couple understand the genetic implications?

What is the woman's fertility status?

Only after those questions have been addressed can treatment be properly planned.

Special Treatment Planning by Dr. Nizamuddin Qasmi

My clinical work in **Sexual Disorders & Infertility** focuses on differentiating conditions that may superficially look similar.

Two men may both have:

“Zero sperm.”

Yet one may have genetic testicular failure and the other may have CBAVD with active spermatogenesis.

Their prognosis and treatment are completely different.



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For a patient with congenital absence of the vas deferens, specialized fertility planning may include:

- confirmation of obstructive azoospermia,
- careful genital examination,
- semen-volume and pH interpretation,
- hormonal assessment,
- CFTR genetic testing,
- female-partner carrier testing,
- renal ultrasonography,
- genetic counselling,
- coordination for epididymal/testicular sperm retrieval,
- IVF/ICSI planning.

Where appropriate, individualized Unani supportive management can be incorporated for the patient's broader sexual, metabolic and general health.

What “Special Treatment” Means Here

Specialized treatment does not mean a medicine that promises to regrow the vas deferens.

It means knowing which treatment the patient actually needs.

For example:

Patient One

Has unilateral vasal absence, normal kidney, and normal fertility.

He may require genetic assessment but may not require fertility treatment.

Patient Two

Has unilateral vasal absence and renal agenesis.

His developmental explanation is different and renal evaluation becomes central.

Patient Three

Has bilateral vasal absence with a CFTR mutation and normal sperm production.

He may need sperm retrieval, ICSI and partner CFTR testing.



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Patient Four

Has bilateral vasal absence and his wife is also a CFTR carrier.

For this couple, **genetic counselling becomes essential before embryo creation or transfer.**

This is personalized reproductive medicine.

Saira Health Care's Contribution to Male Infertility

At **Saira Health Care**, one of our important objectives in male infertility is to move beyond vague descriptions such as:

“sperm zero,”

“male weakness,”

“sperm blockage.”

We try to understand the mechanism.

A patient with CBAVD should know:

- whether sperm production is preserved,
- why sperm do not appear in semen,
- whether there is a CFTR-related cause,
- whether the kidneys require evaluation,
- whether his partner should be tested,
- whether biological fatherhood remains possible.

This allows more informed decisions and prevents unnecessary treatment.

Why Genetic Counselling Is Part of Infertility Treatment

The availability of ICSI has changed reproductive medicine dramatically.

Previously, the absent vas prevented biological fatherhood.

Today, sperm can often be retrieved directly.

But technology also creates responsibility.

ICSI can transmit genetic abnormalities that natural fertility might previously have prevented from being passed on.



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Therefore, genetic counselling is not an optional extra.

It is part of safe and ethical fertility treatment.

The 2025 WHO infertility guideline similarly emphasizes evidence-based, person-centred fertility care and counselling rather than simply proceeding to increasingly complex technology without understanding underlying causes.

Psychological Impact of CBAVD

A man may initially hear:

“You have no sperm in semen.”

He may interpret this as:

“My testes do not work.”

Then he may discover:

“You were born without the sperm tubes.”

Then:

“This may be genetically related to cystic fibrosis.”

This can be emotionally overwhelming.

Patients may worry about:

- masculinity,
- sexual function,
- fertility,
- health of future children.

Good counselling should separate these issues.

CBAVD generally does **not** mean:

- impotence,
- testosterone deficiency,
- lack of masculinity.

It means that sperm transport is anatomically absent.

CBAVD Does Not Define Masculinity

I explain this directly.

The vas deferens are sperm-transport ducts.

They do not determine:

- male identity,
- libido,
- erectile strength,
- sexual satisfaction.

A man can have CBAVD and have entirely normal sexual function.

Infertility should never be presented as a measure of manhood.

Frequently Asked Questions

What is congenital absence of the vas deferens?

It is a developmental condition in which one or both tubes that normally carry sperm from the epididymis toward the ejaculatory ducts failed to develop.

What is CBAVD?

CBAVD stands for:

Congenital Bilateral Absence of the Vas Deferens.

Both sperm-carrying ducts are absent.

What is CUAVD?

CUAVD stands for:

Congenital Unilateral Absence of the Vas Deferens.

Only one vas deferens is absent.

Does CBAVD mean the testicles do not produce sperm?

Usually not.

CBAVD generally causes **obstructive azoospermia**, meaning sperm production can remain relatively preserved but sperm cannot reach the ejaculate.



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Why does my semen show zero sperm?

Because sperm cannot travel from the epididymis/testis through the absent vas deferens into the semen.

Is CBAVD a type of azoospermia?

Yes.

It is an important cause of **obstructive azoospermia**.

Is it the same as non-obstructive azoospermia?

No.

In non-obstructive azoospermia, sperm production itself is severely impaired.

In CBAVD, sperm production is usually much better preserved.

Can CBAVD cause low semen volume?

Yes.

Many men have reduced semen volume because the same developmental abnormality can affect the seminal vesicles and ejaculatory structures.

EAU guidance particularly suggests considering CBAVD when azoospermia occurs with semen volume below approximately 1 mL and acidic pH.

Can the man have normal erections?

Yes.

CBAVD generally does not interfere directly with erection.

Can he have normal orgasm?

Yes.

Can he ejaculate?



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Usually yes.

The ejaculate simply lacks sperm and may have reduced volume.

Does CBAVD cause low testosterone?

Usually not directly.

Testicular hormone production is commonly preserved.

Is CBAVD related to cystic fibrosis?

Very strongly.

A substantial proportion of affected men have clinically relevant CFTR genetic variants.

Does CBAVD mean I have cystic fibrosis?

Not necessarily.

Some men have isolated CBAVD as a mild CFTR-related disorder without the classic lung or pancreatic disease of cystic fibrosis.

Should I have CFTR genetic testing?

Yes.

Current major male-infertility guidelines recommend CFTR testing in men with vasal agenesis.

Should my wife also be tested?

If a clinically significant CFTR variant is identified in the man, the female partner should also receive carrier testing and appropriate genetic counselling.

Why must my wife be tested if she is fertile?

Because the purpose is not to assess her fertility.

It is to determine the risk that a future child could inherit clinically important CFTR variants from both parents.



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Can our child have cystic fibrosis?

Potentially, if both parents carry relevant CFTR abnormalities.

The exact risk depends upon the specific genotype of each partner and should be calculated through genetic counselling rather than assumed from CBAVD alone.

Is CFTR testing important in India?

Yes.

Indian studies demonstrate substantial CFTR variation among men with CBAVD and show that the mutation spectrum differs from Western populations.

What if my CFTR test is negative?

CBAVD can still occur.

Other genetic causes such as **ADGRG2** have been identified, particularly in CFTR-negative men with normal renal anatomy.

The genetics of CFTR-negative CBAVD continue to evolve.

Should I have a kidney ultrasound?

Yes, renal imaging is generally appropriate when vasal agenesis is identified.

The 2024 AUA/ASRM guideline recommends renal ultrasonography in patients with vasal agenesis.

Why are kidney abnormalities connected?

The kidneys and male reproductive ducts develop from closely related embryological systems.

A developmental abnormality can therefore affect both.

Can I become a biological father?

Often yes.



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If sperm production is preserved, sperm can usually be retrieved from the epididymis or testis and potentially used with IVF/ICSI.

Can I father a child naturally?

With complete bilateral absence, natural conception is generally not possible because sperm cannot enter the ejaculate.

Assisted reproduction is normally required.

What is PESA?

Percutaneous Epididymal Sperm Aspiration uses a needle to retrieve sperm from the epididymis.

What is MESA?

Microsurgical Epididymal Sperm Aspiration uses microsurgery to obtain epididymal sperm and can often provide enough sperm for cryopreservation and multiple ICSI attempts.

What is TESA?

Testicular Sperm Aspiration retrieves sperm directly from the testis using a needle technique.

What is TESE?

Testicular Sperm Extraction surgically obtains testicular tissue containing sperm.

Do CBAVD patients need micro-TESE?

Usually not when sperm production is normal.

Micro-TESE is principally designed for severe non-obstructive azoospermia.

Simpler epididymal or testicular retrieval is usually sufficient in classic CBAVD.

Can retrieved sperm be frozen?

Yes.

Cryopreservation is commonly possible and may reduce the need for repeat retrieval procedures.

What is ICSI?

ICSI means **Intracytoplasmic Sperm Injection**.

One sperm is injected directly into a mature egg during an IVF cycle.

Does sperm retrieval guarantee a baby?

No.

It allows the male infertility barrier to be bypassed, but IVF success also depends heavily upon:

- female age,
 - egg quality,
 - ovarian reserve,
 - embryo quality,
 - uterine factors.
-

Can the absent vas deferens be surgically reconstructed?

A vas that never developed cannot generally be reconstructed like an ordinary acquired blockage or reversed vasectomy.

The standard fertility strategy is usually sperm retrieval plus ICSI.

Can medicines grow a new vas deferens?

No established medicine can regenerate a congenitally absent vas deferens.

Can Unani medicine create a missing vas deferens?

No.

There is currently no scientific evidence that an Unani medicine or herbal formulation can create an anatomically absent vas deferens.

Can Unani medicine still help?

It may have an individualized supportive role in the patient's broader reproductive and sexual health—for example nutrition, lifestyle, metabolic health, general wellbeing and associated sexual concerns.

It should not replace genetic evaluation, sperm retrieval or IVF/ICSI where these are required.

Does CBAVD mean “male weakness”?

No.

It is an anatomical and frequently genetic sperm-transport disorder.

Sexual performance may be completely normal.

Is CBAVD caused by masturbation?

No.

Is it caused by excessive intercourse?

No.

Is it caused by a sexually transmitted infection?

Congenital vasal absence is not caused by an STI.

Acquired reproductive-tract obstruction can occur after some infections, but that is a different condition.

Can a man with only one vas deferens be fertile?

Yes.

If the opposite reproductive tract and testicle are functioning normally, natural fertility can remain possible.



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Does unilateral absence need investigation?

Yes.

Renal imaging is important, and CFTR testing may be indicated according to renal anatomy and clinical context.

A Message From Dr. Nizamuddin Qasmi

When a patient comes to me with a semen report showing:

“Azoospermia — sperm not seen,”

I do not want him immediately to conclude:

“My testes have stopped making sperm.”

That may be completely wrong.

I examine him.

If I find that the testes are normal in size, hormone levels are reasonably normal, semen volume is low and the vas deferens cannot be felt, I start thinking about **obstructive azoospermia**.

If both vasa are congenitally absent, the treatment conversation becomes very different.

I explain:

Your problem may not be that sperm are not being made. Your problem may be that sperm have no road through which they can enter the semen.

That is an important difference.

What I Tell Patients About Treatment

If sperm are being produced, we do not need to create an artificial vas deferens.

Modern reproductive medicine allows us to bypass the missing pathway.

Sperm can often be recovered from the epididymis or testis.

Those sperm can potentially be used through ICSI.

But before we do that, we must ask another important question:



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Why was the vas deferens absent?

If CFTR genetics are involved, we need to know the reproductive implications for the child.

That is why I do not regard genetic counselling as separate from infertility treatment.

It is part of responsible infertility treatment.

My Integrative Clinical Philosophy

As a Unani physician working in sexual disorders and infertility, I believe strongly in treating the patient as a whole person.

But whole-person medicine should never mean ignoring anatomy or genetics.

If a tube is congenitally absent, an herbal medicine does not physically create it.

If a CFTR mutation is present, dietary treatment does not erase the mutation.

The intelligent role of integrative medicine is therefore to combine:

accurate diagnosis + responsible genetics + modern fertility technology + individualized supportive care.

This protects the patient from false promises while still recognizing the value of broader health optimization.

Current Medical Understanding

The modern understanding of congenital absence of the vas deferens can be summarized through several important advances.

CBAVD is primarily an obstructive fertility disorder

Most affected men retain meaningful spermatogenesis, allowing sperm retrieval directly from the epididymis or testes.

CFTR genetic testing is essential

Current EAU and AUA/ASRM guidance recommends CFTR testing when vasal agenesis is diagnosed.

The female partner matters genetically

If the male carries a clinically significant CFTR variant, his female partner should be tested before assisted reproduction.



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Kidney imaging is important

Developmental renal abnormalities are particularly frequent in unilateral vasal absence, and the 2024 AUA/ASRM guideline recommends renal ultrasonography for men with vasal agenesis.

Genetics extends beyond CFTR

Newer evidence, including a 2026 report, confirms **ADGRG2** as an important cause of CFTR-negative CBAVD in selected men.

Assisted reproduction has transformed prognosis

MESA/PESA/TESA/TESE combined with IVF/ICSI can allow many affected men to pursue biological fatherhood.

Conclusion

Congenital Absence of the Vas Deferens is an important cause of male infertility and obstructive azoospermia.

When both vas deferens are absent, the condition is called:

CBAVD — Congenital Bilateral Absence of the Vas Deferens.

When only one side is absent, it is called:

CUAVD — Congenital Unilateral Absence of the Vas Deferens.

The most important point is that CBAVD usually prevents **sperm transport rather than sperm production.**

The testes may continue to produce sperm normally, but sperm cannot enter the ejaculate because the normal reproductive ducts are absent.

This is why men can show:

azoospermia despite normal sexual function, relatively normal testicular size and often normal hormone levels.

CBAVD has a strong genetic association with the **CFTR gene**, which also causes cystic fibrosis. Current guidelines therefore recommend CFTR genetic testing in men with vasal agenesis and testing of the female partner when a clinically relevant CFTR abnormality is found.

Renal imaging is also important because reproductive-duct abnormalities and kidney abnormalities share a common embryological background. This association is particularly strong in unilateral absence of the vas deferens.



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The anatomical defect itself cannot generally be corrected with medicine.

However, the infertility can often be bypassed.

Sperm may be retrieved through:

- PESA,
- MESA,
- TESA,
- TESE,

and used for **IVF with ICSI**.

This means that a man with no sperm in his ejaculated semen may nevertheless have a realistic opportunity for biological fatherhood.

From the **Unani perspective**, male reproductive health may be approached holistically through attention to:

- Mizaj,
- nutrition,
- digestive health,
- sleep,
- lifestyle,
- metabolic wellbeing,
- sexual health,
- general vitality.

These aspects can be useful as part of supportive and integrative care.

However, congenital absence of the vas deferens is an anatomical developmental condition.

No Unani medicine, herbal formulation, hormone or nutritional supplement can be expected to regenerate a vas deferens that never developed.

Likewise, Unani care cannot replace:

- CFTR testing,
- female-partner carrier testing,
- genetic counselling,



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- renal evaluation,
- sperm retrieval,
- IVF/ICSI.

At **Saira Health Care**, my preferred approach is therefore firmly diagnosis-led and integrative:

first determine whether azoospermia is obstructive or non-obstructive, confirm the reproductive anatomy, investigate CFTR and other relevant genetic factors, assess kidney anatomy, counsel the couple about inheritance, retrieve sperm when appropriate, use IVF/ICSI when required, and integrate Unani supportive care for the patient's broader reproductive and sexual health.

The most important message I give my patients is:

“Zero sperm in semen does not always mean zero sperm production.”

In congenital absence of the vas deferens, understanding that distinction can completely change the prognosis.

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's clinical work at **Saira Health Care** focuses particularly on sexual disorders, male reproductive health and infertility.

His approach to azoospermia emphasizes distinguishing impaired sperm production from reproductive-tract obstruction rather than treating every “zero sperm” result in the same way.



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In men with congenital absence of the vas deferens, appropriate contemporary evaluation—including examination of the reproductive tract, semen assessment, hormonal testing, CFTR genetic evaluation, renal imaging, genetic counselling and assisted-reproductive planning—is combined with individualized sexual and reproductive-health care.

Where clinically appropriate, Unani principles may be incorporated supportively to address the patient's overall reproductive, metabolic, lifestyle and sexual-health concerns without replacing modern genetic or 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 reproductive urologist, andrologist, clinical geneticist, genetic counsellor, fertility specialist or other healthcare professional.

Congenital absence of the vas deferens is an anatomical developmental disorder and is commonly associated with genetic abnormalities involving CFTR.

Men with vasal agenesis should receive appropriate genetic and reproductive evaluation before assisted reproduction.

When clinically significant CFTR variants are identified, the female partner should also receive appropriate carrier testing and genetic counselling.

Kidney imaging may be required because vasal agenesis can coexist with congenital renal abnormalities.

No herbal, Unani, nutritional, hormonal or conventional medicine has been shown to regenerate a congenitally absent vas deferens.

Patients should not delay appropriate genetic evaluation, sperm-retrieval planning or IVF/ICSI while repeatedly trying unproven treatments for azoospermia.



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