

Endometriosis and Infertility

How Endometriosis Affects Fertility, Ovarian Reserve and Pregnancy — Diagnosis, Natural Conception, Surgery, IUI, IVF/ICSI and an Integrative Unani Approach

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Medical and reproductive-health literature reviewed and updated through September 2026.

Introduction: “Doctor, I Have Endometriosis — Can I Still Become Pregnant?”

This is one of the most important questions women with endometriosis ask me.

A woman may come to me after months or years of painful periods and say:

“Doctor, I have now been diagnosed with endometriosis. Does this mean I cannot have a baby?”

Another patient may have no major pain at all. She may discover an ovarian endometrioma only because pregnancy has not occurred.

Someone else may already have undergone one or two ovarian surgeries and come with a reduced AMH level, wondering whether another operation will improve or further reduce her chances of becoming pregnant.

My first message is always important:

Endometriosis can reduce fertility, but it does not mean that pregnancy is impossible.

Many women with endometriosis conceive naturally. Others conceive after appropriate surgery, ovarian stimulation with intrauterine insemination, or IVF/ICSI. The best approach varies greatly according to the woman's age, ovarian reserve, location and severity of disease, fallopian-tube function, previous surgery, pain, duration of infertility and the male partner's fertility.



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Endometriosis is common. The World Health Organization estimates that it affects approximately **10% of women of reproductive age worldwide—around 190 million people**. WHO also reports that endometriosis may be present in approximately **25–50% of women experiencing infertility**.

This means endometriosis and infertility frequently occur together—but infertility should never be treated as if every woman with endometriosis has exactly the same reproductive problem.

The correct question is not simply:

“Does she have endometriosis?”

The more useful questions are:

Where is the disease? How is it interfering with reproduction? How much reproductive time does the patient have? What is her ovarian reserve? Are the tubes functioning? Is there a male factor as well? And would surgery, natural conception or assisted reproduction provide the best opportunity?

That is the framework I use when counselling patients.

What Is Endometriosis?

Endometriosis is a chronic inflammatory condition in which **tissue resembling the lining of the uterus grows outside the normal uterine cavity**.

These endometriosis lesions can produce inflammation, scarring, fibrosis and adhesions.

They commonly occur around the:

ovaries, fallopian tubes, pelvic peritoneum, ligaments behind the uterus, rectovaginal area, bowel, bladder and other pelvic structures.

Less commonly, endometriosis can occur outside the pelvis.

WHO describes endometriosis as a chronic disease associated with severe menstrual pain, chronic pelvic pain, painful intercourse, bowel or urinary symptoms and infertility. There is currently no single treatment that can guarantee permanent eradication of the disease.

This is important because endometriosis should not be described merely as “menstrual blood collected outside the uterus.”

It is a complex inflammatory and hormone-responsive disease involving lesions, local immune changes, fibrosis and altered pelvic biology.



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The Three Major Clinical Forms of Endometriosis

Modern clinical practice commonly describes endometriosis according to where it occurs.

Superficial peritoneal endometriosis

These are relatively shallow lesions on the pelvic lining or nearby structures.

A woman can have minimal-looking lesions yet significant pain or fertility difficulty.

Ovarian endometriosis or endometrioma

Endometriosis develops within the ovary and forms a cyst known as an **endometrioma**, sometimes informally called a “chocolate cyst” because older blood products can accumulate within it.

Ovarian endometriosis is particularly important for fertility because both the disease and any ovarian surgery can influence ovarian reserve.

Deep endometriosis

Deep lesions extend beneath the surface of the pelvic tissues and may involve structures such as the bowel, bladder, ureters, vagina or pelvic ligaments.

Deep disease can cause severe pain, painful intercourse, bowel symptoms and complex pelvic adhesions.

ESHRE uses these major anatomical forms in current guidance and emphasizes that management has to be individualized rather than determined by one staging system alone.

Endometriosis Stage Does Not Tell the Entire Story

Endometriosis is often classified using the revised American Society for Reproductive Medicine system into:

Stage I — minimal

Stage II — mild

Stage III — moderate

Stage IV — severe

This classification is useful for describing the surgical extent of disease.

But it has limitations.

A woman with Stage I disease can have severe pain.



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Another woman with Stage IV endometriosis may have surprisingly little pain.

Likewise, reproductive outcomes are not determined by stage alone.

NICE specifically advises treating patients according to their **symptoms, fertility priorities and preferences rather than simply the stage of endometriosis.**

Therefore, I do not tell a patient:

“You have Stage IV, so pregnancy is impossible.”

Nor do I tell someone:

“It is only Stage I, so it cannot be causing infertility.”

Both statements can be misleading.

Why Can Endometriosis Cause Infertility?

Endometriosis can interfere with fertility through several mechanisms at the same time.

This is why two women with apparently similar disease may have very different reproductive outcomes.

Modern research describes a combination of:

altered pelvic anatomy, adhesions, inflammatory changes, ovarian dysfunction, oxidative stress, changes in follicular biology, altered oocyte competence and possibly abnormalities in endometrial receptivity.

I explain this to patients using a simple idea:

For pregnancy to occur, the ovary must produce a healthy egg, the tube must capture it, sperm must reach it, fertilization must occur, the embryo must develop, and the uterus must allow implantation. Endometriosis can interfere with more than one of these steps.

1. Pelvic Adhesions Can Disturb Normal Anatomy

Endometriosis creates inflammation.

Repeated inflammation can eventually lead to **fibrosis and adhesions**—bands of scar-like tissue that cause pelvic organs to stick to one another.

The ovary may become fixed behind the uterus.

The fallopian tube may lose normal mobility.



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The fimbrial end of the tube, which normally sweeps over the ovary to collect the ovulated egg, may become distorted.

In severe disease, the ovary, tube, uterus and bowel can become densely adherent.

This can reduce the chance that the egg and sperm will meet naturally.

In advanced cases, the problem may therefore be partly mechanical.

2. Endometriosis Can Affect the Fallopian Tubes Even Without Complete Blockage

A fallopian tube does not need to be completely blocked to function poorly.

It must move properly and transport the egg and embryo.

Pelvic inflammation and adhesions can interfere with:

fimbrial movement, tubal mobility and normal egg pickup.

Therefore, a patient may have a tubal-patency study showing that contrast passes through the tubes, yet the reproductive environment may still be less favorable than normal.

That is why fertility assessment should look beyond the simple question:

“Are the tubes open?”

3. Endometriosis Can Affect the Ovary

Endometriosis involving the ovary is particularly important.

An endometrioma can alter the ovarian environment through inflammation, iron exposure and oxidative stress.

Recent molecular research describes inflammatory and oxidative processes within endometriosis-associated ovaries that may affect granulosa cells, follicular development and oocyte competence.

This does not mean every woman with an endometrioma has poor-quality eggs.

But ovarian endometriosis deserves special reproductive consideration, particularly when disease is bilateral or surgery has already been performed.

4. Endometriosis and Ovarian Reserve



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Ovarian reserve refers broadly to the remaining quantity of recruitable follicles in the ovaries.

Two of the most commonly used clinical measures are:

AMH — Anti-Müllerian Hormone

and

AFC — Antral Follicle Count

A woman with endometriosis can have normal, reduced or occasionally very low ovarian reserve.

Ovarian reserve is influenced by many factors, especially age.

Endometriosis, particularly ovarian disease, may also contribute.

But one of the most important clinical issues is that **surgery for an endometrioma can itself reduce ovarian reserve.**

A 2025 systematic review and meta-analysis confirmed a decline in AMH following laparoscopic endometrioma cystectomy.

This is why I never consider ovarian surgery only from the perspective of removing the cyst.

I also ask:

How much healthy ovarian tissue might be lost?

Endometrioma Surgery Can Reduce AMH

During cystectomy, the surgeon attempts to remove the cyst wall while preserving normal ovarian tissue.

But endometriomas are often intimately attached to healthy ovarian cortex.

Small amounts of normal tissue can therefore be removed along with the cyst wall.

Bleeding-control techniques can also affect ovarian tissue.

This explains why AMH frequently declines after endometrioma surgery.

The concern becomes especially important with:

bilateral endometriomas, repeated ovarian surgery and already reduced ovarian reserve.

A 2026 network meta-analysis of 21 randomized trials confirmed that different surgical techniques can have different short-term effects on ovarian reserve markers and emphasized the need to balance recurrence control against preservation of healthy ovarian tissue.

The message is not:

“Never operate on an endometrioma.”

The message is:

Do not operate automatically without considering fertility consequences.

Does a Bigger Endometrioma Always Mean Lower AMH?

Not necessarily.

A 2026 systematic review and meta-analysis examining 30 cohorts found that, among women who had **not previously undergone ovarian surgery**, endometrioma diameter itself was not independently associated with serum AMH.

This is clinically useful because it challenges the idea that cyst size alone should determine every fertility decision.

Size remains relevant for pain, diagnosis, access to follicles, technical difficulty and other clinical issues.

But the decision to operate should consider the entire reproductive picture rather than one diameter measurement.

5. Oocyte Quality May Be Affected

The egg develops within an ovarian follicle surrounded by granulosa and cumulus cells.

The follicular environment matters greatly.

Endometriosis-associated inflammation and oxidative stress can influence:

mitochondrial function, spindle organization, cell signalling and maturation of the oocyte.

A very recent 2026 review concluded that endometriosis—especially more advanced disease—is associated in some studies with fewer retrieved or mature oocytes and impaired aspects of oocyte competence, although reproductive outcomes remain heterogeneous and good-quality embryos can still produce successful pregnancies.

I explain this carefully because I do not want patients to hear:



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“Your eggs are bad.”

That is not an appropriate conclusion.

Rather:

Endometriosis can alter the ovarian environment in ways that may reduce reproductive efficiency in some women.

6. Inflammation Can Affect Fertilization and Early Embryo Development

Endometriosis creates a biologically active inflammatory environment within the pelvis.

Cytokines, immune cells, prostaglandins, oxidative molecules and other signalling compounds can become altered.

Recent 2025 research describes inflammatory, immune and oxidative pathways capable of affecting the follicle, oocyte, embryo and reproductive tract.

These mechanisms help explain why infertility can occur even when pelvic anatomy appears relatively normal.

7. Does Endometriosis Affect Implantation?

Possibly—but this area remains complex.

Research has described:

progesterone resistance, altered decidualization, inflammatory signalling and abnormalities in endometrial receptivity in women with endometriosis.

However, endometrial dysfunction should not be considered universal in every affected woman.

Recent evidence suggests that when a good-quality embryo is available, implantation and live-birth outcomes can sometimes approach those of women without endometriosis, suggesting that ovarian and oocyte effects may be particularly important in some populations.

Therefore, I avoid oversimplifying the disease by saying:

“Endometriosis always prevents implantation.”

The biological picture is more complex.

8. Painful Intercourse Can Indirectly Reduce Fertility



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Endometriosis commonly causes **deep dyspareunia—pain during intercourse**.

If sexual activity becomes painful, couples may have intercourse less frequently.

The woman may begin anticipating pain.

Pelvic-floor muscles may become tense.

Intimacy may become stressful.

Intercourse may be avoided around fertile days.

WHO recognizes painful intercourse and impaired sexual health among the major burdens of endometriosis.

Therefore, sexual pain can contribute to infertility even when ovulation and tubes are otherwise functional.

This is one reason my focused practice in sexual disorders and infertility considers sexual function part of fertility care rather than a separate subject.

Endometriosis Does Not Affect Every Woman's Fertility Equally

Some women with endometriosis become pregnant very easily.

Others require years of treatment.

The difference can reflect:

age, ovarian reserve, lesion location, tubal damage, adhesions, endometriomas, previous surgery, duration of infertility, male-factor infertility and other reproductive conditions.

Therefore, a diagnosis of endometriosis alone cannot provide an individual probability of pregnancy.

Symptoms That May Suggest Endometriosis

A woman with endometriosis may experience severe menstrual cramps, pelvic pain outside menstruation, painful intercourse, pain during bowel movements, cyclical bowel symptoms, painful urination, heavy menstrual bleeding, fatigue and infertility.

But some women have almost no symptoms.

WHO notes that the clinical presentation varies considerably, and infertility may sometimes be one of the first reasons endometriosis is discovered.

This is important because:



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absence of severe pain does not exclude endometriosis.

When Should Endometriosis Be Suspected in an Infertility Patient?

I become more suspicious when infertility occurs together with severe dysmenorrhea, deep dyspareunia, chronic pelvic pain, cyclical bowel or urinary symptoms, a known ovarian endometrioma, family history of endometriosis, previous pelvic surgery showing endometriosis or imaging suspicious for deep pelvic disease.

A 2024 systematic review of women with otherwise unexplained infertility who underwent laparoscopy found endometriosis in approximately **44%**, with most identified lesions being minimal or mild.

This does not mean every woman with unexplained infertility needs laparoscopy.

It does show that endometriosis can remain hidden despite apparently normal routine fertility tests.

How Is Endometriosis Diagnosed Today?

The diagnostic approach has changed substantially.

Historically, laparoscopy with biopsy was often described as the only definitive way to diagnose endometriosis.

Modern guidelines take a more nuanced approach.

Current NICE guidance recommends expert **transvaginal ultrasound** as an important part of assessment and recommends specialist ultrasound or pelvic MRI when deep endometriosis is suspected. Laparoscopy can still be considered when symptoms remain suggestive even if imaging is normal.

ESHRE similarly moved away from requiring diagnostic laparoscopy as an automatic “gold-standard” first step in every patient.

This is important because surgery itself has risks.

Transvaginal Ultrasound

Expert transvaginal ultrasound can identify:

ovarian endometriomas and many forms of deep endometriosis.

Modern specialist scanning can also assess organ mobility, adhesions and certain bowel, bladder and ligament lesions.



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A normal routine ultrasound does not completely exclude superficial endometriosis. Therefore, the quality and specialization of the ultrasound examination matter.

MRI

MRI can be particularly valuable when deep endometriosis is suspected or when complex pelvic anatomy needs mapping before surgery.

NICE recommends that specialist ultrasound and MRI for deep disease be planned and interpreted by clinicians with appropriate gynecological imaging expertise.

MRI is not necessarily required for every patient.

Is CA-125 Useful for Diagnosing Endometriosis?

CA-125 can be elevated in some women with endometriosis.

But it is nonspecific.

It can also change with menstruation, pregnancy, inflammation and several benign and malignant conditions.

NICE specifically recommends **not using serum CA-125 to diagnose endometriosis**.

Therefore, a normal CA-125 does not exclude endometriosis and an elevated result does not prove it.

Laparoscopy

Laparoscopy remains very important when surgery is clinically indicated or when diagnosis remains uncertain despite appropriate non-invasive assessment.

During laparoscopy, the surgeon can directly visualize pelvic structures and, with prior consent, treat lesions and adhesions during the same procedure.

But I do not believe that every infertile woman with suspected endometriosis should automatically undergo diagnostic surgery.

The decision must be based on what the information or treatment is expected to change.

Complete Fertility Assessment Is Essential



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A major mistake is discovering endometriosis and assuming that it must explain everything.

A complete fertility evaluation should still consider the woman's age, menstrual and ovulatory history, ovarian reserve where appropriate, tubal patency, uterine anatomy and the male partner's semen analysis.

This is especially important because infertility frequently has more than one contributing factor.

WHO's 2025 global infertility guideline emphasizes systematic evaluation of relevant male and female factors rather than treating only the first abnormality identified.

Tubal Patency Assessment

Depending on the clinical situation, tubal assessment may involve:

HSG, HyCoSy or laparoscopy with dye testing.

A woman with advanced endometriosis may have distorted tubes or adhesions.

If both tubes are significantly damaged, continuing repeated natural-conception attempts may be less useful and IVF may become more appropriate.

Ovarian Reserve Testing

AMH and AFC are especially useful when planning fertility treatment in women with ovarian endometriosis, previous ovarian surgery or advancing reproductive age.

But I explain an important limitation:

AMH is not a pregnancy test.

A woman with low AMH can sometimes conceive naturally.

A woman with a high AMH can still have infertility.

AMH is most useful for estimating ovarian response and reproductive planning rather than determining whether pregnancy is absolutely possible or impossible.

Male Partner Evaluation Must Not Be Forgotten

This is extremely important at Saira Health Care.

Suppose a woman has endometriosis and her partner has severe oligozoospermia.



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Performing repeated surgery on the woman without evaluating the man may not meaningfully improve the couple's chance of natural pregnancy.

Likewise, treatment of mild endometriosis may be reasonable if the husband's semen is normal but insufficient if severe male-factor infertility already requires ICSI.

ESHRE explicitly advises taking other fertility investigations—including the partner's semen analysis—into account when deciding treatment after surgery.

This is one reason training and focused practice across both sexual disorders and male infertility can be useful in couple-based fertility counselling.

The Endometriosis Fertility Index — EFI

For women who have undergone endometriosis surgery, clinicians can use the **Endometriosis Fertility Index (EFI)** to help estimate the probability of non-ART pregnancy after surgery.

The EFI combines reproductive and surgical information rather than relying simply on rASRM stage.

ESHRE recommends using the EFI to help identify women who may benefit from assisted reproduction after surgery.

The EFI is not a guarantee.

It is a decision-support tool.

Can Endometriosis Be Treated With Hormones?

Hormonal treatment is extremely important for **endometriosis-related pain**.

Treatments can include combined hormonal contraceptives, progestogens, GnRH agonists or antagonists and other hormone-modifying approaches.

These treatments suppress ovarian activity and can reduce symptoms.

But there is a crucial distinction when infertility is the main concern.

Hormonal suppression does not improve spontaneous pregnancy rates while a woman is actively trying to conceive.

ESHRE strongly recommends against prescribing ovarian-suppression therapy simply to improve fertility in infertile women with endometriosis.

NICE similarly advises not offering hormonal treatment alone or combined with surgery for the purpose of improving spontaneous pregnancy rates in women trying to conceive.



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Why Doesn't Hormonal Suppression Treat Infertility?

Hormonal treatment suppresses ovulation or ovarian hormonal activity.

A woman cannot improve her chance of spontaneous conception during months when treatment intentionally prevents or markedly reduces ovulation.

That does not make hormonal treatment “bad.”

It simply means it has a different objective:

pain and disease-symptom control rather than immediate conception.

Treatment has to match the patient's goal.

Endometriosis Treatment When Pregnancy Is the Priority

When fertility is the immediate goal, the broad options are:

natural conception or expectant management, fertility-enhancing surgery in selected patients, ovarian stimulation with IUI in selected women, or IVF/ICSI.

The correct pathway depends upon age, ovarian reserve, disease location, previous treatment, pain, tubal function, male factors and how long infertility has been present.

There is no universal sequence suitable for every woman.

Can Surgery Improve Natural Pregnancy?

Yes—in selected patients.

NICE recommends excision or ablation of endometriosis with adhesiolysis for endometriosis not involving the bowel, bladder or ureter because it can improve the probability of spontaneous pregnancy.

ESHRE states that operative laparoscopy **may be offered** in rASRM Stage I/II endometriosis because evidence suggests improved ongoing pregnancy rates, although the recommendation is weak because evidence quality is limited.

Therefore, surgery can be useful—but the benefit must be balanced against surgical risk and reproductive time.

Surgery for Minimal and Mild Endometriosis



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For younger women with minimal or mild disease, open tubes, good ovarian reserve and no significant male-factor infertility, laparoscopic treatment may increase the opportunity for natural conception.

After surgery, the appropriate period for attempting pregnancy depends on:

age, EFI, duration of infertility and other fertility factors.

A young woman with a favorable EFI may reasonably try naturally.

A woman approaching the later reproductive years may need to move toward fertility treatment more quickly.

Surgery for Ovarian Endometrioma

This requires particularly careful counselling.

NICE advises that laparoscopic cystectomy or drainage/ablation can improve spontaneous pregnancy prospects in women with endometriomas, while explicitly requiring discussion of the impact on ovarian reserve.

ESHRE similarly allows surgery for endometrioma-associated infertility as an option for improving natural conception but describes the evidence as weak and emphasizes ovarian reserve, age, previous surgery and other factors.

The decision should therefore never be reduced to:

“There is an ovarian cyst, so remove it.”

When I Become Particularly Cautious About Ovarian Surgery

I am particularly cautious when a woman has:

bilateral ovarian endometriomas, previous ovarian surgery, already reduced AMH, only one functioning ovary, advanced reproductive age or an immediate need for IVF.

These are situations where loss of healthy ovarian tissue may have an especially significant fertility impact.

Repeat Endometriosis Surgery and Fertility

Repeated ovarian and pelvic surgery should be considered very carefully.

A 2026 systematic review and meta-analysis comparing women undergoing their first endometriosis operation with those undergoing repeat surgery found significantly better



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spontaneous pregnancy and pregnancy-per-embryo-transfer outcomes after primary surgery than after re-operation.

This does not prove that every repeat operation is harmful or unnecessary.

Some women genuinely require further surgery for pain, organ involvement or other reasons.

But from a fertility perspective:

Repeated surgery should have a clear indication rather than becoming an automatic response to recurrent disease.

Should an Endometrioma Be Removed Before IVF?

This is one of the most important modern treatment questions.

For many years, women with endometriomas were routinely sent for surgery before IVF.

Current evidence does **not** support this approach for every patient.

ESHRE strongly recommends **against routinely performing surgery for ovarian endometrioma before ART solely to improve live-birth rates**, because available evidence shows no reproductive benefit and surgery can reduce ovarian reserve. Surgery may still be considered for severe pain or when the cyst interferes with access to follicles during egg retrieval.

This recommendation has now been reinforced by newer evidence.

What Does the New 2026 Evidence Show?

A 2026 systematic review and meta-analysis evaluated **22 studies involving 3,590 women** with ovarian endometriomas or deep infiltrating endometriosis.

Surgery followed by IVF/ICSI did **not significantly improve live-birth rates** compared with proceeding directly to IVF/ICSI.

Among women with ovarian endometriomas, prior surgery was associated with a reduction in AMH and fewer retrieved oocytes.

The certainty of evidence was low, so this should not be turned into the opposite extreme of saying surgery is never appropriate.

But it strongly supports individualized decision-making.



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When Might Endometrioma Surgery Before IVF Still Be Reasonable?

There may still be valid indications.

Examples include severe pain, concern regarding the diagnosis, an ovarian mass with atypical features, technical difficulty accessing follicles, very large lesions interfering with treatment, infection-related concerns or other patient-specific surgical reasons.

The important distinction is:

Surgery should be done because there is a meaningful clinical indication—not simply because the patient is about to undergo IVF.

Deep Endometriosis and Fertility Surgery

Deep endometriosis can involve the bowel, bladder or ureters.

Surgery may significantly improve pain and quality of life in selected patients.

But whether removing deep lesions improves fertility sufficiently to justify surgery in every infertile woman remains uncertain.

ESHRE states that compelling evidence that surgery for deep endometriosis improves fertility is lacking and recommends basing decisions primarily on pain, patient preference, age, ovarian reserve, previous surgery and other fertility factors.

NICE similarly recommends a detailed discussion of benefits, risks and alternatives in women with deep endometriosis who wish to conceive.

These operations should generally be performed in experienced specialist centres because bowel, ureteric or bladder surgery may be required.

IUI and Endometriosis

Intrauterine insemination (IUI) places prepared motile sperm directly into the uterus around ovulation.

It can be considered in selected women with mild endometriosis, particularly when:

the tubes are open, ovarian reserve is reasonable, female age is favorable and the male partner does not have severe sperm abnormalities.

ESHRE states that IUI combined with ovarian stimulation may be used in women with Stage I/II endometriosis because it can increase pregnancy rates compared with expectant management or unstimulated IUI.

The evidence is less certain in Stage III/IV disease.



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When IVF Becomes More Appropriate

IVF is often considered when one or more of the following makes natural conception or IUI less effective:

tubal function is significantly compromised, there is important male-factor infertility, ovarian reserve is reduced, maternal age makes delay undesirable, EFI is low, previous surgery has not resulted in pregnancy, IUI has failed or disease is sufficiently severe that natural conception is unlikely.

ESHRE specifically recognizes ART as appropriate particularly with compromised tubal function, male-factor infertility, low EFI or previous treatment failure.

This is one of the reasons fertility treatment needs to be personalized.

IVF and Endometriosis

During IVF, the ovaries are stimulated to develop several follicles.

Eggs are retrieved directly from the ovaries, fertilized in the laboratory and resulting embryos are transferred to the uterus or frozen.

IVF therefore bypasses many—but not all—of the ways endometriosis can reduce fertility.

It can bypass tubal pickup problems and significant pelvic adhesions.

However, ovarian reserve and oocyte quality still matter.

Does Endometriosis Reduce IVF Success?

The answer is not identical for every patient.

Endometriosis can be associated with:

fewer retrieved oocytes, reduced ovarian response and abnormalities in oocyte competence, particularly in advanced ovarian disease.

However, successful IVF pregnancies occur regularly in women with endometriosis.

The presence of endometriosis should therefore not be interpreted as meaning IVF will fail.

Female age and embryo quality remain extremely important determinants.



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Is ICSI Required Just Because a Woman Has Endometriosis?

No.

ICSI is primarily used when sperm-related fertilization problems exist or when there are other laboratory indications.

Endometriosis alone does not automatically mean every IVF cycle must use ICSI.

The decision depends on semen quality, previous fertilization history and IVF-laboratory practice.

This is another reason the male partner needs proper assessment.

Should GnRH Agonist Treatment Be Given for Months Before IVF?

Extended GnRH-agonist suppression before IVF was historically used in some women with endometriosis.

However, current ESHRE guidance **does not recommend prolonged GnRH-agonist pretreatment specifically to improve live-birth rates**, because the benefit remains uncertain.

Likewise, there is insufficient evidence to recommend prolonged combined oral contraceptive or progestogen pretreatment solely to improve ART live birth.

Treatment should therefore not be prolonged automatically when reproductive time is important.

Fertility Preservation

Women with extensive ovarian endometriosis sometimes ask whether they should freeze eggs.

This can be particularly relevant before bilateral or repeat ovarian surgery.

ESHRE recommends discussing the **advantages and disadvantages of fertility preservation in extensive ovarian endometriosis**, although it also emphasizes that the true overall benefit remains uncertain.

Important factors include:

age, AMH/AFC, unilateral versus bilateral disease, previous ovarian surgery, anticipated surgery and future reproductive plans.

Egg freezing is not automatically necessary for every woman with endometriosis.



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But the conversation should occur before ovarian reserve has already been substantially reduced.

Should Women With Endometriosis Delay Pregnancy?

There is no universal recommendation that every woman with endometriosis must become pregnant immediately.

However, fertility naturally declines with age, and ovarian surgery or progression of ovarian disease can sometimes further complicate fertility.

Women who know that future biological pregnancy is important to them may therefore benefit from earlier fertility counselling—particularly if they have bilateral endometriomas, low reserve or repeated surgery.

Pregnancy Is Not a Treatment for Endometriosis

An old belief is:

“Just become pregnant and the endometriosis will disappear.”

That is incorrect.

Pregnancy temporarily changes the hormonal environment and some women experience improvement in symptoms.

But endometriosis can remain present, symptoms can return, and pregnancy does not reliably eradicate the disease.

ESHRE explicitly advises that patients should **not be told to become pregnant solely for the purpose of treating endometriosis**.

Pregnancy should occur because the patient wants a child—not as a medical prescription for endometriosis.

Endometriosis and Pregnancy Outcomes

Several observational studies have associated endometriosis with increased rates of some pregnancy complications.

However, associations vary by disease type and study design.

A 2026 expert consensus reviewing pregnancy in women with endometriosis concluded that, despite reported associations with outcomes such as placenta previa, preterm delivery and other complications, evidence does **not** currently justify routine

intensification of antenatal surveillance solely because a woman has endometriosis if she has no additional risk factors.

Therefore, once pregnancy occurs, obstetric care should be individualized according to the woman's complete risk profile.

Endometriosis and Recurrent Miscarriage

Some studies have reported an association between endometriosis and pregnancy loss.

But miscarriage has many causes, particularly chromosomal abnormalities related to maternal age.

A woman with recurrent miscarriages should therefore receive an appropriate recurrent-pregnancy-loss evaluation rather than automatically attributing every loss to endometriosis.

What Should a Couple Do If Pregnancy Has Not Occurred?

WHO defines infertility as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**.

However, waiting a full year is not appropriate for every patient.

Earlier fertility evaluation is reasonable when the woman has a known significant reproductive condition such as endometriosis, advanced reproductive age, low ovarian reserve, previous ovarian surgery or another major risk factor.

The exact timing should be individualized.

The Importance of Female Age

Age may be more important to fertility planning than the anatomical stage of endometriosis.

A 25-year-old woman with mild endometriosis and good ovarian reserve has a different reproductive situation from a 39-year-old woman with bilateral endometriomas and reduced AMH.

Even if both women have “Stage III endometriosis,” their best treatment strategy may be completely different.

This is why guidelines emphasize age, ovarian reserve and other fertility factors rather than simply disease stage.

The Importance of Ovarian Reserve Before Surgery

Before elective endometrioma surgery in a woman who wants children, I believe ovarian reserve deserves explicit discussion.

This is especially important before:

repeat ovarian surgery, bilateral surgery or surgery in a woman with already reduced reserve.

Recent 2025 and 2026 analyses continue to confirm measurable postoperative AMH reduction following cystectomy.

A patient should understand this risk before—not after—the operation.

Endometriosis and Infertility in the Unani System of Medicine

As a physician trained in the **Unani System of Medicine**, I believe endometriosis-related infertility requires both respect for traditional medical principles and careful recognition of what modern reproductive evidence does and does not support.

The first important point is:

Classical Unani terminology should not simply be equated with modern endometriosis.

Classical physicians described conditions involving painful menstruation, pelvic pain, uterine inflammation, abnormal menstrual flow and infertility.

CCRUM publications discuss traditional concepts of painful menstruation and pelvic inflammatory conditions, but these historical descriptions were developed before laparoscopy, high-resolution ultrasound, MRI and modern pathology.

Therefore, it would be scientifically inappropriate to say:

“Endometriosis is exactly this one classical Unani disease.”

The modern diagnosis should first be established accurately.

The Unani Principle of Cause-Oriented Treatment

The Unani therapeutic framework emphasizes treating a disease according to its nature and causes.

CCRUM officially describes four major treatment approaches:

Ilaj-bil-Tadbir — Regimental Therapy

Ilaj-bil-Ghiza — Dietotherapy

Ilaj-bil-Dawa — Pharmacotherapy

Ilaj-bil-Yad — Surgery

CCRUM's current research policy also includes '**Uqr — infertility**' among the areas of research interest in Unani medicine.

For me, this cause-oriented philosophy can be applied responsibly to endometriosis and infertility.

The woman may need different components depending on whether her main problem is pain, ovarian reserve, tubal distortion, an endometrioma, sexual pain, metabolic health or the need for assisted reproduction.

Ilaj-bil-Ghiza — Dietotherapy

Diet can support general health and may be especially helpful when the patient also has:

obesity, metabolic problems, anemia, constipation or poor nutritional habits.

A balanced diet can support:

healthy body weight, bowel function, nutritional adequacy and general well-being.

But I explain clearly:

There is currently no scientifically proven “endometriosis fertility diet” that removes lesions, opens blocked tubes or guarantees pregnancy.

ESHRE concluded that evidence is insufficient to recommend dietary or other non-medical interventions specifically for increasing fertility in women with endometriosis.

Therefore, dietary advice is supportive—not a replacement for fertility treatment.

Ilaj-bil-Tadbir — Lifestyle and Regimental Care

Unani regimental and lifestyle care can have a valuable supportive role.

An individualized programme may consider:



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sleep, activity, stress, bowel health, weight, mental well-being and pelvic comfort.

Women with chronic pelvic pain can also benefit from appropriate pelvic-floor physiotherapy and psychological support when indicated.

WHO recognizes multidisciplinary pain management—including physiotherapy and cognitive-behavioural approaches—as potentially useful for endometriosis-related pain and quality of life.

Again, pain improvement and fertility improvement are not identical outcomes.

Pelvic-Floor Care and Painful Intercourse

Some women with endometriosis develop hypertonic pelvic-floor muscles because intercourse and menstruation have been painful for years.

The pelvic floor begins to contract defensively.

This can make intercourse even more painful.

For a couple trying to conceive naturally, this can become a practical fertility problem because intercourse becomes stressful or impossible around ovulation.

Pelvic-floor treatment, sexual-health counselling and couple support can therefore be useful parts of an integrative reproductive plan.

Ilaj-bil-Dawa — Unani Pharmacotherapy

Unani medicine contains a large pharmacopeia traditionally used for menstrual, pelvic, inflammatory and reproductive complaints.

However, scientific transparency is essential.

At present, high-quality randomized evidence has not established a specific Unani formulation as a treatment that reliably removes endometriotic lesions or improves live-birth rates in women with endometriosis-associated infertility.

This does not mean an individualized Unani approach has no role.

It means its role must be described accurately.

It may be used as **supportive and integrative care** for appropriately selected symptoms and general health while the woman receives proper fertility assessment and, where necessary, gynecological surgery or assisted reproduction.



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Herbal Treatment During Fertility Therapy Requires Caution

This is especially important during:

ovulation induction, IUI, IVF, embryo transfer and early pregnancy.

A herbal medicine suitable before conception may not necessarily be appropriate after ovulation or after embryo transfer.

Some herbs may influence:

hormones, uterine activity, bleeding, liver enzymes or interactions with fertility medicines.

Therefore, all Unani and herbal preparations should be disclosed to the reproductive specialist.

“Natural” does not automatically mean safe during IVF or pregnancy.

Ilaj-bil-Yad — When a Structural Problem Requires Surgery

The inclusion of **Ilaj-bil-Yad, or procedural/surgical treatment**, within official Unani therapeutic principles is particularly relevant.

If dense adhesions prevent the tube from functioning, an herbal medicine cannot physically separate the organs.

If an endometrioma needs surgery because of a clear clinical indication, appropriate laparoscopic treatment may be necessary.

If deep endometriosis obstructs the ureter or significantly affects bowel or bladder structures, multidisciplinary surgery may be required.

A responsible integrative approach recognizes when the problem is structural.

Where I Believe Unani Medicine Is Most Useful in Endometriosis-Related Infertility

For me, the useful role lies primarily in **individualized supportive care around an accurate reproductive diagnosis**.

This can include helping the patient improve diet, sleep, weight, stress and general well-being; addressing associated menstrual and sexual-health complaints where appropriate; and supporting the woman emotionally through a condition that is often chronic.

But Unani treatment should not delay:



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fertility testing, expert imaging, investigation of low AMH, management of significant endometriomas, surgery for organ-threatening disease, treatment of severe male-factor infertility or timely IVF when reproductive age makes delay important.

That is what I consider responsible integrative medicine.

What I Do Not Recommend

I do not recommend telling every woman with endometriosis that she needs surgery.

I also do not recommend telling every woman that surgery should always be avoided.

I do not recommend suppressing ovulation for months when her immediate goal is natural pregnancy and there is no separate reason to do so.

I do not recommend ignoring the male partner.

And I do not recommend giving herbal or fertility medicines for years without assessing ovarian reserve and reproductive age.

The correct strategy depends on the patient.

My Individualized Approach at Saira Health Care

When a woman with endometriosis consults me about infertility, I do not begin by asking:

“Which medicine should we give?”

I begin by asking:

“What is preventing pregnancy in this particular couple?”

This distinction changes everything.

First: I Understand the Woman's Reproductive Timeline

I want to know her age, how long pregnancy has been attempted and whether she has ever conceived before.

At age 24, we may have considerably more reproductive time than at age 39.

The disease name may be the same, but the treatment urgency is not.

Second: I Understand the Endometriosis Phenotype

Is there superficial disease?

An ovarian endometrioma?

Bilateral ovarian disease?

Deep endometriosis?

Previous surgery?

Severe adhesions?

Painful intercourse?

Bowel or bladder involvement?

The location matters as much as the label.

Third: I Assess Ovarian Reserve

AMH and AFC can become especially important if ovarian disease or ovarian surgery is present.

If reserve is already low, I am particularly careful about recommending repeated ovarian operations unless there is a clear indication.

Fourth: I Evaluate Tubal Function

If natural conception or IUI is being considered, tubal function matters.

Severe tubal distortion can make repeated natural attempts unrealistic.

Fifth: I Evaluate the Male Partner

This step should happen early.

Semen analysis can completely change the treatment plan.

A woman should not undergo repeated procedures while severe male-factor infertility remains undiagnosed.

Sixth: I Address Sexual Pain

If intercourse is painful, fertility care should not simply instruct the couple:

“Have intercourse more often.”



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The pain itself needs treatment.

Pelvic-floor care, lubrication advice, psychosexual counselling, treatment of endometriosis-related pain and relationship support may all be relevant.

Seventh: I Decide Whether Time Should Be Given to Natural Conception

In a younger woman with good reserve, open tubes, mild disease and normal semen analysis, spontaneous conception may still be realistic.

In another patient, moving toward ART sooner may be much more appropriate.

This is where age, ovarian reserve, EFI and other fertility factors become central.

Eighth: I Use Unani Care as an Integrative Support Where Appropriate

My Unani approach focuses on the whole patient's health rather than claiming that one medicine will dissolve every lesion.

Diet, lifestyle, sleep, stress, menstrual-health support and carefully selected treatment can be individualized.

But I continue to monitor objective reproductive factors.

Ninth: I Refer for Specialist Gynecologic or Reproductive Treatment When Needed

Endometriosis surgery—particularly ovarian or deep bowel, bladder or ureteric disease—belongs with appropriately trained gynecologic/endometriosis surgeons.

IVF and ICSI require a reproductive-medicine and embryology team.

A comprehensive clinic should know when to coordinate care rather than trying to perform every part of the treatment itself.

The Contribution of Saira Health Care

Saira Health Care describes its clinical model as patient-centred and individualized, combining traditional knowledge and lifestyle guidance with contemporary diagnostic understanding, with a focused practice in sexual disorders and infertility. Its current public physician profile lists Dr. Nizamuddin Qasmi's reproductive-health training and credentials used in this article.



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For endometriosis-associated infertility, I consider the clinic's most useful contribution to be **connecting fertility with sexual health and couple-based evaluation**.

A woman may have endometriosis.

But her difficulty becoming pregnant may involve several simultaneous factors: endometriosis, low ovarian reserve, sexual pain, a tubal problem and an abnormal semen analysis.

Looking at only one factor risks incomplete treatment.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

His current Saira Health Care professional profile lists the following education and additional training:

BUMS – Hamdard University, Delhi

MD

CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

Saira Health Care's published profile describes a specialized clinical focus on sexual disorders and infertility, including male and female reproductive-health problems and individualized integration of Unani supportive care.

In complex endometriosis, this focused infertility role should complement—not replace—specialist gynecological, reproductive-endocrinology, endometriosis-surgery or IVF care when those services are required.

Endometriosis Does Not Mean You Must Go Straight to IVF

This is another common fear.

Some women can attempt natural conception.

Some may benefit from surgery first.

Some may be candidates for stimulated IUI.



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Others should proceed more directly to IVF.

The correct pathway depends upon the entire reproductive profile.

Current ESHRE guidance explicitly recognizes surgery and medically assisted reproduction as reasonable options but does not support one universal treatment pathway for every woman.

Nor Does Endometriosis Mean You Should Keep Trying Naturally Forever

The opposite mistake is equally problematic.

A woman in her late 30s with declining ovarian reserve should not necessarily spend several years repeatedly trying natural treatment because she hopes her endometriosis will disappear.

Reproductive time matters.

The aim should not be to avoid IVF at all costs.

The aim should be to choose the strategy offering the best realistic opportunity for that individual couple.

Frequently Asked Questions About Endometriosis and Infertility

Can endometriosis cause infertility?

Yes. Endometriosis can reduce fertility through adhesions and altered pelvic anatomy, ovarian/endometrioma effects, inflammation, oxidative stress, altered oocyte competence and other reproductive mechanisms.

Does every woman with endometriosis become infertile?

No. Many women with endometriosis become pregnant naturally.

How common is endometriosis?

WHO estimates that it affects around 10% of reproductive-age women worldwide.

How common is endometriosis among infertile women?

WHO reports that endometriosis may occur in approximately 25–50% of women with infertility.

Can endometriosis exist without severe pain?

Yes. Some women have little pain and first discover the disease during infertility evaluation.

Can ultrasound diagnose endometriosis?

Expert ultrasound can identify ovarian endometriomas and many forms of deep endometriosis. Superficial disease may remain difficult to visualize.

Do I always need laparoscopy to diagnose endometriosis?

No. Current guidance increasingly uses symptoms and expert imaging before considering laparoscopy. Laparoscopy remains useful in selected cases, including when imaging is normal but clinical suspicion persists or when treatment is planned.

Is CA-125 a diagnostic test for endometriosis?

No. NICE specifically advises against using CA-125 to diagnose endometriosis.

Can endometriosis lower AMH?

Ovarian disease may be associated with reduced ovarian reserve in some women, but ovarian surgery itself is an especially important contributor to postoperative AMH decline.

Can endometrioma surgery reduce ovarian reserve?

Yes. Meta-analyses consistently show a fall in AMH following cystectomy, which is particularly relevant in women with bilateral disease or previous surgery.

Should every endometrioma be removed before IVF?

No. ESHRE advises against routine endometrioma surgery before ART solely to improve live birth because benefit has not been shown and surgery may reduce ovarian reserve.

What does the latest evidence say?

A 2026 meta-analysis of 3,590 women found that surgery before IVF/ICSI did not significantly improve live birth for ovarian endometrioma or deep endometriosis, while ovarian endometrioma surgery was associated with lower AMH and fewer retrieved eggs.

Can surgery help natural pregnancy?

Yes, particularly in selected women with minimal/mild disease or surgically correctable pelvic disease. The expected benefit varies with age, reserve and other factors.

Can repeated surgery reduce fertility?

It can. A 2026 meta-analysis found better reproductive outcomes following primary surgery than repeat surgery, supporting careful consideration before re-operation.

Can hormonal medicines cure infertility caused by endometriosis?

Hormonal suppression can control pain but should not be prescribed solely to increase spontaneous pregnancy in a woman actively trying to conceive.

Can IUI help?

Stimulated IUI can be considered particularly in selected women with Stage I/II disease, open tubes and no severe male factor.

When is IVF appropriate?

IVF becomes particularly relevant when tubes are significantly compromised, ovarian reserve or age makes delay undesirable, male-factor infertility is present, EFI is low or previous treatment has failed.

Does endometriosis mean IVF will fail?

No. Endometriosis may reduce ovarian response or oocyte competence in some patients, but many women with endometriosis achieve successful pregnancies through IVF.

Should I freeze my eggs?

Not every woman with endometriosis needs fertility preservation. ESHRE recommends discussing the advantages and disadvantages particularly in extensive ovarian endometriosis.

Can pregnancy cure endometriosis?

No. Pregnancy should not be prescribed as a treatment for endometriosis.

Can Unani medicine treat endometriosis-related infertility?

Unani medicine can provide **individualized supportive care** through diet, lifestyle, menstrual-health support, stress management and appropriately selected treatment. However, high-quality evidence does not currently demonstrate that a specific Unani formulation reliably removes endometriosis lesions or increases live-birth rates. It should therefore complement rather than delay appropriate fertility and gynecological care.

A Message to My Patients

When a woman asks me:

“Doctor, I have endometriosis. Will I ever become pregnant?”

I do not want her to leave with either false hope or unnecessary fear.

I want her to understand that endometriosis is only one part of the fertility equation.



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We need to know:

how old she is,
how long she has been trying,
whether her ovaries still have a good reserve,
whether one or both ovaries contain endometriomas,
whether she has already had surgery,
whether her tubes can function,
whether intercourse is painful,
and whether her husband's semen is normal.

Then we can make a meaningful plan.

Another woman may ask:

“Should I remove my ovarian endometrioma before IVF?”

My answer is not automatically yes.

We now have good evidence that routine surgery before IVF does not improve live birth in every woman and may reduce ovarian reserve.

Another patient may ask:

“Can I treat everything naturally for one or two years first?”

If she is young, has good reserve and mild disease, there may sometimes be time for a conservative approach.

If she is approaching the end of her reproductive window, has low AMH and bilateral endometriomas, losing two years may be far more significant than the choice of any particular medicine.

That is why individualization matters.

The Central Principle: Treat the Patient, Not the Scan

An ultrasound report may say:

“Endometrioma 4 cm.”

That number does not tell me:

the woman's age,



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her ovarian reserve,
whether she has severe pain,
whether the opposite ovary is healthy,
whether she has already had ovarian surgery,
whether the tubes are open,
or whether her husband has severe male infertility.
Therefore, the scan cannot make the fertility decision by itself.
Likewise, Stage IV does not automatically mean IVF.
Stage I does not automatically mean natural conception.
AMH does not automatically mean pregnancy.
And surgery does not automatically mean cure.

Conclusion

Endometriosis and infertility have a complex relationship, but a diagnosis of endometriosis is not a diagnosis of permanent infertility.

Endometriosis can reduce fertility through several mechanisms: distortion of pelvic anatomy, adhesions, impaired tubal function, ovarian endometriomas, inflammation, oxidative stress, possible impairment of oocyte competence and alterations in the reproductive environment. Recent 2025–2026 research continues to support a multifactorial rather than one-cause model.

The most important modern principle is:

Treatment must be individualized.

Current ESHRE and updated NICE guidance support surgery in selected women seeking natural conception, particularly for minimal/mild disease and certain endometriomas, while emphasizing age, ovarian reserve, pain, prior surgery, other infertility factors and patient preference.

At the same time, surgery should not be performed automatically before assisted reproduction.

The newest 2026 evidence shows no clear live-birth advantage from surgery before IVF/ICSI for ovarian endometrioma or deep endometriosis and demonstrates a potential cost to ovarian reserve and oocyte yield.



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This makes ovarian-reserve preservation particularly important.

Repeated surgery also deserves caution, with 2026 evidence suggesting poorer reproductive outcomes after re-operation compared with primary surgery.

Hormonal suppression is valuable for endometriosis-related pain but **does not improve spontaneous pregnancy rates when used simply as fertility treatment in a woman actively trying to conceive.**

IUI can be useful for selected mild cases.

IVF or IVF/ICSI can be appropriate when tubal damage, age, reduced reserve, low EFI, male-factor infertility or previous treatment failure makes natural conception less likely.

From the **Unani perspective**, the therapeutic principles of **Ilaj-bil-Ghiza, Ilaj-bil-Tadbir, Ilaj-bil-Dawa and Ilaj-bil-Yad** provide a useful framework for individualized care. CCRUM also includes infertility among areas of Unani research.

The most scientifically responsible role of Unani medicine in endometriosis-associated infertility is as **integrative supportive care**—helping address diet, general health, lifestyle, stress, associated menstrual and sexual-health concerns and overall well-being while modern fertility investigation identifies structural, ovarian, tubal, surgical and assisted-reproduction needs.

At **Saira Health Care**, my preferred approach can be summarized in one principle:

Do not treat “endometriosis” as one identical disease in every woman. Identify how it is affecting this woman's fertility, protect her ovarian reserve, assess her partner, correct what can reasonably be corrected and use natural conception, surgery or assisted reproduction at the time that best fits the couple's reproductive circumstances.

When a patient asks me:

“Can I become a mother despite endometriosis?”

the answer is not determined by the word *endometriosis* alone.

It depends on the complete reproductive picture.

And that complete picture—not fear, not a single scan and not a single AMH result—should guide treatment.

Saira Health Care

Dr. Nizamuddin Qasmi — Founder & Chief Physician

Focused Practice in Sexual Disorders & Infertility

Medical Disclaimer: This article is intended for medical education and general patient awareness. Endometriosis-associated infertility requires individualized assessment.



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Patients should not start, stop or delay hormonal treatment, Unani medicines, herbal products, surgery, IUI, IVF/ICSI or fertility-preservation treatment solely on the basis of online information. Endometrioma and deep-endometriosis surgery should be considered with appropriate gynecological/endometriosis expertise, particularly when fertility and ovarian reserve are important. No conventional, surgical, Unani, herbal or assisted-reproductive treatment can guarantee pregnancy or live birth.



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