

Fertility Preservation for Men

Sperm Banking, Cryopreservation, Onco-TESE, Fertility Protection Before Cancer Treatment and an Integrative Unani Approach

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When I speak with a young man who is about to undergo chemotherapy, radiotherapy, removal of a testicle or another treatment that may affect his fertility, one question becomes extremely important:

“Have we discussed your future fertility before treatment begins?”

Sometimes the patient is unmarried.

Sometimes he is only eighteen or twenty years old.

Sometimes he says:

“Doctor, right now I only want to treat my disease. I will think about children later.”

That reaction is completely understandable.

When someone has just been diagnosed with cancer or another serious disease, future fertility can feel less important than immediate treatment.

But fertility preservation exists precisely because the patient may think very differently ten years later.

A man who is not interested in fatherhood at age 20 may strongly wish to have biological children at age 30.

By that time, however, chemotherapy, radiotherapy, surgery or another treatment may have permanently reduced sperm production.

Modern fertility-preservation practice therefore aims to protect reproductive choices **before those choices are lost.**

The 2025 American Society of Clinical Oncology guideline specifically recommends evaluating and counselling people with cancer about reproductive risks **at diagnosis and again during survivorship**, and recommends offering sperm cryopreservation to males before cancer-directed treatment.

Similarly, the American Society for Reproductive Medicine's 2026 guidance states that people facing medical treatments capable of damaging future fertility should receive **prompt fertility-preservation counselling and access to appropriate preservation services.**



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My message to patients is therefore very simple:

Fertility preservation does not mean that you must decide today whether you want children. It means preserving the possibility that you may want them in the future.

At **Saira Health Care**, my role in such patients is to evaluate reproductive risk, explain available fertility-preservation options, assess semen and hormonal function, and coordinate appropriately with oncology, urology, reproductive medicine and IVF services.

Where clinically appropriate, Unani principles may support the man's general reproductive health.

But no herbal or Unani treatment should replace sperm cryopreservation when a patient's future sperm production is genuinely at risk.

What Is Male Fertility Preservation?

Fertility preservation means taking steps to protect or store reproductive cells before an illness or medical treatment damages a man's ability to father biological children.

For post-pubertal males, the most established method is:

Sperm Cryopreservation

also commonly called:

- sperm banking,
- semen freezing,
- semen cryopreservation.

The National Cancer Institute defines sperm banking as collecting sperm, assessing it in the laboratory, freezing it and storing it for possible future reproductive use.

Later, frozen sperm may be used through:

- intrauterine insemination in suitable cases,
- IVF,
- ICSI.

When sperm cannot be obtained through ejaculation, sperm can sometimes be retrieved surgically from the testis and frozen.

Fertility Preservation Is Different From Infertility Treatment



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This distinction is important.

Infertility treatment

Attempts to overcome a fertility problem that already exists.

For example:

- treatment of varicocele,
- hormonal treatment,
- IVF/ICSI,
- sperm retrieval for azoospermia.

Fertility preservation

Attempts to protect reproductive potential **before it is lost**.

For example:

A man has normal sperm today but will soon receive highly gonadotoxic chemotherapy.

Instead of waiting to see whether he becomes infertile afterward, sperm can be frozen before treatment.

This is proactive reproductive medicine.

Who Should Consider Fertility Preservation?

Fertility preservation may be relevant whenever a man's future sperm production, ejaculation or reproductive anatomy is likely to be compromised.

Important situations include:

- chemotherapy,
- pelvic or testicular radiotherapy,
- total-body irradiation,
- stem-cell transplantation,
- removal of one or both testes,
- selected pelvic or retroperitoneal surgery,
- severe progressive male-factor infertility,
- certain genetic infertility conditions when rare sperm are still present,
- medical treatment expected to suppress spermatogenesis,



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- gonadectomy,
- selected gender-affirming treatment when future biological parenthood may matter.

ASRM's 2026 guidance also lists non-cancer medical indications such as certain hematological, rheumatological and autoimmune diseases when their treatment carries reproductive risk.

The exact need depends upon the treatment—not simply the disease name.

Why Should Fertility Be Discussed Before Treatment?

Because once sperm-producing cells are destroyed, they cannot always be restored.

Chemotherapy and radiation therapy can damage:

- mature sperm,
- developing sperm cells,
- spermatogonial stem cells,
- hormonal pathways regulating the testes.

Surgery can also remove reproductive structures or interfere with ejaculation.

NCI guidance states that changes in male fertility after cancer treatment may be **temporary or permanent**, depending upon treatment type, dose, duration, age, cancer site, baseline fertility and time since treatment.

Therefore, the safest fertility-preservation strategy is usually:

preserve sperm before exposure occurs.

Why Fertility Preservation Matters Even for an Unmarried Man

This is one of the most important counselling points.

A young unmarried man may say:

“I do not have a wife, so why should I freeze sperm?”

Because sperm banking preserves his **future option**, not his present family situation.

The frozen sperm remain his reproductive material.

If he later decides to have biological children, those preserved sperm may provide reproductive opportunities that his post-treatment sperm production can no longer provide.

Current ASCO recommendations therefore base counselling on potential future reproductive goals—not marital status.

Fertility Preservation Should Not Delay Life-Saving Treatment Unnecessarily

Cancer treatment always remains the priority.

Fertility preservation should be organized rapidly and efficiently.

The purpose is not to postpone necessary oncology treatment for weeks.

For post-pubertal males, sperm banking is particularly practical because semen can usually be collected without a prolonged treatment cycle.

AUA/ASRM guidance notes that even a few days before gonadotoxic treatment may allow collection of one or more semen samples or surgical sperm retrieval where ejaculation is unsuccessful.

When cancer treatment is genuinely urgent, fertility specialists and oncologists should coordinate rather than allowing fertility preservation to create unsafe delay.

Sperm Cryopreservation — The Standard Fertility-Preservation Method for Men

For post-pubertal males, ejaculated sperm cryopreservation is the best-established fertility-preservation technique.

ASRM's 2026 recommendation describes ejaculated semen cryopreservation as an **established technology** for adult men and adolescents who have completed sufficient puberty to produce sperm.

The process is relatively straightforward.

The patient provides semen.

The laboratory evaluates the sperm.

A cryoprotective solution is added.

The specimen is divided into storage portions.

The samples are frozen and maintained at extremely low temperatures.



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Later, when reproduction is desired, a sample can be thawed and used in fertility treatment.

How Is a Sperm Sample Collected?

The usual method is masturbation into a sterile collection container.

Patients sometimes feel embarrassed about this process.

I explain that fertility laboratories handle these samples routinely and professionally.

The objective is medical.

Privacy should be provided.

For patients unable to masturbate because of illness, pain, anxiety, neurological disease or other difficulties, alternative collection methods may be available.

What If the Patient Cannot Ejaculate?

This does not automatically prevent fertility preservation.

ASRM describes several possibilities for medically assisted sperm collection, including selected use of:

- medication for erectile problems,
- penile vibratory stimulation,
- electroejaculation,
- sperm recovery in retrograde ejaculation,
- surgical sperm retrieval.

The method depends on the reason ejaculation is difficult.

Penile Vibratory Stimulation

In selected neurological conditions, vibration can stimulate the ejaculatory reflex.

This is particularly useful in some men with spinal-cord injury.

The collected semen can then be evaluated and frozen.



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Electroejaculation

Electroejaculation uses controlled electrical stimulation to trigger ejaculation in selected patients who cannot otherwise ejaculate.

NCI recognizes electroejaculation as a possible sperm-collection strategy when neurological damage or another condition prevents normal ejaculation.

It is performed in specialist settings.

Retrograde Ejaculation

In retrograde ejaculation, semen enters the bladder rather than emerging normally through the urethra.

This may occur after:

- diabetes-related nerve injury,
- certain operations,
- some medications.

In selected cases, sperm can be recovered from post-ejaculatory urine and preserved or used in assisted reproduction.

What If No Sperm Are Present in the Ejaculate?

This depends upon why sperm are absent.

If sperm production exists but ejaculation is impossible or the reproductive ducts are blocked, sperm may often be retrieved directly.

If the testes themselves produce very few sperm, surgical retrieval may still sometimes be possible.

Techniques include:

- TESA,
- TESE,
- micro-TESE,
- epididymal sperm retrieval in obstructive cases.

The exact method should match the underlying condition.



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What Is TESE?

TESE means:

Testicular Sperm Extraction.

A small sample of testicular tissue is surgically obtained.

The laboratory then searches that tissue for sperm.

When sperm are found they may be:

- used immediately,
- frozen for future IVF/ICSI.

NCI recognizes TESE as an option for males who cannot provide semen, have very low sperm numbers or have azoospermia in selected settings.

What Is Onco-TESE?

Onco-TESE means sperm retrieval performed in the setting of cancer treatment.

It becomes particularly useful when:

- a man cannot provide an ejaculated semen sample,
- he is azoospermic before therapy,
- sperm numbers are too low to bank adequately,
- testicular surgery is about to be performed.

ASRM's 2026 guidance identifies Onco-TESE as an established surgical fertility-preservation strategy for appropriate males who cannot obtain adequate sperm through ejaculation.

Onco-TESE During Testicular Cancer Surgery

This is a particularly important scenario.

A man may have testicular cancer and already be azoospermic before his cancer treatment begins.

If the affected testicle is being removed, sperm may sometimes be recovered from appropriate testicular tissue at or immediately after orchiectomy.

ASRM describes successful extraction from the removed affected testis on a sterile back table in selected azoospermic patients.



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For some men, this may represent the only opportunity to preserve their own sperm.

Testicular Cancer Can Reduce Fertility Even Before Treatment

This is why fertility counselling should occur early.

Some men with testicular cancer already have:

- low sperm concentration,
- poor semen quality,
- or azoospermia

before chemotherapy is given.

Current EAU guidance notes substantial pretreatment semen abnormalities among men with testicular germ-cell cancer and recommends offering sperm cryopreservation before gonadotoxic treatment or surgery likely to impair fertility.

Therefore:

do not assume that fertility preservation can always wait until after the testicle is removed.

How Many Sperm Samples Should Be Frozen?

When time and health allow, obtaining more than one sample is generally preferable.

ASRM's 2026 guidance recommends attempting multiple semen collections when feasible because having more cryopreserved sperm increases future reproductive options.

AUA/ASRM similarly encourages banking multiple specimens before gonadotoxic treatment when possible.

However:

even one useful sample can be very valuable.

This is especially true because ICSI can work with much smaller sperm numbers than natural conception or IUI.

“My Sperm Count Is Already Low—Is Freezing Still Worthwhile?”

Often yes.



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Patients sometimes assume that sperm banking is only useful when sperm count is completely normal.

That is incorrect.

Even semen with:

- oligospermia,
- poor motility,
- severe male-factor abnormality

may still contain usable sperm.

If the total sperm quantity is insufficient for IUI, cryopreserved sperm may still potentially be used with IVF/ICSI.

In selected men with extremely low counts, repeated collections may be pooled or frozen separately.

The laboratory and reproductive physician can advise what is realistic.

Even Rare Sperm Can Be Valuable

Suppose a man has only a few hundred thousand sperm per millilitre.

Natural conception may be difficult.

But IVF with ICSI requires dramatically fewer sperm because an embryologist injects one selected viable sperm into each mature egg.

Therefore, low sperm numbers do not automatically mean preservation is pointless.

This is especially relevant in:

- severe oligospermia,
 - cryptozoospermia,
 - selected genetic infertility.
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What Is Cryptozoospermia?

Cryptozoospermia means that sperm are so rare that they may not appear during ordinary initial examination but can sometimes be detected after the sample is centrifuged and examined carefully.



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For a man at risk of losing sperm production, identifying even a very small number can create an opportunity for cryopreservation.

A high-quality andrology laboratory is important.

When Is Sperm Cryopreservation Particularly Urgent?

I consider it particularly important when the patient has:

- cancer requiring chemotherapy,
- anticipated testicular or pelvic radiation,
- total-body irradiation,
- bone-marrow or stem-cell transplant conditioning,
- bilateral or potentially bilateral testicular surgery,
- removal of the only functioning testicle,
- rapidly deteriorating sperm production,
- rare sperm in a condition that may progress to azoospermia.

The urgency depends on the underlying disease.

Chemotherapy and Fertility Preservation

Chemotherapy may damage rapidly dividing germ cells.

The risk varies according to:

- drug,
- dose,
- number of cycles,
- combination regimen.

Alkylating drugs are among the most established causes of severe gonadotoxicity.

NCI specifically identifies alkylating agents as high-risk treatments for male fertility because they can injure both sperm and the cells responsible for producing future sperm.

Therefore:

sperm should ideally be preserved before chemotherapy begins.



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Why Banking Sperm After Chemotherapy Starts Is Less Desirable

Once gonadotoxic treatment begins, sperm may have been exposed to therapy capable of inducing genetic damage.

The 2025 ASCO guideline warns that sperm collected soon after the initiation or completion of cancer treatment may carry increased treatment-related genetic damage.

ASRM's 2026 guidance notes that many centres avoid using sperm collected after chemotherapy or radiotherapy has begun unless no better option exists.

That is why pre-treatment preservation is preferable.

Radiotherapy and Fertility Preservation

The testes are particularly sensitive to radiation.

Potential fertility risk arises from:

- direct testicular radiation,
- pelvic radiation,
- abdominal or retroperitoneal scatter,
- total-body irradiation.

Radiation to the brain can also affect fertility indirectly by damaging the hypothalamus or pituitary gland that controls FSH and LH.

NCI recognizes each of these pathways as potential mechanisms of treatment-related male infertility.

Sperm cryopreservation should therefore be discussed before clinically meaningful gonadal radiation exposure.

Testicular Shielding

When technically possible without compromising cancer treatment, the testes can sometimes be shielded from unnecessary scatter radiation.

NCI recognizes **testicular or gonadal shielding** as a fertility-protection technique during selected radiation treatments.

The purpose is to reduce avoidable exposure.



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Cancer treatment must never be made less effective merely to protect fertility.

Stem-Cell Transplantation

Patients undergoing hematopoietic stem-cell or bone-marrow transplantation frequently receive:

- high-dose chemotherapy,
- total-body irradiation,
- or both.

These treatments carry a high risk of profound fertility impairment.

Therefore, male fertility preservation should ideally occur **before transplant conditioning begins**.

Non-Cancer Diseases May Also Require Fertility Preservation

Cancer is the best-known indication, but it is not the only one.

ASRM identifies other medical conditions in which treatment may expose reproductive cells to gonadotoxic agents, including selected:

- hematologic disorders,
- rheumatological diseases,
- autoimmune diseases.

Examples may include patients requiring:

- cytotoxic immunosuppressive therapy,
- stem-cell transplantation,
- other treatments known to impair gonadal function.

The relevant question is:

Will this disease or its treatment threaten future spermatogenesis?

If yes, fertility preservation should be discussed.

Sickle Cell Disease and Thalassemia



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Some patients with severe hematological disorders may undergo:

- intensive chemotherapy,
- bone-marrow transplantation.

The conditioning treatments rather than the blood disorder alone may present major reproductive risk.

When future biological parenthood is important, preservation should be discussed before gonadotoxic therapy.

Autoimmune and Rheumatological Disease

Certain severe autoimmune diseases may require cyclophosphamide or other agents capable of damaging germ cells.

A young male receiving such treatment deserves the same fertility discussion as a cancer patient receiving an equivalent gonadotoxic drug.

Fertility preservation should therefore be based upon **reproductive risk**, not on whether the disease is malignant.

Fertility Preservation Before Removal of the Testes

Removal of both testes permanently eliminates sperm and natural testosterone production.

Therefore, sperm preservation should be discussed whenever bilateral orchidectomy or removal of the only functioning testis is anticipated and biologically usable sperm may still be available.

Where sperm are absent from semen, surgical retrieval can sometimes be coordinated with surgery.

Before Certain Pelvic or Retroperitoneal Operations

Some operations can impair ejaculation rather than sperm production.

Retroperitoneal lymph-node dissection, for example, can injure sympathetic pathways important for emission and ejaculation.

AUA/ASRM specifically recommends counselling men undergoing such surgery regarding the risk of aspermia.



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Preserving sperm beforehand can provide reproductive security.

Fertility Preservation Before Testosterone Therapy

This is another area where patients frequently receive incomplete information.

External testosterone can suppress:

- LH,
- FSH,
- intratesticular testosterone,

and thereby reduce sperm production.

Some men become severely oligospermic or azoospermic.

Current AUA/ASRM guidance states that **exogenous testosterone should not be prescribed to a man interested in current or future fertility without addressing its reproductive consequences.**

EAU guidance similarly recommends against testosterone therapy as treatment in men who wish to father children.

A man who is considering long-term testosterone treatment but wants future fertility should therefore discuss:

- fertility-preserving endocrine alternatives,
 - baseline semen analysis,
 - sperm cryopreservation in selected circumstances.
-

Bodybuilding Steroids Can Also Threaten Future Fertility

Anabolic steroids act similarly to external testosterone.

They suppress the hypothalamic-pituitary-testicular axis.

A man may progress from normal semen to:

- severe oligospermia,
- azoospermia.

Recovery often occurs after stopping, but may require many months and is not guaranteed to be complete in every patient.



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Men should not use anabolic steroids casually and assume future sperm production will always return.

Fertility Preservation and Gender-Affirming Treatment

For individuals with testes who are considering gender-affirming hormone therapy or gonadectomy, future biological parenthood should be discussed before treatment if it could be important to them.

ASRM's 2026 guidance notes that gender-affirming hormone therapy may reduce reproductive potential and that removal of the gonads produces permanent infertility; major professional organizations therefore recommend fertility counselling before treatment.

Sperm cryopreservation can preserve future reproductive options.

Care should be individualized and respectful of the patient's goals.

Severe Progressive Male Infertility

Fertility preservation can also be useful in selected men whose sperm production appears likely to deteriorate.

Examples may include:

- extremely severe oligospermia,
- cryptozoospermia,
- selected genetic conditions,
- testicular disease before potentially damaging surgery.

If only a few viable sperm remain, freezing them may protect against future progression to azoospermia.

This decision should be made after appropriate diagnosis rather than freezing sperm solely because one mildly abnormal semen result was obtained.

Klinefelter Syndrome and Fertility Preservation

Most men with classic 47,XXY Klinefelter syndrome are azoospermic, but a small proportion—particularly mosaic patients—may occasionally have sperm in the ejaculate.



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When ejaculated sperm are identified, cryopreservation should be discussed because future samples may not contain sperm.

Azoospermic men may instead require specialist assessment for testicular sperm retrieval.

Fertility preservation should be individualized rather than assuming every adolescent patient requires invasive surgery.

Y-Chromosome AZFc Deletion

Some men with an AZFc deletion have:

- severe oligospermia,
- cryptozoospermia

before eventually developing azoospermia.

If viable ejaculated sperm are available, cryopreservation can therefore be especially valuable.

The sperm remain genetically affected, however, and male offspring can inherit the affected Y chromosome.

Genetic counselling remains essential.

Before Vasectomy

Some men considering permanent contraception ask whether they should bank sperm beforehand.

Vasectomy is intended as permanent contraception even though reversal or surgical sperm retrieval may sometimes be possible.

A man who is uncertain about future biological parenthood should resolve that uncertainty before proceeding.

Elective sperm banking can be discussed if he wants a reproductive backup option.

It should not, however, be used to make a man comfortable with vasectomy if he is fundamentally uncertain about permanent contraception.

Fertility Preservation in Adolescents

Adolescent fertility preservation requires sensitive communication.

A young patient may feel embarrassed or frightened.

The discussion should be age appropriate.

The 2025 ASCO guideline states that established fertility-preservation methods should be offered to children and adolescents who have entered puberty when medically appropriate, with appropriate involvement of the young person and parent or guardian.

If mature sperm are being produced, semen cryopreservation is usually the preferred option.

“He Is Only 14—Can He Really Produce Sperm?”

Chronological age does not perfectly predict reproductive maturity.

Some boys who have begun puberty can produce sperm even before they appear fully physically mature.

Assessment should therefore consider pubertal development rather than age alone.

A fertility specialist experienced with adolescents can guide this process.

What If an Adolescent Cannot Produce a Semen Sample?

The reasons may include:

- anxiety,
- embarrassment,
- developmental maturity,
- illness,
- pain,
- inability to ejaculate.

Specialist counselling can help.

In selected cases, medically assisted ejaculation or surgical sperm retrieval may be considered.

Fertility Preservation Before Puberty

Prepubertal boys do not yet produce mature ejaculated sperm.



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Therefore, standard sperm banking cannot be performed.

Researchers are studying:

Testicular Tissue Cryopreservation

A small amount of testicular tissue containing immature germ cells is removed and frozen.

The hope is that future technologies may eventually allow these cells to generate mature sperm.

However, an extremely important distinction must be made.

Testicular Tissue Freezing in Prepubertal Boys Is Still Experimental

The **2025 ASCO guideline** classifies testicular tissue cryopreservation in prepubertal boys as experimental and recommends offering it within clinical trials.

ASRM's **2026 guidance likewise considers it investigational** because there is not yet an established clinical method for turning preserved prepubertal testicular tissue into mature sperm that can routinely produce pregnancies.

Parents should therefore receive realistic counselling.

The procedure preserves biological material for possible future technologies.

It does not currently guarantee future fertility.

Testicular Tissue Banking Should Not Be Marketed as a Guaranteed Future Baby

This is important.

Scientific research is progressing rapidly.

But experimental fertility preservation must be described as experimental.

Parents should understand:

- what is currently possible,
- what remains theoretical,
- the surgical risks,
- storage requirements,
- uncertainty about future clinical use.



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Hope should be combined with transparency.

What Happens in the Laboratory During Sperm Freezing?

After collection, semen is evaluated for:

- volume,
- sperm concentration,
- motility,
- other relevant characteristics.

A special cryoprotectant is added to reduce freezing injury.

The semen is divided into labelled storage containers.

It is cooled and maintained in cryogenic conditions.

ASRM laboratory guidance emphasizes strict identification, storage monitoring, documentation and temperature control because cryopreserved gametes may be irreplaceable.

Do All Sperm Survive Freezing and Thawing?

No.

Some sperm lose motility or viability during the freeze-thaw process.

This is expected.

The important question is whether enough viable sperm remain for the intended treatment.

A sample with excellent sperm numbers may later be suitable for IUI.

A very limited sample may be reserved for IVF/ICSI.

EAU patient guidance similarly notes that not every frozen sperm survives thawing, although many remain suitable for fertility treatment.

How Long Can Frozen Sperm Be Stored?

Under correctly controlled cryogenic conditions, sperm can be preserved for very long periods without ordinary biological ageing.



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NCI describes sperm as capable of being stored for an indefinite period under appropriate cryopreservation conditions.

In practice, storage duration, renewal, consent and disposal procedures are also governed by:

- clinic policy,
- applicable regulations,
- patient consent.

Patients should review these details when banking sperm.

Does Frozen Sperm Become “Old”?

Not in the same way sperm inside an ageing man's body does.

Cryogenic storage essentially suspends cellular metabolism.

The more important concerns are:

- sperm quality before freezing,
 - survival after thawing,
 - female partner's reproductive factors when the sperm are eventually used.
-

How Are Frozen Sperm Used Later?

The fertility technique depends largely upon the number and quality of sperm available after thawing.

IUI

May be possible when an adequate number of motile sperm are available.

Conventional IVF

May be used when sufficient sperm quality exists, although severe male-factor cases often require ICSI.

ICSI

One viable sperm is injected directly into each mature egg.

For patients with extremely limited frozen sperm, surgically retrieved sperm or very low sperm concentration, ICSI is usually the most efficient reproductive technique.



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One Frozen Sample Can Sometimes Be Enough

Patients sometimes worry:

“I could only give one sample before chemotherapy.”

One sample may still be very valuable.

Modern laboratory techniques can divide specimens into multiple cryopreserved units.

If sperm numbers are limited, IVF with ICSI may allow very small quantities to be used efficiently.

The reproductive team can advise how many potential treatment attempts a specimen might support.

Why Multiple Samples Are Still Better

More samples provide greater flexibility.

They may allow:

- several IUI attempts,
- several IVF/ICSI cycles,
- backup if part of a sample does not survive thawing adequately.

Therefore, multiple collections are preferred when treatment urgency allows.

Does Sperm Freezing Reduce the Chance of Pregnancy?

Cryopreservation does affect some sperm characteristics, particularly motility.

But frozen sperm are routinely used successfully in assisted reproduction.

For many patients, the relevant comparison is not:

fresh sperm versus frozen sperm.

It is:

frozen sperm available in the future versus no usable sperm available at all.

That makes preservation extremely valuable.

Does Freezing Increase Birth Defects?



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Modern sperm cryopreservation has been used for decades.

Available experience with cryopreserved sperm has generally been reassuring.

The more important genetic concern arises when sperm are collected **after exposure to mutagenic chemotherapy or radiation**, which is why pretreatment collection is preferred.

Can Sperm Be Banked After Cancer Treatment?

Possibly, but timing matters.

If spermatogenesis returns later and sperm are present, cryopreservation can be considered.

This can be valuable because future sperm production may fluctuate.

However, sperm collected during or immediately after gonadotoxic therapy raises additional concerns about treatment-related DNA damage.

The 2025 ASCO guidance recommends counselling men about this risk.

When Can a Man Try for Pregnancy After Chemotherapy or Radiotherapy?

There is no single rule applicable to every cancer and every treatment.

The 2024 AUA/ASRM male infertility guidance recommends avoiding conception for at least **12 months after chemotherapy or radiotherapy** because of concern about treatment-related germ-cell mutations.

Other oncology recommendations may differ according to the cancer and therapy.

The final timing should therefore come from the treating:

- oncologist,
- reproductive specialist.

Do not rely on a universal internet waiting period.

Fertility Should Be Reassessed During Survivorship

Fertility preservation is not only a conversation before treatment.

The 2025 ASCO update specifically recommends revisiting reproductive goals during survivorship.

A man who froze sperm at twenty may later want to know:

- Has natural sperm production recovered?
- Should I use my frozen sperm?
- Can we try naturally?
- Do we need IVF?
- Should I continue paying for storage?

These questions can be addressed with updated reproductive assessment.

Semen Analysis After Gonadotoxic Treatment

AUA/ASRM recommends informing patients that semen analysis used to judge recovery after chemotherapy or radiation is generally most informative at **12 months or later and preferably around 24 months**, because spermatogenic recovery can take time.

This does not mean no one should test earlier.

Earlier testing may answer specific questions.

But an early azoospermia result is not necessarily the final outcome.

Sperm Production Can Sometimes Recover

Cancer survivors should not automatically assume infertility is permanent.

Depending upon treatment, spermatogonial stem cells may survive and gradually repopulate the testes.

Some men recover:

- low sperm numbers,
- then progressively better counts.

Others remain azoospermic.

Treatment history and time matter.

Cryopreserved Sperm Remain Valuable Even if Natural Fertility Recovers

A man may eventually regain sufficient sperm production for natural conception.

His frozen sperm are then simply a reproductive backup.



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That does not mean preserving them was unnecessary.

No physician can reliably predict before chemotherapy which particular patient will recover completely.

Fertility preservation is therefore a form of reproductive insurance against uncertainty.

Fertility Preservation and Genetic Disorders

Some men have progressive genetic infertility rather than treatment-induced infertility.

For example, a man with selected Y-chromosome abnormalities may still have rare sperm today but could later become azoospermic.

Cryopreservation may preserve those sperm.

However, genetic counselling remains important because cryopreservation does not remove the underlying genetic abnormality.

Fertility Preservation Does Not Correct Genetic Risk

Suppose a man has an AZFc deletion.

Freezing sperm preserves sperm availability.

It does not remove the deleted chromosome region.

A future son conceived from affected sperm may inherit the abnormal Y chromosome.

Likewise, sperm banking from a man with a hereditary cancer syndrome preserves fertility but does not automatically eliminate inherited cancer risk.

Genetic counselling and, in selected families, preimplantation genetic testing may need to be discussed.

Psychological Importance of Fertility Preservation

A fertility-preservation decision is not merely technical.

Patients may feel:

- frightened,
- embarrassed,
- overwhelmed,



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- pressured to make decisions quickly.

An unmarried adolescent may find sperm banking emotionally difficult.

A cancer patient may think that discussing future parenthood feels inappropriate while facing a serious disease.

These reactions deserve respect.

NCI notes that cancer survivors who had access to fertility counselling reported less regret about their fertility decisions, regardless of whether they ultimately chose preservation.

Good counselling therefore has value even when the patient decides **not** to bank sperm.

Fertility Preservation Is a Choice

A physician's responsibility is to provide:

- information,
- realistic expectations,
- access to appropriate services.

The patient then decides whether fertility preservation fits his goals.

Not every man wishes to have children.

Not every man wishes to preserve sperm.

A fully informed decision either way should be respected.

Consent and Future Use of Frozen Sperm

Sperm cryopreservation creates long-term decisions that should be documented clearly.

Patients may be asked to specify what should happen to stored sperm in circumstances such as:

- discontinuation of storage,
- death,
- inability to make decisions.



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ASRM laboratory guidance emphasizes careful consent, identification and documentation for cryopreserved reproductive material.

These decisions should not be treated as minor paperwork.

The sperm may represent irreplaceable reproductive tissue.

The Unani Perspective on Fertility Preservation

As a physician trained in Unani medicine and focused on sexual disorders and infertility, I believe reproductive care should consider the complete health of the man.

Traditional Unani medicine emphasizes factors such as:

- **Mizaj**, or constitutional temperament,
- nutrition,
- digestion,
- sleep,
- physical activity,
- emotional wellbeing,
- reproductive function,
- sexual health.

These principles can be valuable in improving a patient's general reproductive environment.

However, fertility preservation requires an important distinction.

Fertility preservation is primarily about physically preserving viable reproductive cells before they are lost.

No oral medicine can perform the same function as sperm cryopreservation.

Unani Medicine Cannot Replace Sperm Banking

Suppose a man is about to receive chemotherapy with a high probability of destroying spermatogonial stem cells.

We have two different strategies.

Sperm cryopreservation



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Physically stores viable sperm **before** treatment.

Supportive Unani treatment

May support general health but cannot guarantee protection of sperm-producing cells from cytotoxic chemotherapy.

These interventions are not equivalent.

Therefore, when medically indicated:

sperm should be banked first rather than relying on medicines to protect future fertility.

What Does Published Unani Research Show?

Published Unani research has investigated selected men with **idiopathic oligospermia**.

A CCRUM-associated retrospective analysis involving 126 men reported improvement in selected semen parameters after different Unani interventions.

Another small uncontrolled clinical study involving 30 men reported improvement in sperm count and motility after a traditional Unani formulation.

These findings support continued investigation of Unani approaches in selected male infertility conditions.

However, they should be interpreted carefully.

These Studies Are Not Fertility-Preservation Studies

The published studies involved men who already had oligospermia.

They did **not** demonstrate that an herbal formulation can:

- protect testes during chemotherapy,
- prevent radiation-induced germ-cell destruction,
- replace sperm cryopreservation,
- regenerate sperm after bilateral gonadectomy.

That distinction is essential.

A supportive infertility treatment and a fertility-preservation technology are not the same thing.



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Where Unani Medicine May Be Useful

Individualized Unani support may have a role before or after fertility preservation when the patient also has:

- poor nutrition,
- obesity,
- metabolic disturbance,
- digestive problems,
- sleep disturbance,
- stress,
- selected sexual-health concerns,
- idiopathic semen abnormalities.

The objective is to optimize the man's broader reproductive health.

But if future fertility is about to be placed at substantial medical risk, preservation of sperm should not be delayed.

Unani Medicine During Active Chemotherapy Requires Special Caution

Cancer patients should not assume:

“Herbal means safe.”

Certain herbs, supplements and concentrated nutrients can interact with:

- chemotherapy,
- targeted therapy,
- other anticancer medications.

Therefore, any Unani or herbal medicine during active cancer treatment should be reviewed with the oncology team.

Cancer control always comes first.

High-Dose Antioxidants Are Not Automatically Protective

Many male-fertility supplements contain antioxidants.

It may seem logical to take large doses during chemotherapy to “protect sperm.”



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However, some anticancer treatments rely partly upon oxidative mechanisms.

Therefore, supplements should not be used during active cancer therapy without oncological review.

The safer strategy for protecting reproductive options is:

preserve sperm before treatment.

My Specialized Approach at Saira Health Care

At **Saira Health Care**, fertility preservation begins with identifying the patient's actual reproductive risk.

I ask:

Why is fertility threatened?

Is he about to receive chemotherapy?

Radiotherapy?

Stem-cell transplantation?

Testicular surgery?

Long-term hormone treatment?

Does he already have severe oligospermia?

Are rare sperm still present?

Does he have a genetic condition in which sperm production may decline?

Then I ask:

What is his current semen status?

This may involve:

- semen analysis,
- sperm concentration,
- motility,
- morphology,
- assessment for cryptozoospermia.

When clinically indicated, I also consider:

- FSH,



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- LH,
- testosterone,
- testicular examination,
- genetic evaluation,
- underlying disease.

Special Treatment Planning by Dr. Nizamuddin Qasmi

My focused clinical work in **Sexual Disorders & Infertility** allows fertility preservation to be considered alongside sexual and reproductive health rather than as an isolated laboratory procedure.

Depending upon the patient, my role may include:

- explaining the future fertility risk,
- reviewing semen quality,
- identifying severe oligospermia or azoospermia,
- discussing sperm cryopreservation,
- recognizing when surgical sperm retrieval may be required,
- assessing hormonal and sexual-health concerns,
- coordinating referral to reproductive urology or IVF services,
- reviewing fertility after treatment has finished.

Individualized Unani management may also be incorporated when appropriate to support the patient's broader reproductive and general health.

What “Special Treatment” Means Here

Specialized fertility care does **not** mean providing every patient with the same sperm-enhancing medicine.

Consider five men.

Patient One

Has normal semen and will receive high-risk chemotherapy next week.

His priority is:



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sperm cryopreservation before chemotherapy.

Patient Two

Has testicular cancer and severe oligospermia before orchiectomy.

His priority is:

urgent sperm freezing and possible Onco-TESE planning if necessary.

Patient Three

Cannot ejaculate because of neurological disease but must begin gonadotoxic treatment.

He may require:

assisted ejaculation or surgical sperm retrieval.

Patient Four

Has already completed cancer treatment and now has persistent azoospermia.

He requires:

post-treatment fertility evaluation rather than pretreatment preservation.

Patient Five

Has normal fertility today but is considering long-term exogenous testosterone.

He requires:

fertility counselling before suppressive hormonal therapy and consideration of fertility-preserving alternatives.

The correct plan is therefore determined by the individual situation.

Saira Health Care's Contribution to Sexual Disorders and Infertility

One of the important contributions of **Saira Health Care** in male sexual and reproductive health is helping patients think about fertility **before it becomes a problem.**

Many men only seek infertility treatment after several years of unsuccessful conception.

Fertility preservation is different.

It asks:

“Is there something happening today that may make fatherhood difficult tomorrow?”

Recognizing that risk early can completely change future options.

Our objective is to help the patient understand:

- his current fertility,
- future risk,
- available preservation methods,
- realistic reproductive choices.

Where required, care can be coordinated with:

- oncologists,
- reproductive urologists,
- IVF specialists,
- endocrinologists,
- genetic counsellors.

Fertility Preservation Does Not Guarantee Future Pregnancy

This point must be stated honestly.

Freezing sperm preserves reproductive material.

It does not guarantee:

- fertilization,
- embryo development,
- implantation,
- pregnancy,
- live birth.

Future pregnancy also depends upon:

- number and quality of stored sperm,
- reproductive method,
- female partner's age,



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- egg quality,
- uterine factors.

Nevertheless, preserved sperm can protect an opportunity that might otherwise be permanently lost.

The Female Partner's Future Age Matters

A man may freeze sperm at age twenty-five and use it at age forty.

The sperm themselves remain cryopreserved.

But if his future partner is also older, female reproductive age may substantially influence the final chance of pregnancy.

Fertility preservation therefore protects the **male component** of fertility; it does not freeze the reproductive ageing of a future partner.

Frequently Asked Questions

What is male fertility preservation?

Male fertility preservation means protecting or storing sperm or testicular reproductive tissue so biological fatherhood may remain possible after a disease or medical treatment threatens fertility.

What is the best-established method?

For post-pubertal males, **ejaculated sperm cryopreservation or sperm banking** is the established first-line method.

When should sperm be frozen?

Ideally **before chemotherapy, radiation or other gonadotoxic treatment begins**.

Can an unmarried man freeze sperm?

Yes.

Marital status does not determine biological suitability for sperm cryopreservation.

The purpose is to preserve future reproductive choice.



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Can teenagers freeze sperm?

Post-pubertal adolescents who are producing mature sperm can usually undergo semen cryopreservation when medically appropriate.

What if a boy has not reached puberty?

He does not yet produce mature ejaculated sperm.

Testicular tissue cryopreservation can be considered only as an **experimental/investigational technique**, generally within research programmes.

How is sperm collected?

Usually by masturbation into a sterile container in a private clinical setting.

What if I cannot masturbate or ejaculate?

Depending upon the cause, options may include:

- penile vibratory stimulation,
- electroejaculation,
- retrieval from post-ejaculatory urine,
- surgical sperm retrieval.

What if my sperm count is very low?

Sperm freezing may still be worthwhile.

Very limited sperm numbers can sometimes be used efficiently with IVF/ICSI.

What if my semen shows zero sperm?

The cause must be investigated.

Some men may still have testicular sperm that can be surgically retrieved.



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In cancer settings, Onco-TESE may sometimes be performed before or during necessary surgery.

What is Onco-TESE?

Onco-TESE means testicular sperm extraction performed as part of fertility preservation in a patient with cancer.

It may be useful when an adequate semen sample cannot be obtained or when azoospermia exists before cancer treatment.

Can sperm be taken from a testicle being removed for cancer?

In selected azoospermic patients, sperm retrieval can sometimes be performed from appropriate tissue at the time of orchiectomy.

How many semen samples should I freeze?

Multiple samples are preferable when time and health permit.

However, one specimen may still be extremely valuable, particularly when ICSI is available.

How long can sperm remain frozen?

Properly cryopreserved sperm can remain stored for very long periods. NCI describes sperm as capable of indefinite storage under appropriate cryogenic conditions, while practical storage duration depends upon clinic policies and applicable regulations.

Do all sperm survive freezing?

No.

Some sperm lose viability or motility during freeze-thawing.

Many still remain suitable for assisted reproduction.

Can frozen sperm be used naturally?

Frozen sperm normally require a fertility procedure after thawing.



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Depending upon sperm quantity and quality, this may be:

- IUI,
- IVF,
- ICSI.

What is ICSI?

ICSI means **Intracytoplasmic Sperm Injection**.

One selected sperm is injected directly into a mature egg.

It is particularly useful when only small numbers of sperm are available.

Can one semen sample be enough for ICSI?

Possibly.

The specimen may be divided into several storage portions, and ICSI requires only a small number of viable sperm compared with natural conception.

The fertility laboratory should assess the actual sample.

Can sperm be frozen after chemotherapy starts?

Sometimes, but this is less desirable.

Chemotherapy and radiotherapy may cause genetic damage to sperm after exposure, so pretreatment collection is strongly preferred.

Can I try for pregnancy immediately after chemotherapy?

Usually not.

Current AUA/ASRM guidance advises avoiding conception for at least 12 months after chemotherapy or radiotherapy, although treatment-specific recommendations may differ and should come from the oncology team.

Can sperm production recover after chemotherapy?

Yes, in some men.



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Recovery may take months or years.

Other men experience permanent infertility.

The outcome depends upon the chemotherapy regimen, dose and remaining spermatogonial stem cells.

If my sperm recovers, was freezing unnecessary?

No.

Before treatment, it is usually impossible to know with certainty whose fertility will recover fully.

Cryopreservation preserved a reproductive option during that uncertainty.

Can radiation shielding protect fertility?

Testicular shielding can sometimes reduce scatter radiation when technically appropriate and when it does not interfere with effective cancer treatment.

Should sperm be frozen before testicular surgery?

It should be discussed when surgery may impair fertility, particularly in testicular cancer or when only one functioning testis remains.

Current EAU guidance recommends offering preservation before gonadotoxic therapy or fertility-threatening surgery in relevant cancer patients.

Should sperm be frozen before testosterone treatment?

A man who wants future biological children should discuss fertility before exogenous testosterone because testosterone can markedly suppress spermatogenesis.

Sperm banking may be considered depending upon the individual situation, although fertility-preserving endocrine alternatives may sometimes be preferable.

Do anabolic steroids reduce fertility?

Yes.

They suppress FSH and LH and can produce severe oligospermia or azoospermia.



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Can sperm be preserved before gender-affirming treatment?

Yes.

For individuals with testes who may want biological children in the future, fertility counselling and sperm cryopreservation can be considered before hormonal treatment or gonadectomy.

Can a man freeze sperm simply because he wants to preserve future options?

Sperm cryopreservation is technically possible for multiple clinical and personal reasons, but the benefits, costs and likelihood of future use should be discussed with a fertility service.

Medical necessity is particularly strong when there is a known threat to future fertility.

Does sperm freezing guarantee a future baby?

No.

It preserves sperm.

Pregnancy additionally depends upon fertilization, embryo development and female reproductive factors.

Can Unani medicine preserve sperm instead of freezing?

No.

Unani treatment cannot physically store viable sperm for future use.

When a treatment carries a genuine risk of permanent infertility, sperm cryopreservation remains the established preservation method.

Can Unani medicine protect sperm from chemotherapy?

There is currently insufficient high-quality evidence to claim that any Unani formulation reliably prevents chemotherapy-induced destruction of spermatogonial stem cells.

Fertility should therefore be preserved before treatment rather than relying on an unproven protective remedy.



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Can Unani medicine be used after sperm is frozen?

Potentially, where medically appropriate.

Individualized Unani care may support broader reproductive, nutritional, metabolic and sexual health.

It should be coordinated with the patient's other treatment.

Should herbal medicines be taken during chemotherapy to preserve fertility?

Not without oncology approval.

Herbal or nutritional products may interact with cancer therapy.

Fertility preservation should be based on established methods rather than self-treatment with supplements.

A Message From Dr. Nizamuddin Qasmi

When a young patient says to me:

“Doctor, I will worry about fertility after my cancer treatment,”

I explain something very important:

Sometimes we can treat infertility afterward.

But sometimes the opportunity to preserve fertility exists **only before treatment begins.**

If healthy sperm are present today and there is a significant risk that chemotherapy will destroy future sperm production, preserving today's sperm may be much easier than trying to recover sperm several years later.

That is why fertility preservation is not pessimism.

It is planning.

What I Tell Young Unmarried Patients

I often explain:

“You do not need to decide today whether you will definitely have children.”



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You are only deciding whether to **preserve the option**.

A frozen sperm sample does not force you to use it.

If your natural fertility returns after treatment, you may never need those samples.

But if fertility does not recover, those preserved sperm may become extremely valuable.

This is the real purpose of fertility preservation.

My Approach to Men With Very Low Sperm Count

Another common situation is:

“Doctor, the sperm count is so low that the laboratory says there is hardly anything worth freezing.”

I do not automatically agree.

The question is:

Are viable sperm present?

With ICSI, very small numbers can sometimes be sufficient.

If a disease or treatment may cause complete azoospermia later, preserving even rare viable sperm can be worthwhile.

The decision should be made with an experienced fertility laboratory.

My Approach When No Sperm Are Present

If semen shows azoospermia before fertility-threatening treatment, I investigate the cause.

Is the problem:

- obstruction,
- severe testicular failure,
- cancer-associated suppression?

Could testicular sperm still be present?

Would Onco-TESE be appropriate?

These questions should be answered rapidly because treatment deadlines may be approaching.



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The 2025–2026 Change in Fertility-Preservation Care

The most important recent development is that fertility preservation is increasingly being treated as a **standard component of comprehensive medical care rather than an optional luxury**.

The **2025 ASCO guideline update** recommends:

- reproductive-risk counselling at cancer diagnosis,
- reassessment during survivorship,
- referral when the patient is interested or uncertain,
- sperm cryopreservation before cancer therapy,
- testicular sperm extraction when an adequate semen sample cannot be obtained,
- clinical-trial-only use of prepubertal testicular tissue cryopreservation.

The **2026 ASRM guidance** likewise identifies sperm cryopreservation as the established male preservation method, supports medically assisted and surgical collection where necessary, and continues to classify prepubertal testicular tissue freezing as investigational.

These recommendations reinforce an important message:

Fertility should be discussed before it becomes permanently compromised.

Current Medical Understanding

Modern male fertility preservation is based on several key principles.

1. Discuss fertility early

Do not wait until after gonadotoxic treatment if future biological parenthood could matter.

2. Freeze ejaculated sperm whenever possible

It is established, effective and less invasive than surgical retrieval.

3. Try to obtain more than one sample when clinically possible

This creates more future reproductive options.



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4. Do not give up when semen collection fails

Assisted ejaculation or surgical sperm retrieval may provide alternatives.

5. Consider Onco-TESE in selected cancer patients

Especially when azoospermia or inability to ejaculate makes standard banking impossible.

6. Do not present prepubertal testicular tissue banking as established treatment

It remains experimental.

7. Protect fertility before exogenous testosterone where relevant

External testosterone can suppress sperm production.

8. Revisit fertility during survivorship

Reproductive goals change over time.

Conclusion

Male Fertility Preservation is the proactive protection of reproductive potential before disease or medical treatment causes permanent infertility.

For post-pubertal males, the principal established method is:

Sperm Cryopreservation

or sperm banking.

This is particularly important before:

- chemotherapy,
- radiotherapy,
- stem-cell transplantation,
- fertility-threatening testicular or pelvic surgery,
- selected gonadotoxic treatments for non-cancer illnesses,
- gonadectomy,
- other treatments expected to substantially suppress sperm production.

The latest **2025 ASCO fertility-preservation guideline** recommends counselling people with cancer about reproductive risks at diagnosis and throughout survivorship



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and specifically recommends sperm cryopreservation before cancer-directed treatment.

The **2026 ASRM fertility-preservation guidance** confirms ejaculated sperm cryopreservation as the established male fertility-preservation method and recommends obtaining multiple samples where clinically feasible.

When ejaculation is impossible or semen contains inadequate sperm, alternatives may include:

- vibratory stimulation,
- electroejaculation,
- retrieval of sperm in retrograde ejaculation,
- TESE,
- Onco-TESE.

For boys who have not reached puberty, **testicular tissue cryopreservation remains experimental**, because there is not yet an established clinical method that reliably converts stored prepubertal testicular tissue into future fertility.

Sperm should preferably be preserved **before** chemotherapy or radiotherapy because gonadotoxic treatment can both reduce sperm production and produce treatment-related genetic damage in sperm exposed during therapy.

Fertility preservation may also be relevant before long-term treatments that suppress spermatogenesis. In particular, men who want present or future fertility should understand that **exogenous testosterone can reduce or completely suppress sperm production**.

From the **Unani perspective**, male reproductive health can be supported through attention to:

- Mizaj,
- nutrition,
- digestion,
- sleep,
- physical activity,
- metabolic health,
- emotional wellbeing,
- sexual function.



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Published Unani studies have reported improvement in selected semen parameters among some men with idiopathic oligospermia.

However, these studies do not demonstrate fertility preservation from chemotherapy, radiotherapy or gonadectomy.

Therefore:

Unani medicine should be used as supportive reproductive care where appropriate—not as a replacement for sperm cryopreservation.

At **Saira Health Care**, my approach is preventive, integrative and diagnosis-led:

identify men whose fertility is at risk, assess the current semen status, preserve sperm before irreversible damage whenever possible, recognize when assisted or surgical sperm collection is required, coordinate with oncology and fertility specialists, reassess fertility after treatment, and use individualized Unani supportive care to optimize the patient's wider reproductive and sexual health.

The most important message I give patients is:

Preserve the opportunity before it is lost.

A man who freezes sperm may never need to use it.

But when treatment causes permanent azoospermia, sperm preserved before treatment may provide a reproductive opportunity that cannot easily be recreated afterward.

About the Author

Dr. Nizamuddin Qasmi

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Qualifications & Professional Training

BUMS — Hamdard University, Delhi

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Certificate in Urology — London, UK

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

His approach to male fertility preservation emphasizes early recognition of reproductive risk, objective semen and hormonal assessment, prevention of avoidable fertility loss and appropriate coordination with modern reproductive technology.

For patients facing cancer treatment or other gonadotoxic therapy, fertility preservation is planned in collaboration with the appropriate oncology, urology and reproductive-medicine teams.

Where clinically appropriate, individualized Unani principles may be incorporated to support general reproductive, nutritional, metabolic and sexual wellbeing without replacing established fertility-preservation methods.

Medical Disclaimer

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

Patients should never delay or alter medically necessary cancer treatment without the treating oncology team's approval.

Whenever clinically possible, fertility preservation should be discussed **before chemotherapy, radiotherapy or other gonadotoxic treatment begins.**

Sperm cryopreservation does not guarantee a future pregnancy or live birth.

Testicular tissue cryopreservation in prepubertal boys remains experimental.

Men interested in current or future biological fertility should discuss reproductive consequences before beginning exogenous testosterone or other treatment known to suppress spermatogenesis.

Herbal, Unani, nutritional or antioxidant products should not be assumed to protect fertility during chemotherapy or radiotherapy and should not be used during active cancer treatment without oncology approval.

Fertility-preservation decisions should be individualized according to the patient's diagnosis, treatment urgency, current sperm production, future reproductive goals and available specialist services.