

Hyperprolactinemia and Fertility

High Prolactin, Irregular Ovulation, Amenorrhea, Prolactinoma, Male and Female Infertility, Diagnosis, Cabergoline Treatment, Pregnancy and an Integrative Unani Approach

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

Introduction: “Doctor, My Prolactin Is High — Can This Be the Reason I Am Not Becoming Pregnant?”

When a woman comes to me with irregular periods and infertility and shows me a blood report saying “**Prolactin High**,” she often asks:

“Doctor, does high prolactin really stop pregnancy?”

The answer is:

Yes. Persistent hyperprolactinemia can interfere with ovulation and fertility—but in many patients the cause can be identified and successfully treated.

High prolactin can disrupt the hormonal communication between the brain, pituitary gland and ovaries. Ovulation may become infrequent or stop completely. Menstrual periods can become irregular or disappear. Estrogen levels may fall, and pregnancy may become difficult.

The condition is particularly important because successful treatment often restores the reproductive hormonal axis. The newest 2026 review on prolactinoma and fertility reports that dopamine-agonist treatment—primarily cabergoline—can normalize prolactin and restore gonadal function in most appropriately treated patients, often within months. [PubMed](#)



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WHO's first global infertility guideline, published in November 2025, specifically addresses infertility caused by hyperprolactinemic ovulatory dysfunction and recommends **cabergoline over bromocriptine**. NICE independently updated its fertility guideline in March 2026 and now recommends cabergoline for ovulatory disorders due to hyperprolactinemia. [World Health Organization](#)

This makes hyperprolactinemia one of the infertility conditions in which finding the correct hormonal cause can make a major difference.

However, there is an equally important second message:

A high prolactin result does not automatically mean that you have a pituitary tumor.

Pregnancy, stress, certain medicines, hypothyroidism, kidney disease, pituitary-stalk disorders and even laboratory phenomena such as macroprolactin can increase the measured value. [Nature](#)

This is why I do not treat a prolactin number alone.

I first want to know **why it is elevated**.

What Is Prolactin?

Prolactin is a hormone produced mainly by specialized cells called **lactotrophs in the anterior pituitary gland**, a small endocrine gland located at the base of the brain.

Prolactin is best known for its role in milk production after childbirth.

During pregnancy and breastfeeding, prolactin normally rises substantially.

That is physiological.

Outside pregnancy and breastfeeding, however, persistently excessive prolactin may interfere with reproductive function.

Unlike many pituitary hormones that are stimulated by the hypothalamus, prolactin is normally kept under continuous **inhibitory control by dopamine** produced in the hypothalamus. Dopamine reaches the pituitary and binds to D2 receptors on lactotroph cells, suppressing prolactin secretion. [Nature](#)

This explains why medicines that block dopamine can increase prolactin—and why dopamine-agonist medicines such as cabergoline can lower it.

What Is Hyperprolactinemia?



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Hyperprolactinemia means that circulating prolactin is persistently above the appropriate laboratory reference range.

There is no single numerical cutoff that should be copied across every laboratory.

Prolactin assays differ, reference intervals differ between laboratories, and levels can vary temporarily with stress, sleep, exercise, breast stimulation and other physiological factors. The Pituitary Society therefore recommends using assay-specific reference ranges and repeating measurements when a mild or unexpected elevation is found.

[Nature](#)

ASRM's 2024 amenorrhea guidance notes that values around **20–40 ng/mL**, when only mildly elevated, should generally be repeated before a diagnosis is made because transient elevations are common. [ASRM](#)

Therefore:

One mildly elevated prolactin result is not automatically a diagnosis of disease.

How Does High Prolactin Affect Fertility?

To understand this, we need to understand the normal reproductive hormonal pathway.

The hypothalamus releases **GnRH**.

GnRH stimulates the pituitary gland to release:

FSH — Follicle-Stimulating Hormone

and

LH — Luteinizing Hormone.

In women, FSH and LH regulate ovarian follicular development, ovulation and ovarian hormone production.

In men, they support testosterone production and spermatogenesis.

When prolactin becomes excessively elevated, it interferes with this reproductive signalling system.

The result can be **hypogonadotropic hypogonadism**—the brain and pituitary no longer stimulate the ovaries or testes normally.

In women this can lead to reduced estrogen, irregular ovulation, anovulation or amenorrhea.

In men it can produce reduced testosterone, low libido, erectile dysfunction and impaired sperm production.



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This is why hyperprolactinemia can affect **both sexual function and fertility**. [Nature](#)

Hyperprolactinemia and Female Infertility

In women, excessive prolactin can interfere with fertility at several levels.

A follicle may not mature correctly.

Ovulation can become irregular.

Ovulation can stop completely.

Progesterone production after ovulation can become abnormal.

Estrogen levels may fall.

Menstrual cycles may become irregular or disappear.

Sexual desire can decline.

Vaginal dryness can develop when estrogen deficiency is significant.

Therefore, a patient may initially come to me not because she knows her prolactin is high, but because she has:

infertility + irregular periods.

Hyperprolactinemia is one of the recognized common endocrine causes of secondary amenorrhea and menstrual irregularity, which is why prolactin testing forms part of the standard evaluation when these symptoms are present. [ASRM](#)

Can High Prolactin Cause Anovulation?

Yes.

This is one of its most important reproductive effects.

Excess prolactin suppresses the hypothalamic-pituitary-ovarian axis.

The ovary may therefore fail to receive the correctly timed FSH and LH signals needed for normal follicular development and ovulation.

The result may be:

oligo-ovulation — ovulation occurs infrequently,

or

anovulation — ovulation does not occur.



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When the underlying hyperprolactinemia is treated successfully, reproductive hormonal signalling can recover and spontaneous ovulation may return. [OUP Academic](#)

Can High Prolactin Stop Periods Completely?

Yes.

Significant hyperprolactinemia can cause **amenorrhea**, meaning menstrual periods stop.

ASRM recommends investigating secondary amenorrhea when menstruation has been absent for more than three months in a woman whose cycles were previously regular, or six months in someone whose cycles were already irregular. [ASRM](#)

But amenorrhea itself has many possible causes.

These include:

PCOS/PMOS, pregnancy, thyroid disease, functional hypothalamic amenorrhea, primary ovarian insufficiency and hyperprolactinemia.

This is why an absent period does not automatically mean high prolactin.

Can Hyperprolactinemia Cause Irregular Periods Without Complete Amenorrhea?

Yes.

Milder degrees of reproductive-axis suppression may result in:

long menstrual cycles,

unpredictable periods,

infrequent ovulation,

or occasional anovulatory cycles.

Therefore, a woman can still menstruate and have a prolactin-related fertility problem.

ASRM notes that prolactin concentrations tend to be higher in women with amenorrhea than those with oligomenorrhea, but both menstrual patterns can occur. [ASRM](#)

Can You Have High Prolactin Without Breast Milk Discharge?

Absolutely.

This is an important misconception.



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Breast milk discharge outside pregnancy or breastfeeding is called **galactorrhea**.

It is an important clue to hyperprolactinemia, but its absence does not exclude the condition.

ASRM reports that only approximately one-third of women with hyperprolactinemia have galactorrhea. [ASRM](#)

Therefore, a woman with:

irregular periods + infertility + no breast discharge

can still have clinically important hyperprolactinemia.

Symptoms of Hyperprolactinemia in Women

Depending on the degree of prolactin elevation, duration and underlying cause, patients may develop menstrual irregularity, amenorrhea, infertility, galactorrhea, reduced sexual desire, vaginal dryness and sometimes discomfort during intercourse due to estrogen deficiency.

If the cause is a sufficiently large pituitary mass, symptoms can also include:

headache,

visual disturbance,

loss of peripheral vision,

or symptoms caused by deficiencies of other pituitary hormones.

A large pituitary tumor producing visual symptoms requires much more urgent specialist evaluation than an isolated mildly elevated prolactin level.

Hyperprolactinemia and Male Fertility

Although hyperprolactinemia is frequently discussed as a female infertility problem, it also matters in men.

High prolactin can suppress GnRH, LH and FSH.

Testosterone may fall.

Men may develop:

low sexual desire,

erectile dysfunction,



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reduced spontaneous erections,
reduced ejaculatory volume,
and impaired sperm production.

The 2026 review on prolactinoma specifically addresses infertility in both women and men and reports that successful dopamine-agonist treatment can restore gonadal-axis function in many patients. [PubMed](#)

Therefore, if a couple has infertility and the male partner also has unexplained low testosterone, reduced libido or a pituitary disorder, prolactin may form part of his endocrine evaluation.

What Causes Hyperprolactinemia?

This is the most important diagnostic question.

Hyperprolactinemia can be caused by:

physiological conditions, medicines, endocrine or systemic illnesses, pituitary or hypothalamic disease, or laboratory phenomena.

The Pituitary Society's international consensus divides the causes into physiological, pharmacological and pathological categories. [Nature](#)

The treatment depends completely on which category applies.

Physiological Causes

Prolactin normally rises during:

pregnancy,

breastfeeding,

sleep,

stress,

exercise,

sexual activity,

and breast or nipple stimulation.

These are not prolactinomas.



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The Pituitary Society specifically lists pregnancy, breast stimulation, stress, sleep, intercourse and exercise among physiological causes of increased prolactin. [Nature](#)

This explains why the circumstances surrounding blood collection can sometimes matter.

Pregnancy Must Always Be Excluded

Pregnancy naturally increases prolactin.

Therefore, when a woman of reproductive age presents with amenorrhea or an unexpected prolactin elevation, pregnancy should not be overlooked.

Both ASRM and the Pituitary Society emphasize pregnancy as an early consideration in the investigation. [ASRM](#)

Stress Can Temporarily Raise Prolactin

Even the stress associated with venipuncture can occasionally raise prolactin modestly.

This is why the Pituitary Society recommends repeating prolactin when the concentration is less than about five times the laboratory upper limit and using a more controlled blood-sampling approach when stress-related elevation is suspected.

[Nature](#)

A mildly elevated test taken during acute anxiety should therefore not automatically lead to an MRI.

Medication-Induced Hyperprolactinemia

Medication review is extremely important.

A number of drugs interfere with dopamine pathways or otherwise increase prolactin.

Particularly important examples include certain **antipsychotic medications**, some antidepressants, anti-nausea/prokinetic medicines such as metoclopramide, certain antihypertensive drugs, opioids and other agents. The Pituitary Society strongly recommends a rigorous medication review whenever hyperprolactinemia is investigated. [Nature](#)

This does not mean the medicine should be stopped suddenly.

Never Stop Essential Psychiatric or Other Medication on Your Own



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This deserves special emphasis.

If an antipsychotic or another important prescription medicine is contributing to hyperprolactinemia, treatment options may include changing dose, changing medication or choosing another strategy.

But such changes should be coordinated with the clinician who prescribed the medicine—particularly psychiatrists managing psychotic or severe mood disorders.

Stopping medication abruptly can be far more dangerous than the prolactin elevation itself.

The goal is to treat fertility without destabilizing the patient's general health.

Hypothyroidism

Primary hypothyroidism is an important reversible cause of mild-to-moderate hyperprolactinemia.

When thyroid hormone is low, hypothalamic TRH rises.

TRH can stimulate prolactin-producing pituitary cells.

Therefore, clinically important hypothyroidism can cause both menstrual irregularity and elevated prolactin.

The Pituitary Society recognizes primary hypothyroidism as a cause of hyperprolactinemia, and ASRM recommends thyroid evaluation when prolactin is elevated. [Nature](#)

In this situation, treating the thyroid disorder may allow prolactin and menstrual function to normalize.

Kidney Disease

Prolactin is partly cleared by the kidneys.

Chronic renal impairment can therefore produce elevated circulating prolactin.

The Pituitary Society specifically identifies renal insufficiency as an important systemic cause of hyperprolactinemia. [Nature](#)

Again, this is biologically different from a prolactinoma.

Liver Disease



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Advanced liver disease can also contribute to elevated prolactin.

Pituitary Society guidance includes liver failure/cirrhosis among recognized non-pituitary causes. [Nature](#)

Therefore, prolactin should be interpreted in the context of overall medical health.

Pituitary Stalk Compression — The “Stalk Effect”

Dopamine produced by the hypothalamus has to travel down the pituitary stalk to suppress prolactin release.

If a mass compresses or interrupts the stalk, dopamine cannot reach lactotroph cells normally.

Prolactin then rises even if the mass itself is **not a prolactinoma**.

This is known as the **stalk effect**.

Causes can include:

nonfunctioning pituitary adenomas,

craniopharyngiomas,

Rathke cleft cysts,

meningiomas,

inflammatory lesions,

and other masses around the hypothalamic-pituitary region. [Nature](#)

This distinction matters because treatment of a nonfunctioning compressive tumor can differ substantially from treatment of a true prolactinoma.

What Is a Prolactinoma?

A **prolactinoma** is a usually benign pituitary adenoma composed of prolactin-producing cells.

It is one of the most common functioning pituitary tumors.

The Pituitary Society defines:

Microprolactinoma: tumor less than 10 mm.

Macroprolactinoma: tumor 10 mm or larger.



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Giant prolactinoma: macroprolactinoma larger than approximately 40 mm. [Nature](#)

Tumor size matters because the reproductive consequences may come not only from prolactin but also from pressure on surrounding structures.

Microprolactinoma

Microprolactinomas are particularly common in reproductive-age women.

They rarely enlarge significantly and are generally very responsive to dopamine-agonist therapy.

For a woman seeking pregnancy, treatment usually focuses on normalizing prolactin and restoring ovulation.

The prognosis for fertility is frequently favorable when no other infertility factor is present. [Nature](#)

Macroprolactinoma

Macroprolactinomas require closer evaluation because of their larger size.

They may compress normal pituitary tissue.

If they extend upward, they can approach the **optic chiasm**, producing visual-field abnormalities.

Treatment with cabergoline can often produce substantial tumor shrinkage as well as prolactin normalization. [Nature](#)

Women with macroprolactinomas who want pregnancy require careful preconception planning because tumor size and proximity to the optic pathways influence pregnancy management.

Headache and Visual Problems Are Important

A patient with elevated prolactin plus:

persistent or severe headache,

new loss of peripheral vision,

double vision,

or other neurological symptoms



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requires appropriate pituitary assessment.

These symptoms should not be treated as an ordinary infertility complaint.

Large pituitary lesions can affect vision and other pituitary hormones and may require coordinated endocrinology, ophthalmology and neurosurgical care.

Macroprolactin: When the Laboratory Prolactin Is High but the Patient Has Few Symptoms

This is one of the most important diagnostic pitfalls.

Most biologically active circulating prolactin is a relatively small molecule called **monomeric prolactin**.

Sometimes prolactin forms large complexes with antibodies.

This is known as **macroprolactin** or “big-big prolactin.”

Macroprolactin can be detected by routine laboratory assays even though it has much less biological activity.

Therefore, a patient's report may show “high prolactin” while she has:

regular periods,

normal ovulation,

no galactorrhea,

and no symptoms of estrogen deficiency.

The Pituitary Society estimates that macroprolactin can occur in a meaningful minority of people with laboratory hyperprolactinemia and recommends evaluating it particularly when prolactin elevation is moderate or symptoms and laboratory findings do not match. [Nature](#)

ASRM similarly recommends considering macroprolactin when mild persistent hyperprolactinemia is found in an otherwise asymptomatic patient. [ASRM](#)

Why Macroprolactin Testing Matters

Macroprolactin testing can prevent:

unnecessary MRI,

unnecessary dopamine-agonist treatment,



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unnecessary worry,
and misdiagnosis of infertility.

Laboratories commonly use **polyethylene glycol precipitation** to help distinguish biologically active monomeric prolactin from macroprolactin. [ASRM](#)

This is one reason I do not believe every elevated prolactin result should immediately be treated.

The “Hook Effect” — A Rare but Important Laboratory Error

There is an opposite problem.

Occasionally a patient has a **very large prolactinoma with extremely high true prolactin**, but the laboratory result looks only mildly elevated.

This is called the **high-dose hook effect**.

Very large amounts of prolactin overwhelm certain immunoassays, producing an artificially low measurement.

The Pituitary Society recommends diluted prolactin testing when a giant pituitary adenoma is present but the reported prolactin concentration seems unexpectedly modest. [Nature](#)

This is rare with modern laboratory technology but clinically important.

A large prolactinoma should not be mistaken for a nonfunctioning tumor because of an assay artifact.

How I Investigate High Prolactin

A good hyperprolactinemia assessment is systematic rather than complicated.

The first task is confirming that the elevation is real.

The second is identifying the cause.

The third is determining whether it is affecting fertility or broader health.

Step 1: Confirm the Result

If prolactin is only mildly elevated, I want the result repeated under suitable conditions.



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ASRM specifically recommends repeating values around 20–40 ng/mL before making the diagnosis. Pituitary Society guidance recommends repeat testing for elevations below approximately five times the assay's upper limit. [ASRM](#)

There is no advantage in diagnosing a patient with pituitary disease from one questionable laboratory value.

Step 2: Exclude Pregnancy

Pregnancy must be considered in a reproductive-age woman with delayed menstruation.

This is particularly important because fertility may return very rapidly once treatment is begun.

Step 3: Review All Medicines

I ask about:

psychiatric medication,
anti-nausea medicine,
gastrointestinal prokinetic drugs,
opioids,
hormones,
and other prescription or non-prescription products.

Medication history is not an optional detail.

It can reveal the entire cause.

Step 4: Check Thyroid Function

TSH and, where appropriate, free T4 help identify thyroid-related hyperprolactinemia.

Treating hypothyroidism may correct the reproductive disturbance without requiring long-term dopamine-agonist treatment.

Step 5: Consider Kidney and Liver Function

This is particularly relevant when history or examination suggests systemic disease.



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Step 6: Check Macroprolactin When Appropriate

If prolactin elevation is modest and the clinical picture does not fit, macroprolactin testing can prevent unnecessary imaging and treatment. [ASRM](#)

Step 7: Evaluate Other Reproductive Hormones When Needed

Depending on the patient's menstrual and fertility history, assessment may include:

FSH,

LH,

estradiol,

thyroid hormones,

and other targeted investigations.

The goal is to determine how strongly the prolactin excess has suppressed ovarian function and whether another endocrine disorder is present simultaneously.

When Is Pituitary MRI Needed?

Persistently elevated biologically active prolactin without an obvious physiological explanation generally warrants consideration of **pituitary MRI**, particularly when a prolactinoma or another sellar lesion is suspected.

ASRM recommends MRI for persistent hyperprolactinemia after relevant laboratory considerations, while the Pituitary Society recommends MRI as the primary imaging modality for pituitary and parasellar lesions. [ASRM](#)

The exact decision should account for the degree of prolactin elevation, symptoms, medication history and endocrine findings.

MRI should not be ordered simply because one borderline prolactin measurement is slightly above range.

Does the Prolactin Number Tell Us the Tumor Size?

Often there is a broad relationship between prolactin level and prolactinoma size, but the relationship is not absolute.

Very high concentrations make a prolactinoma more likely.



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Moderate elevations can occur from medications, stalk compression and other causes.

Pituitary Society guidance therefore advises reconsidering the diagnosis whenever tumor size and prolactin concentration seem inconsistent. [Nature](#)

This is another reason laboratory and imaging information should be interpreted together.

Fertility Assessment Should Not Stop After Finding High Prolactin

This is extremely important.

Imagine that we treat the prolactin successfully and ovulation returns—but both fallopian tubes are blocked.

Pregnancy may still not occur naturally.

Or perhaps the male partner has severe oligozoospermia.

Again, treating the prolactin alone may not solve the couple's infertility.

WHO's 2025 infertility guideline emphasizes systematic fertility evaluation rather than assuming that the first abnormality identified explains everything. [World Health Organization](#)

At Saira Health Care, this couple-based approach is particularly important because my work focuses on both sexual disorders and infertility.

Hyperprolactinemia Can Also Affect Sexual Health

Infertility is not the only consequence.

Reduced estrogen in women can contribute to:

low libido,

vaginal dryness,

reduced arousal,

and discomfort during intercourse.

In men, reduced testosterone can contribute to:

low desire,

erectile dysfunction,

and reduced sexual confidence.



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These sexual effects can further reduce the frequency of intercourse during fertile periods.

This is one reason fertility and sexual health sometimes need to be treated together.

Long-Standing Hyperprolactinemia and Bone Health

When prolactin suppresses estrogen or testosterone for a prolonged period, bone health can also be affected.

The Pituitary Society recognizes increased fracture risk in prolactinoma and recommends considering bone-mineral-density assessment in patients with prolonged hypogonadism or other osteoporosis risk factors. [Nature](#)

Therefore, this is not simply a “fertility hormone.”

Long-standing untreated reproductive-hormone suppression can have broader health consequences.

Treatment of Hyperprolactinemia and Infertility

Treatment depends on the cause.

There is no medical justification for giving cabergoline to every person whose prolactin is slightly above the laboratory range.

The treatment pathways are very different for:

physiological prolactin elevation,

macroprolactinemia,

drug-induced hyperprolactinemia,

hypothyroidism,

prolactinoma,

and stalk compression.

Cabergoline — Current Preferred Treatment for Hyperprolactinemic Ovulatory Infertility

For clinically meaningful hyperprolactinemia requiring dopamine-agonist therapy, **cabergoline is currently the preferred medicine in most modern guidance.**



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The 2025 WHO infertility guideline recommends cabergoline over bromocriptine for infertility caused by hyperprolactinemic ovulatory dysfunction. [OUP Academic](#)

The March 2026 NICE fertility guideline is even more direct:

offer cabergoline to treat ovulatory disorders due to hyperprolactinemia. [Nice](#)

The Pituitary Society also recommends cabergoline as the preferred dopamine agonist because of its efficacy, long duration of action and generally better tolerability. [Nature](#)

How Does Cabergoline Work?

Cabergoline is a **dopamine D2-receptor agonist**.

In simple terms, it acts like dopamine at the pituitary.

It tells prolactin-producing lactotroph cells to reduce prolactin secretion.

In prolactinomas, it can also shrink tumor volume.

As prolactin falls, GnRH signalling can recover.

LH and FSH may normalize.

Ovarian follicular development can resume.

Ovulation may return.

Therefore, cabergoline is not merely “a medicine that lowers a blood-test number.”

In the right patient, lowering prolactin can restore the reproductive axis. [Nature](#)

How Quickly Can Fertility Return?

Sometimes surprisingly quickly.

Ovulation may return before a woman has had her first clearly normal menstrual period.

European endocrine guidance specifically warns that fertility can return rapidly after dopamine-agonist treatment—even before the patient recognizes that regular cycles have resumed. [OUP Academic](#)

For a woman actively seeking pregnancy, this can be encouraging.

For someone not currently wishing to conceive, it means contraception needs to be discussed when treatment begins.



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Bromocriptine

Bromocriptine is another dopamine agonist with a long history of use.

It remains effective.

However, cabergoline generally has better tolerability and greater efficacy, which is why modern WHO, NICE and Pituitary Society recommendations now favor cabergoline for most patients. [OUP Academic](#)

Bromocriptine can still have a role when cabergoline is unavailable, unsuitable or not tolerated.

Side Effects of Cabergoline

Possible side effects include:

nausea,

dizziness,

headache,

abdominal discomfort,

constipation,

and low blood pressure, particularly when standing.

Some patients tolerate it very well.

Others require careful dose adjustment.

The medicine should be prescribed and monitored rather than self-started from an old prescription or another patient's treatment plan.

Can Cabergoline Permanently Cure Hyperprolactinemia?

It depends on the cause.

Medication-induced hyperprolactinemia may resolve when the causative medication is appropriately changed.

Hypothyroidism-associated elevation may normalize with thyroid treatment.

Some prolactinomas remain controlled for years and selected patients may eventually be able to discontinue dopamine-agonist therapy after careful reassessment.

Others relapse when the medicine is stopped.



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The Pituitary Society emphasizes that patients should understand that long-term therapy may be required and permanent remission is not guaranteed. [Nature](#)

When Is Surgery Considered for a Prolactinoma?

Most prolactinomas are treated medically first.

However, pituitary surgery can be appropriate in selected cases.

Reasons may include:

intolerance of dopamine agonists,

resistance to medical therapy,

tumor anatomy suitable for a high probability of surgical cure,

significant compression,

certain cystic lesions,

or an informed patient preference after discussion of risks and benefits.

The 2023 Pituitary Society consensus has moved toward discussing surgery more actively for selected non-invasive microprolactinomas and well-contained macroprolactinomas when expert pituitary surgery is available. [Nature](#)

But surgery is not automatically superior to cabergoline.

Surgery and Future Fertility

Surgery can normalize prolactin if the tumor is removed successfully.

However, pituitary surgery can also damage normal pituitary tissue and produce hormone deficiencies.

The Pituitary Society specifically advises that patients contemplating surgery before pregnancy should understand the possible risk of postoperative hypopituitarism and its effect on fertility. [Nature](#)

This is why surgery should be planned in experienced pituitary centres.

What If Prolactin Normalizes but Pregnancy Still Does Not Occur?

Then we should not keep increasing prolactin treatment unnecessarily.



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Once prolactin and ovulation normalize, the rest of the fertility assessment becomes important.

Questions include:

Are the fallopian tubes open?

Is ovulation now regular?

What is the woman's reproductive age?

Is ovarian reserve appropriate?

Does the uterus have another problem?

Is semen analysis normal?

Is intercourse occurring during fertile periods?

The 2026 fertility review notes that some patients whose gonadal axis does not recover fully may require additional reproductive treatment. [PubMed](#)

Treatment can then progress according to the actual remaining fertility problem.

Does Hyperprolactinemia Automatically Require IVF?

No.

In fact, many women with prolactin-related anovulation do **not** need IVF simply because prolactin is elevated.

If treatment restores regular ovulation and no other infertility factor exists, natural conception may occur.

This is one of the most encouraging aspects of the condition.

IVF becomes relevant when:

another fertility factor exists,

ovulation does not recover adequately,

female age makes prolonged waiting inappropriate,

tubal disease is present,

severe male-factor infertility is present,

or appropriately treated infertility persists.



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Can Ovulation-Induction Medicine Be Used After Prolactin Treatment?

Sometimes.

If prolactin is controlled but the patient remains anovulatory because she also has PCOS/PMOS or another ovulatory disorder, fertility-directed ovulation induction may be appropriate.

But the correct order matters.

If hyperprolactinemia is itself causing the ovulatory disturbance, treating the prolactin should usually come first rather than simply stimulating the ovaries around an untreated endocrine problem.

Hyperprolactinemia, PCOS/PMOS and Diagnostic Confusion

This is another common issue.

Women with PCOS/PMOS can have:

irregular periods,

anovulation,

infertility,

and sometimes a mildly elevated prolactin result.

But persistent hyperprolactinemia should not simply be labelled “part of PCOS” without appropriate evaluation.

Conversely, a woman with a prolactinoma can be incorrectly diagnosed with PCOS because her periods are irregular.

The conditions can even coexist.

Therefore, elevated prolactin should be evaluated on its own merits rather than automatically incorporated into a PCOS diagnosis.

Hyperprolactinemia and Pregnancy

Pregnancy management deserves a separate discussion because prolactin physiology changes dramatically after conception.

Before pregnancy, dopamine-agonist treatment is used to normalize prolactin and restore fertility.

Once pregnancy occurs, the treatment plan often changes.



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What Should Happen Before Pregnancy in a Woman With Prolactinoma?

Before attempting pregnancy, the clinician should understand:

tumor size,

relationship to the optic structures,

current prolactin control,

response to medication,

and other pituitary hormone function.

The Pituitary Society recommends a comprehensive pre-pregnancy assessment, particularly for macroprolactinomas. [Nature](#)

For large tumors, meaningful shrinkage should ideally be demonstrated before conception.

Cabergoline Until Pregnancy Is Confirmed

European endocrine guidance recommends cabergoline at the **lowest effective dose until pregnancy is confirmed** for women with prolactinoma actively seeking conception. [OUP Academic](#)

The Pituitary Society similarly considers dopamine-agonist treatment the preferred preconception approach for most patients. [Nature](#)

This allows prolactin normalization and restoration of ovulation.

What Happens to Cabergoline After a Positive Pregnancy Test?

In most women with a controlled microprolactinoma—and many with adequately treated macroprolactinomas—the dopamine agonist is discontinued once pregnancy is confirmed.

Both the Pituitary Society and European Society of Endocrinology recommend stopping dopamine-agonist treatment in most pregnancies after conception is established. [Nature](#)

However, women with a large macroprolactinoma, particularly near the optic chiasm, may require continued or restarted therapy depending on tumor behavior.



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Therefore, a pregnant woman should not stop or continue cabergoline solely based on an internet article.

Her pituitary anatomy matters.

Is Cabergoline Exposure Around Conception Safe?

The accumulated evidence is generally reassuring.

A 2025 systematic review evaluated **1,662 pregnancies exposed to cabergoline** and found no clear increased risk of major congenital malformations or spontaneous abortion compared with other treatments or no exposure, although study quality was generally low and heterogeneous. [PMC](#)

This is important reassurance for women who become pregnant while taking cabergoline.

But reassuring conception exposure does not mean the medicine should automatically be continued throughout every pregnancy.

Why Is Prolactin Not Routinely Measured During Pregnancy?

Because prolactin normally rises during pregnancy.

The value therefore becomes difficult to interpret as a marker of tumor size.

Both the Pituitary Society and European endocrine guideline specifically recommend **not measuring prolactin routinely during pregnancy** in women with prolactinoma. [Nature](#)

This is an important point because patients sometimes become frightened when a pregnancy prolactin result looks extremely high.

During pregnancy, clinical symptoms and appropriate imaging—not routine serial prolactin values—are more useful for assessing tumor growth.

Microprolactinoma During Pregnancy

Pregnancy in women with small intrasellar microprolactinomas is usually uneventful.

The Pituitary Society recommends clinical follow-up rather than frequent laboratory prolactin measurement. [Nature](#)

The risk of clinically significant tumor enlargement is low.

Macroprolactinoma During Pregnancy

Macroprolactinomas require more careful surveillance.

Pregnancy causes normal pituitary enlargement and estrogen stimulation can affect lactotroph tissue.

The Pituitary Society recommends closer clinical monitoring of macroprolactinoma patients, including attention to headache, visual symptoms and periodic visual-field assessment when appropriate. [Nature](#)

If significant tumor growth is suspected, **MRI without gadolinium** can be performed. [Nature](#)

What If a Prolactinoma Enlarges During Pregnancy?

If clinically meaningful tumor enlargement develops after dopamine-agonist treatment was stopped, treatment can often be restarted.

If medication does not produce sufficient tumor shrinkage and vision is threatened, pituitary surgery may occasionally become necessary, generally with specialist multidisciplinary management. [Nature](#)

Fortunately, this situation is uncommon.

Breastfeeding After Prolactinoma

Breastfeeding is often possible.

The Pituitary Society states that breastfeeding is generally **not contraindicated**, although the decision depends on whether dopamine-agonist treatment must be restarted for tumor control. [Nature](#)

This needs individualized endocrine and obstetric planning.

Prolactinoma Can Sometimes Improve After Pregnancy

Interestingly, prolactinoma behavior can change following pregnancy.

The 2026 review notes that postpartum reassessment is appropriate because some patients may demonstrate disease remission. [PubMed](#)



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This should be assessed properly rather than assuming either permanent cure or inevitable recurrence.

Hyperprolactinemia and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine**, I believe hyperprolactinemia is an important example of where traditional cause-oriented principles can complement modern endocrine investigation—but only if we clearly understand the limits of each approach.

The first important point is:

“Hyperprolactinemia” is a modern biochemical diagnosis based on measurement of a specific pituitary hormone.

Classical Unani medicine developed before prolactin assays, pituitary MRI and modern reproductive endocrinology.

Classical physicians described problems such as:

irregular menstruation,

amenorrhea,

infertility,

abnormal lactation,

sexual weakness,

and systemic disturbances.

These historical descriptions can overlap with symptoms of modern hyperprolactinemia, but they should not automatically be presented as exactly the same disease.

The modern diagnosis should therefore be established scientifically first.

Izala-i-Sabab — Identify and Address the Cause

One of the most useful Unani principles in this condition is **Izala-i-Sabab**, meaning that treatment should address the causative factor.

CCRUM describes Unani therapy as being selected according to the nature and cause of disease, with treatment approaches including **Ilaj-bil-Tadbir, Ilaj-bil-Ghiza, Ilaj-bil-Dawa and Ilaj-bil-Yad**. [CCRUM](http://CCRUM.org)



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This principle fits modern hyperprolactinemia particularly well.

Consider four women with the same laboratory result:

One has hypothyroidism.

One is taking a prolactin-raising antipsychotic medicine.

One has macroprolactinemia.

One has a macroprolactinoma.

All four may have “high prolactin.”

But all four need different management.

That is exactly why **cause-oriented treatment** matters.

Ilaj-bil-Ghiza — Dietotherapy

Unani medicine recognizes **Ilaj-bil-Ghiza**, or dietotherapy, as an important therapeutic approach. [CCRuM](#)

Diet cannot directly remove a prolactinoma.

Nor can a particular food reliably normalize prolactin when a pituitary adenoma is actively secreting the hormone.

However, appropriate nutritional care can support:

healthy body weight,

metabolic health,

adequate micronutrient intake,

general preconception health,

and recovery from nutritional deficiency.

This becomes particularly important when infertility coexists with PCOS/PMOS, obesity, anemia or other metabolic problems.

There Is No Scientifically Proven “Prolactin-Lowering Food”

Patients frequently encounter claims that one food, seed or herbal drink will permanently lower prolactin.

There is currently no high-quality evidence supporting such a universal claim.



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A woman with a pituitary prolactinoma should not delay MRI, endocrine care or cabergoline because she is waiting for dietary treatment to shrink the adenoma.

Diet can support health.

It should not replace diagnosis-specific endocrine treatment.

Ilaj-bil-Tadbir — Lifestyle and Regimental Care

CCRUM formally recognizes **Ilaj-bil-Tadbir**, or regimental therapy, as one of the major therapeutic modalities of Unani medicine. [CCRUM](#)

In contemporary supportive care, I consider lifestyle factors such as:

sleep,

appropriate physical activity,

stress management,

weight management where necessary,

and overall health habits.

These can be particularly relevant when mild physiological prolactin elevation is being aggravated by sleep disruption or stress.

But lifestyle intervention does not replace treatment of a prolactinoma, hypothyroidism or medication-induced hyperprolactinemia.

Stress Management Is Supportive—Not a Substitute for Diagnosis

Because stress can transiently raise prolactin, patients sometimes conclude:

“My prolactin is high only because I worry too much.”

That may occasionally contribute to a borderline result.

But persistent clinically meaningful hyperprolactinemia should not be dismissed as “stress.”

Repeat testing and appropriate endocrine investigation are necessary.

A pituitary tumor should not be missed because symptoms have been attributed to anxiety.

Ilaj-bil-Dawa — Unani Pharmacotherapy



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Unani medicine contains many traditional formulations used for menstrual, reproductive and general health complaints.

However, scientific transparency is essential.

There is currently no high-quality clinical evidence showing that a specific Unani formulation reliably normalizes pathological hyperprolactinemia, shrinks prolactinomas or restores fertility better than established dopamine-agonist therapy.

I therefore regard Unani pharmacotherapy as a possible **supportive individualized component**, not as a substitute for endocrine treatment when a prolactinoma or other defined cause is present.

This distinction protects patients from losing reproductive time.

Unani Medicines and Drug Interactions

A woman receiving:

cabergoline,

thyroid medication,

psychiatric medicines,

fertility drugs,

or treatment for a pituitary disorder

should disclose all herbal and Unani products she is taking.

CCRUM maintains drug-standardization programmes addressing quality parameters for Unani medicines, including manufacturing standards and testing for issues such as heavy metals, microbial contamination and pesticide residues. [CCRUM](#)

Quality matters particularly in fertility treatment and pregnancy.

Ilaj-bil-Yad — When Surgery Is Required

CCRUM also recognizes **Ilaj-bil-Yad**, meaning surgical treatment, as one of the established therapeutic modalities of the Unani system. [CCRUM](#)

This is very relevant when an endocrine disease has a structural cause.



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If a selected prolactinoma cannot be controlled medically, compresses the optic apparatus or is an excellent surgical candidate after specialist review, pituitary surgery may be appropriate.

A responsible integrative approach should recognize that.

Traditional and modern treatment should not be placed in competition where a clear structural problem requires expert intervention.

The Specialized Saira Health Care Approach to Hyperprolactinemia and Fertility

At **Saira Health Care**, my approach to hyperprolactinemia begins with one principle:

Do not treat the laboratory number before understanding the patient.

If a patient shows me a high prolactin report, my first question is not:

“Which prolactin medicine should we start?”

I first want to establish whether the result is genuine and clinically meaningful.

Step 1: Confirm the Elevated Prolactin

If the elevation is mild, repeating the test may be appropriate.

I consider:

stress,

recent exercise,

sleep,

breast stimulation,

medication,

and laboratory methodology.

This helps prevent a temporary physiological rise from becoming a lifelong diagnosis.

Step 2: Exclude Pregnancy

This is essential in reproductive-age women.

Pregnancy is itself associated with high prolactin.



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Step 3: Understand the Menstrual Pattern

I ask:

Were periods previously regular?

When did they become irregular?

How often do they occur?

Has menstruation stopped completely?

Does the patient experience hot flushes or vaginal dryness?

Does she have galactorrhea?

The menstrual history helps tell me how significantly reproductive function may have been suppressed.

Step 4: Review Medication Carefully

This includes psychiatric medicines, gastrointestinal medications, opioids and any other relevant prescription or supplement.

I do not advise a patient to discontinue important medication without coordinating with the prescribing clinician.

Step 5: Look for Thyroid and Systemic Causes

TSH is particularly important.

Kidney and liver function may be assessed when clinically indicated.

If hypothyroidism is the cause, treating the thyroid disorder can be more rational than immediately starting long-term prolactin-specific medicine.

Step 6: Consider Macroprolactin

If the patient has a laboratory elevation but few or no symptoms, macroprolactin deserves consideration.

This can prevent unnecessary pituitary imaging and unnecessary medication.

Step 7: Arrange Pituitary Imaging When Appropriate



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Persistent biologically active hyperprolactinemia without another convincing explanation may require pituitary MRI.

If a tumor is identified, its size and relationship to the optic structures determine the next step.

Step 8: Assess the Rest of the Fertility System

This is especially important at Saira Health Care.

Even after high prolactin has been identified, I want to know:

Is ovulation returning?

Are the fallopian tubes functional?

What is the woman's age?

Does she have PCOS/PMOS?

Does she have endometriosis?

Are there uterine abnormalities?

And what does her partner's semen analysis show?

Infertility should be evaluated as a couple-level condition.

Step 9: Treat the Cause

A prolactinoma may require cabergoline.

Hypothyroidism requires thyroid treatment.

Medication-induced hyperprolactinemia requires coordinated medication review.

Macroprolactinemia often needs no prolactin-lowering treatment if biologically active prolactin is normal and symptoms are absent.

A compressive nonfunctioning pituitary lesion needs specialist evaluation.

Treatment should therefore follow diagnosis.

Step 10: Restore Fertility Without Wasting Reproductive Time

If prolactin normalizes and ovulation returns, natural conception may become possible.



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If pregnancy still does not occur, we investigate the remaining fertility factors rather than simply increasing cabergoline indefinitely.

Depending on the couple, the next step might involve:

timed intercourse,

ovulation induction for a separate ovulatory disorder,

IUI,

IVF,

or ICSI where another indication exists.

Step 11: Integrate Unani Support Where Appropriate

The Unani component of care can focus on:

nutrition,

healthy routine,

metabolic health,

sleep,

stress,

sexual well-being,

and carefully selected supportive treatment.

But the objective outcomes remain important.

Has prolactin normalized?

Has menstruation resumed?

Has ovulation returned?

Has the tumor responded?

Is fertility improving?

This prevents supportive treatment from becoming an indefinite substitute for objective medical care.

Step 12: Coordinate Specialist Care for Prolactinoma



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A significant prolactinoma—especially a macroprolactinoma—may require collaboration with:

an endocrinologist,

pituitary neurosurgeon,

ophthalmologist,

gynecologist/reproductive-medicine specialist,

and obstetrician when pregnancy occurs.

Complex pituitary disease is best managed by a multidisciplinary team. [Nature](#)

Saira Health Care's Contribution to Sexual Disorders and Infertility

Hyperprolactinemia is particularly relevant to a clinic focused on sexual disorders and infertility because it can produce reproductive and sexual symptoms at the same time.

A woman may have infertility plus low sexual desire.

Another may have amenorrhea and vaginal dryness.

A man may have low testosterone, erectile dysfunction and abnormal semen parameters.

A couple can then develop performance anxiety because intercourse becomes scheduled around fertility treatment.

At **Saira Health Care**, the useful contribution of focused reproductive and sexual-health care is to recognize these connections rather than treating each symptom as a completely separate disease.

Hyperprolactinemia Is Not Always the Only Fertility Problem

This is a point I repeat to patients.

Finding one abnormal test can create a false sense that the diagnosis is complete.

For example:

A woman may have hyperprolactinemia **and** PCOS.

Another may have a prolactinoma **and** blocked fallopian tubes.

Another may have controlled prolactin but her partner may have severe male-factor infertility.



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The correct treatment pathway depends on all of these findings.

Common Mistakes I Encourage Patients to Avoid

One common mistake is assuming that every high prolactin result means a pituitary tumor.

Another is starting cabergoline after only one borderline laboratory result.

Some patients ignore medications that may be causing the elevation.

Others forget to check thyroid function.

Some undergo MRI without first considering macroprolactin.

The opposite error is equally dangerous: assuming persistent high prolactin is “just stress” without investigating it.

Another serious mistake is continuing fertility treatment for months while a macroprolactinoma with visual symptoms remains inadequately assessed.

And some patients take traditional or herbal medicines hoping the prolactinoma will dissolve while delaying endocrine treatment.

A good plan avoids all of these extremes.

Can Hyperprolactinemia Be Permanently Cured?

Sometimes.

It depends entirely on the cause.

If hypothyroidism causes the elevation, treating the thyroid disorder may correct it.

If a medication causes it, an appropriate medication change may resolve it.

Macroprolactinemia may require no treatment.

Some prolactinomas enter long-term remission after medical treatment or successful surgery.

Others require ongoing therapy.

Therefore, the word “**cure**” should not be promised before the cause is known.

Frequently Asked Questions About Hyperprolactinemia and Fertility



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Can high prolactin really prevent pregnancy?

Yes. Persistent hyperprolactinemia can suppress GnRH, LH and FSH, causing irregular ovulation or anovulation and thereby reducing fertility. [Nature](#)

Can I become pregnant after my prolactin becomes normal?

Yes. Many women resume ovulation after appropriate treatment, and fertility can return rapidly. [OUP Academic](#)

Does high prolactin always mean prolactinoma?

No. Medication, pregnancy, hypothyroidism, kidney or liver disease, stress, pituitary-stalk disorders and macroprolactin can also cause an elevated result. [Nature](#)

Can stress raise prolactin?

Yes, usually temporarily. This is one reason a mild elevation should sometimes be repeated before diagnosis. [Nature](#)

Do I need galactorrhea to have hyperprolactinemia?

No. Only a minority of affected women have breast discharge. [ASRM](#)

What is macroprolactin?

Macroprolactin is a large, relatively biologically inactive form of prolactin that can make laboratory prolactin appear elevated without producing the usual clinical symptoms. [Nature](#)

Why is macroprolactin testing important?

Because it can prevent unnecessary MRI and unnecessary treatment when the biologically active prolactin is not actually elevated.

Can hypothyroidism raise prolactin?

Yes. Primary hypothyroidism is a recognized cause and should be investigated when appropriate. [ASRM](#)

Can psychiatric medicines increase prolactin?

Yes. Several dopamine-blocking antipsychotics and certain other medications can increase prolactin. Medication changes must be coordinated with the treating physician rather than stopped abruptly. [Nature](#)

What is a prolactinoma?

It is a usually benign prolactin-secreting pituitary adenoma.

What is the difference between a microprolactinoma and macroprolactinoma?



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A microprolactinoma is smaller than 10 mm; a macroprolactinoma measures 10 mm or more. [Nature](#)

What is the preferred fertility treatment for hyperprolactinemic ovulatory dysfunction?

WHO 2025 suggests cabergoline over bromocriptine, and NICE 2026 recommends cabergoline for ovulatory disorders caused by hyperprolactinemia. [OUP Academic](#)

Does cabergoline shrink prolactinomas?

Yes. Dopamine agonists can both lower prolactin and reduce tumor size in many prolactinoma patients. [Nature](#)

How quickly can fertility return?

Ovulation can return within weeks to months, and sometimes before the first obvious normal menstrual period. A 2026 review reports restoration of the reproductive axis within 6–12 months in most appropriately treated prolactinoma patients. [PubMed](#)

Do I need IVF if I have high prolactin?

Not necessarily. Many women can conceive naturally after prolactin is controlled and ovulation returns, provided no other major fertility factor exists.

Is cabergoline safe before conception?

Current evidence is generally reassuring for conception and early pregnancy exposure. A 2025 systematic review covering 1,662 exposed pregnancies did not identify a clear increase in major malformations or spontaneous abortion, although the quality of evidence was limited. [PMC](#)

Should cabergoline continue throughout pregnancy?

Usually not. In most controlled prolactinomas, dopamine agonists are stopped once pregnancy is confirmed. Selected large macroprolactinomas may require continued or restarted therapy. [Nature](#)

Should prolactin be tested during pregnancy?

Routine prolactin measurement is not recommended in women with prolactinoma during pregnancy because normal pregnancy itself raises prolactin substantially. [OUP Academic](#)

Can a woman with prolactinoma breastfeed?

Usually yes, depending on tumor status and whether medication needs to be restarted for tumor control. [Nature](#)

Can high prolactin affect men?

Yes. It can suppress testosterone and contribute to low libido, erectile dysfunction and impaired fertility. [PubMed](#)

Can Unani medicine lower prolactin?

A responsible Unani approach can support nutrition, lifestyle, metabolic health, sleep, stress and general reproductive health. However, there is currently no high-quality evidence that a particular Unani formulation can reliably treat pathological hyperprolactinemia or shrink a prolactinoma. Proven endocrine treatment should not be delayed.

A Message to My Patients

When a woman tells me:

“Doctor, my prolactin is 40 or 50. Does that mean I have a brain tumor?”

I explain that the answer is **no—not necessarily**.

We first need to repeat or confirm the result where appropriate.

We need to check pregnancy.

We need to look at medicines.

We need to check the thyroid.

We may need to consider macroprolactin.

Only then do we decide whether pituitary imaging is needed.

Another patient may ask:

“My periods have stopped and prolactin is high. Can I still become pregnant?”

In many cases, yes.

If hyperprolactinemia is suppressing your reproductive hormones and we correct the cause, ovulation may return.

And another patient may ask:

“Can I just take cabergoline from a pharmacy?”

My answer is no.

The medicine is very useful in the correct patient, but first we need to understand why the prolactin is elevated.

Treating a laboratory value without diagnosing the cause can hide the real problem.



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My Approach to a Patient Who Wants Pregnancy

When pregnancy is the goal, I think about four separate questions.

First:

Is the prolactin truly elevated and biologically active?

Second:

What is causing it?

Third:

Has the high prolactin actually suppressed ovulation or gonadal function?

And fourth:

Does this couple have any other fertility problem?

Once those questions are answered, treatment becomes far more precise.

A woman with mild stress-related prolactin elevation does not need the same treatment as someone with a macroprolactinoma.

A woman with macroprolactinemia should not be treated in the same way as someone with biologically active hyperprolactinemia.

And a woman with treated prolactinoma plus bilateral tubal blockage should not spend years waiting for prolactin treatment alone to create a pregnancy.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

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

Professional 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



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At **Saira Health Care**, Dr. Nizamuddin Qasmi's focused reproductive-health approach includes evaluation and counselling for sexual disorders, male and female infertility and the interaction between hormonal, sexual and reproductive problems.

For hyperprolactinemia-related infertility, the emphasis is on combining a detailed reproductive and sexual history with appropriate modern hormonal investigation, identification of reversible causes, couple-based fertility assessment and individualized Unani supportive care where clinically appropriate.

When pituitary endocrinology, MRI interpretation, ophthalmological assessment, pituitary surgery, advanced reproductive endocrinology or IVF/ICSI is required, appropriate specialist collaboration should form part of comprehensive care.

The Contribution of Saira Health Care in Hyperprolactinemia and Infertility

At **Saira Health Care**, I believe the main contribution of focused sexual and infertility care is not simply prescribing a prolactin-lowering medicine.

It is distinguishing between:

temporary prolactin elevation,
true pathological hyperprolactinemia,
macroprolactinemia,
drug-induced disease,
thyroid-related hyperprolactinemia,
prolactinoma,
and other pituitary disorders.

It also means determining whether the patient actually has an ovulation problem and whether other female or male fertility factors are present.

This prevents both under-treatment and over-treatment.

A Special Integrative Approach at Saira Health Care

My preferred integrative approach combines:

modern reproductive endocrinology,
careful fertility assessment,
sexual-health evaluation,



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and appropriately selected Unani supportive principles.

The objective is not to replace cabergoline with herbs when cabergoline is medically indicated.

It is also not to ignore lifestyle, nutrition and whole-person health simply because modern medication is available.

The best care uses each approach for the problem it can reasonably address.

In this way:

modern diagnostics identify the endocrine cause,

evidence-based treatment corrects the prolactin abnormality,

and

Unani supportive care can help optimize nutrition, lifestyle, general health, sleep, stress and reproductive well-being.

That is the type of integration I consider clinically meaningful.

What the Latest 2025–2026 Evidence Adds

The most important recent change for infertility practice is that the **WHO's first global infertility guideline**, published in November 2025, now specifically recommends **cabergoline rather than bromocriptine** for female infertility caused by hyperprolactinemic ovulatory dysfunction. [World Health Organization](#)

NICE followed in March 2026 with a clear recommendation to **offer cabergoline for ovulatory disorders caused by hyperprolactinemia**. [Nice](#)

A 2026 review focusing specifically on prolactinoma, fertility and pregnancy confirms that prolactinoma remains an important but frequently treatable cause of infertility and that dopamine-agonist therapy restores gonadal function in most appropriately treated patients. [PubMed](#)

The 2023 Pituitary Society international consensus remains the most comprehensive current specialist guidance on diagnosis, prolactinoma imaging, macroprolactin, the hook effect, medical therapy, surgery and pregnancy monitoring. [Nature](#)

And the 2025 systematic review of cabergoline-exposed pregnancies offers reassuring—but not definitive—safety data, with no clear increase in major malformations or spontaneous abortion across more than 1,600 reported exposures. [PMC](#)

Taken together, these newer sources reinforce a highly practical principle:



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Hyperprolactinemic infertility should usually be treated by correcting the prolactin disorder first—not by immediately escalating to IVF.

Conclusion

Hyperprolactinemia and Fertility are closely connected because excessive prolactin can interfere directly with the hormonal system that controls ovulation, menstruation, testosterone production and reproduction.

In women, persistent hyperprolactinemia can produce:

irregular menstruation,

oligo-ovulation,

anovulation,

amenorrhea,

low estrogen,

galactorrhea,

sexual symptoms,

and infertility.

In men, it can suppress testosterone and contribute to:

reduced libido,

erectile dysfunction,

and impaired sperm production.

But high prolactin is **not one single disease**.

Its causes range from physiological conditions and medications to hypothyroidism, systemic illness, pituitary-stalk compression and true prolactinoma. Laboratory phenomena such as macroprolactin and the rare hook effect can further complicate diagnosis. [Nature](#)

That is why a mildly elevated result should generally be confirmed before treatment.

Medication history, pregnancy testing, thyroid assessment and consideration of macroprolactin are important.

Persistent true hyperprolactinemia may require pituitary MRI.

When a prolactinoma or clinically significant hyperprolactinemia is responsible for infertility, modern treatment is highly effective in many patients.

The 2025 WHO infertility guideline and 2026 NICE guideline now favor **cabergoline** for hyperprolactinemia-related ovulatory infertility. [OUP Academic](#)

Cabergoline can lower prolactin, restore reproductive hormonal signalling, restart ovulation and shrink prolactinomas. In many appropriately treated women, fertility returns without IVF. [Nature](#)

Pregnancy requires individualized planning.

Most women stop dopamine-agonist treatment once pregnancy is confirmed, while selected large macroprolactinomas require closer surveillance or continued treatment. Prolactin should not routinely be monitored during pregnancy because normal pregnancy itself raises prolactin. [OUP Academic](#)

From the **Unani perspective**, the principle of **Izala-i-Sabab—identify and address the causative factor**—fits especially well with hyperprolactinemia.

CCRUM recognizes **Ilaj-bil-Ghiza, Ilaj-bil-Tadbir, Ilaj-bil-Dawa and Ilaj-bil-Yad** as the principal therapeutic approaches of Unani medicine. [CCRuM](#)

In modern integrative practice, these principles can support nutrition, lifestyle, general health, stress, sleep, menstrual well-being and sexual health.

But scientific responsibility requires one clear statement:

No Unani or herbal formulation has currently been proven in high-quality clinical trials to reliably shrink a prolactinoma or replace established dopamine-agonist therapy for pathological hyperprolactinemia.

Therefore, at **Saira Health Care**, my preferred approach is:

confirm the prolactin abnormality, find its cause, determine its effect on ovulation and fertility, evaluate both partners, correct reversible factors, use evidence-based endocrine treatment when indicated, and integrate appropriate Unani supportive care without delaying necessary modern treatment.

When a patient asks me:

“Doctor, my prolactin is high. Does this mean I cannot become pregnant?”

my answer is:

No. Hyperprolactinemia is often a very treatable cause of infertility. The important step is to identify why the prolactin is elevated and treat that cause correctly.

The goal is not merely to make a laboratory number normal.

The real goal is:

to restore healthy reproductive function, protect the patient's broader health and give the couple the best realistic opportunity for pregnancy.

Medical Disclaimer: This article is intended for medical education and general patient awareness. Hyperprolactinemia should be confirmed and investigated according to the clinical situation. Patients should not start or stop cabergoline, bromocriptine, thyroid medicines, psychiatric medicines, fertility hormones, herbal products or Unani formulations solely on the basis of an online article. Persistent prolactin elevation, visual symptoms, severe headache or a suspected pituitary tumor may require endocrinology, ophthalmology and neurosurgical evaluation. Treatment recommendations during pregnancy depend on tumor size and clinical circumstances. No conventional, surgical, Unani, herbal or assisted-reproductive treatment can guarantee conception or live birth.



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