

## Hydrosalpinx and Infertility

**Blocked Fluid-Filled Fallopian Tube, Causes, Symptoms, Diagnosis, Natural Pregnancy, Ectopic Pregnancy, Tubal Surgery, IVF, Salpingectomy and an Integrative Unani Approach**

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

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### **Introduction: “Doctor, My HSG Shows Hydrosalpinx — Can I Still Become Pregnant?”**

When a woman comes to me with an HSG or ultrasound report saying “**hydrosalpinx**”, her first question is usually:

**“Doctor, does this mean my fallopian tube is completely damaged? Can I still become pregnant?”**

Another patient may say:

**“One tube has hydrosalpinx but the other tube is open. Do I need IVF?”**

And a woman preparing for IVF may ask an equally important question:

**“If IVF bypasses the fallopian tubes, why is my doctor recommending removal or blockage of the hydrosalpinx before embryo transfer?”**

These questions are important because hydrosalpinx is not simply a “blocked tube.”

A hydrosalpinx is a **damaged, distended fallopian tube that has become filled with fluid**, usually because its distal end near the ovary has become blocked. The underlying disease may also damage the delicate cilia and inner lining of the tube that are responsible for transporting the egg and early embryo.

Hydrosalpinx is therefore important in fertility for two separate reasons.



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First, it can prevent the egg and sperm from meeting naturally.

Second—and this surprises many patients—the fluid inside a hydrosalpinx can sometimes flow backward toward the uterus and **reduce embryo implantation even when IVF is being used.**

This is why the newest major international guidelines specifically address hydrosalpinx. The World Health Organization's first global infertility guideline, published in November 2025, recommends that women with hydrosalpinx who are proceeding to IVF should generally have the affected tube **removed by salpingectomy or disconnected from the uterine cavity by tubal occlusion** beforehand. [NCBI](#)

The updated **NICE fertility guideline published in March 2026** independently recommends offering laparoscopic salpingectomy or tubal occlusion for hydrosalpinges before IVF. [Nice](#)

This does not mean every woman with hydrosalpinx needs the same surgery.

A young woman with mild disease and a potentially repairable tube is different from a woman with severe bilateral hydrosalpinges, dense adhesions and diminished reproductive time.

The central question should therefore be:

**How badly is the tube damaged, can it still function, is one or both tubes involved, and would preserving, removing or bypassing the tube provide this particular couple with the most appropriate path toward pregnancy?**

That is the framework I use when counselling patients with hydrosalpinx.

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## What Is a Hydrosalpinx?

The word **hydrosalpinx** comes from two ideas:

**hydro** — fluid

**salpinx** — fallopian tube.

A hydrosalpinx develops when a fallopian tube becomes obstructed—usually at its distal or fimbrial end—and fluid gradually collects within the tube.

The tube becomes:

- swollen,
- elongated,
- distended,



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- and often functionally damaged.

It may affect **one tube or both tubes**.

When both sides are affected, the condition is called **bilateral hydrosalpinx**.

When only one tube is affected, it is called **unilateral hydrosalpinx**.

The severity can also vary enormously. One woman may have a relatively thin-walled mildly dilated tube with preserved internal folds, while another may have a very large, thick, fibrotic tube with extensive pelvic adhesions and almost complete destruction of the normal tubal lining.

That difference is crucial when deciding whether the tube should be repaired or removed.

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### Understanding the Normal Fallopian Tube

To understand why hydrosalpinx causes infertility, it is helpful to understand what a healthy fallopian tube actually does.

The fallopian tube is not simply a hollow pipe connecting the ovary and uterus.

It is an active reproductive organ.

The outer end has delicate finger-like structures called **fimbriae**.

Around ovulation, the fimbriae help capture the egg after it is released from the ovary.

Inside the tube are microscopic hair-like structures called **cilia**.

These cilia and coordinated muscular contractions help transport the egg, sperm and eventually the early embryo.

Fertilization normally occurs within the fallopian tube.

The early embryo then travels toward the uterine cavity, where implantation occurs several days later.

For natural fertility, a tube therefore needs more than an open channel.

It needs:

**normal anatomy + functioning fimbriae + healthy cilia + coordinated tubal movement.**

A tube can technically appear “open” yet still function poorly if its internal lining has been severely damaged.



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## How Does a Hydrosalpinx Develop?

Hydrosalpinx usually represents the final result of previous inflammation and scarring.

Inflammation damages the inner lining of the tube.

The fimbrial end can become scarred and sealed.

Normal secretions produced inside the tube can no longer drain appropriately.

Fluid accumulates.

The tube gradually enlarges.

If the proximal end remains connected to the uterus, this fluid may intermittently flow backward into the uterine cavity.

This is clinically important because treatment before IVF is largely intended to **prevent hydrosalpinx fluid from reaching the uterine cavity**. WHO explicitly identifies this as the objective of hydrosalpinx treatment before IVF. [NCBI](#)

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## What Causes Hydrosalpinx?

Several diseases can damage the fallopian tubes.

The most important causes include:

**Pelvic inflammatory disease**

**Previous sexually transmitted infection**

**Genital tuberculosis**

**Endometriosis**

**Previous pelvic or abdominal surgery**

**Previous ectopic pregnancy or tubal surgery**

**Pelvic adhesions**

**Less commonly, other inflammatory disorders of the pelvis**

Among these, previous **pelvic inflammatory disease—PID—is one of the most important worldwide causes.**

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## Pelvic Inflammatory Disease



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PID is an infection and inflammatory condition involving the upper female reproductive tract.

Important infectious causes include organisms associated with **chlamydia and gonorrhea**, although PID can involve multiple organisms.

Some women have dramatic symptoms.

Others may have relatively mild infection and never realize their fallopian tubes were affected.

The infection can heal, but the resulting fibrosis and ciliary damage can remain.

This is why a woman may say:

**“Doctor, I never had a serious pelvic infection.”**

and still have tubal-factor infertility years later.

Hydrosalpinx frequently represents the **structural consequence of an infection that has already passed**, not necessarily an active infection occurring today. A systematic review of ultrasound diagnosis notes that prior PID is the most frequent historical association with hydrosalpinx. [PubMed Central \(PMC\)](#)

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## **Chlamydia and Gonorrhea**

Untreated sexually transmitted infections can spread upward from the cervix into the uterus and fallopian tubes.

Once the tube becomes inflamed, the delicate internal structures can be permanently injured.

The body heals the infection by forming scar tissue.

That scar tissue may:

narrow the tube,

block the fimbriae,

produce adhesions around the tube,

or eventually create a hydrosalpinx.

This is why STI prevention, early diagnosis and appropriate treatment have reproductive-health importance even when symptoms appear mild.

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## **Female Genital Tuberculosis and Hydrosalpinx**



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In India and other settings where tuberculosis remains clinically relevant, **female genital tuberculosis—FGTB—deserves particular attention in selected infertility patients.**

Genital tuberculosis can damage:

the fallopian tubes,

endometrium,

ovaries,

and surrounding pelvic tissues.

Tubal involvement is especially common.

A 2025 review describes FGTB as an important and often under-recognized cause of infertility, particularly in developing-country settings. [PubMed](#)

A 2025 systematic review of diagnostic laparoscopy and hysteroscopy found tubal beading, adhesions and hydrosalpinx among recurrent findings associated with genital tuberculosis. [PubMed](#)

Recent Indian data remain relevant. A 2026 report from North India studying infertile women undergoing hystero-laparoscopic evaluation emphasized the diagnostic complexity of genital tuberculosis and the limitations of relying on a single laboratory test. [PubMed](#)

However, I want to emphasize an important point:

**Hydrosalpinx does not automatically mean genital tuberculosis.**

Tuberculosis testing should be selected according to:

history,

clinical risk,

imaging findings,

previous TB exposure,

pelvic findings,

and specialist judgement.

Empirical anti-tuberculosis therapy should not be started simply because an HSG shows blocked tubes.

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## Endometriosis and Hydrosalpinx



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Endometriosis can create chronic pelvic inflammation and adhesions.

These adhesions can distort the relationship between:

ovary,

fimbriae,

fallopian tube,

uterus,

and bowel.

In selected patients, this can contribute to distal tubal obstruction or a hydrosalpinx.

A woman with endometriosis may therefore have more than one mechanism of infertility:

ovarian disease,

pelvic inflammation,

adhesions,

and tubal damage.

This is why diagnosing hydrosalpinx should not automatically end the infertility investigation.

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### **Previous Pelvic Surgery**

Previous operations can sometimes produce adhesions around the tubes.

Examples can include:

previous ectopic-pregnancy surgery,

tubal procedures,

pelvic infection surgery,

endometriosis surgery,

or other abdominal and pelvic operations.

Postoperative adhesions can distort tubal anatomy and occasionally contribute to distal obstruction.

The surgical history may therefore provide an important clue.



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## **Hydrosalpinx Can Be Unilateral or Bilateral**

This distinction has major fertility implications.

### **Unilateral Hydrosalpinx**

Only one tube is affected.

If the opposite tube is anatomically and functionally healthy, spontaneous conception may still be possible.

However, the hydrosalpinx itself can remain clinically important, especially if it communicates with the uterus.

### **Bilateral Hydrosalpinx**

Both tubes are affected.

If both are severely blocked and nonfunctional, natural fertilization becomes extremely difficult because sperm and egg cannot meet normally.

IVF is often required.

However, because IVF places the embryo directly into the uterus, many patients understandably ask:

### **“Then why remove or block the tubes?”**

The answer lies in the effect of the hydrosalpinx fluid on implantation.

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## **How Does Hydrosalpinx Cause Natural Infertility?**

Hydrosalpinx can interfere with natural conception in several ways.

The fimbriae may be sealed.

The egg may not enter the tube.

Sperm may be unable to reach the egg.

The tube's cilia may be damaged.

Tubal movement may be abnormal.

Pelvic adhesions may prevent the tube and ovary from interacting normally.

Even if fertilization occurs, transport of the embryo toward the uterus may be impaired.

This creates not only infertility but also an increased risk that the embryo may implant inside the damaged tube instead of reaching the uterus.



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That condition is an **ectopic pregnancy**.

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## Hydrosalpinx and Ectopic Pregnancy

Tubal disease is an important risk factor for ectopic pregnancy.

If a damaged tube remains partially functional, fertilization can occasionally occur but the embryo may fail to travel normally.

The embryo can then implant within the tube.

After fertility-preserving surgery for hydrosalpinx, this risk remains clinically important.

A 2023 systematic review involving **1,317 women** who underwent reproductive surgery for hydrosalpinx found a pooled natural intrauterine-pregnancy rate of approximately **27%** and ectopic-pregnancy rate of about **4.8%**, with far better outcomes in mild disease than severe disease. [PubMed](#)

An earlier larger salpingostomy meta-analysis found a natural clinical-pregnancy rate of about 27% and an ectopic-pregnancy rate around 10%, highlighting variation between study populations and surgical techniques. [PubMed](#)

For this reason:

**Any pregnancy occurring after significant tubal disease or tubal reconstructive surgery deserves appropriately timed early ultrasound to confirm that the pregnancy is inside the uterus.**

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## Why Does Hydrosalpinx Reduce IVF Success?

This is one of the most important facts about this condition.

IVF bypasses the fallopian tubes.

Eggs are collected directly from the ovaries.

Fertilization occurs in the laboratory.

The embryo is placed directly into the uterine cavity.

So logically, it would appear that damaged fallopian tubes should no longer matter.

But hydrosalpinx still matters because fluid from a communicating tube can reflux into the uterus.

Several mechanisms have been proposed.

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## 1. Mechanical Flushing of the Embryo

Hydrosalpinx fluid may intermittently enter the uterine cavity.

This may physically interfere with embryo-endometrial contact.

In simple terms, fluid continuously entering the uterus can create an unfavorable environment for an embryo attempting to implant.

ASRM identifies mechanical flushing as one of the plausible explanations for reduced implantation in women with hydrosalpinx. [ASRM](#)

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## 2. Altered Endometrial Receptivity

Implantation requires carefully coordinated interaction between the embryo and uterine lining.

Hydrosalpinx fluid and associated inflammatory processes may alter the molecular environment of the endometrium.

ASRM identifies reduced endometrial receptivity as another possible mechanism underlying poorer IVF outcomes. [ASRM](#)

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## 3. Inflammatory or Embryotoxic Effects

Hydrosalpinx fluid contains products produced within an abnormal, inflamed tube.

Laboratory and clinical research has suggested that this environment may adversely affect:

sperm,

embryonic development,

or implantation.

The exact importance of direct “toxicity” relative to mechanical and endometrial factors remains debated, so I do not tell patients that hydrosalpinx fluid is simply “poison.”

The scientifically safer conclusion is that **several biological and mechanical mechanisms probably contribute simultaneously.**

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## How Much Can Hydrosalpinx Affect IVF?

The negative association is clinically substantial.



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Historical meta-analyses found pregnancy, implantation and delivery rates roughly **50% lower** in IVF patients with untreated hydrosalpinges compared with tubal-infertility patients without hydrosalpinx. [ASRM](#)

More modern systematic reviews continue to find lower implantation and clinical-pregnancy rates and higher risks of miscarriage and ectopic pregnancy when hydrosalpinx is present. [PubMed](#)

The effect appears especially important when the hydrosalpinx is sufficiently large to be visible on ultrasound. [ASRM](#)

This is why major guidelines recommend treatment before IVF rather than simply ignoring the damaged tube.

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### **Does One-Sided Hydrosalpinx Affect IVF?**

Yes.

Even unilateral hydrosalpinx may reduce IVF pregnancy rates if it communicates with the uterus.

ASRM specifically notes poorer IVF pregnancy rates in unilateral disease and improvement after treatment in published studies. [ASRM](#)

Therefore:

**“Only one tube is affected” does not automatically mean it is irrelevant before IVF.**

The anatomy and communication with the uterine cavity matter.

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### **Does Hydrosalpinx Cause Miscarriage?**

Hydrosalpinx is associated with a higher miscarriage rate in fertility-treatment populations.

However, miscarriage has many possible causes—including embryo chromosome abnormalities, maternal age and other uterine or medical conditions.

Therefore, if a woman with hydrosalpinx experiences a miscarriage, we should not automatically conclude that the tube was definitely responsible.

The association means that untreated hydrosalpinx is an important potentially modifiable factor, particularly before IVF—not that it explains every pregnancy loss.

[PubMed](#)



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## Symptoms of Hydrosalpinx

Many women with hydrosalpinx have **no symptoms at all**.

The first clue may simply be infertility.

Possible symptoms include:

- difficulty becoming pregnant,
- chronic or intermittent pelvic pain,
- pelvic pressure or discomfort,
- pain associated with menstruation,
- discomfort during intercourse in some women,
- previous recurrent pelvic infection,
- and occasionally abnormal watery vaginal discharge.

If fever, severe pelvic pain or marked tenderness develops, an active infection or another acute pelvic condition should be considered rather than assuming the symptoms come only from a chronic hydrosalpinx.

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## Hydrosalpinx Does Not Usually Cause Hormonal Infertility

Hydrosalpinx affects the **fallopian tubes**.

It does not normally stop the ovary from releasing eggs.

A woman can therefore have:

regular periods,

normal ovulation,

normal AMH,

and normal reproductive hormones

while still being infertile because both fallopian tubes are nonfunctional.

This distinction is extremely important.

Treating ovulation in a woman whose only major problem is bilateral hydrosalpinx will not restore the physical pathway through which egg and sperm must normally meet.

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## Does Hydrosalpinx Lower AMH?



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Hydrosalpinx itself is primarily tubal disease rather than an ovarian-reserve disorder.

A woman can have excellent ovarian reserve despite severe tubal damage.

However, age and coexisting conditions such as endometriosis or previous ovarian surgery may independently affect AMH.

There is also ongoing concern about whether **salpingectomy** can affect ovarian blood supply because the tube and ovary share nearby vascular connections.

Evidence is mixed.

A 2022 meta-analysis found no clear reduction when patients were compared with themselves before and after surgery, but some case-control comparisons suggested lower AMH/AFC following salpingectomy. [PubMed](#)

WHO therefore specifically advises surgeons performing pre-IVF salpingectomy to take care not to compromise ovarian vascular supply. [NCBI](#)

This concern becomes particularly relevant in women with:

low ovarian reserve,

bilateral disease,

previous pelvic surgery,

dense adhesions,

or only one functioning ovary.

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## Diagnosing Hydrosalpinx

Diagnosis should answer several questions:

Is a hydrosalpinx actually present?

Is it unilateral or bilateral?

How severely is the tube damaged?

Does it communicate with the uterus?

Is the opposite tube patent?

Are pelvic adhesions present?

Is endometriosis present?

Could genital tuberculosis be relevant?



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And what does all of this mean for this patient's fertility plan?

Several diagnostic methods may be used.

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### Transvaginal Ultrasound

A significant hydrosalpinx can often be identified on expert transvaginal ultrasound.

It commonly appears as an **elongated, tubular, fluid-filled structure separate from the ovary**.

Characteristic features may include:

incomplete septations,

folding of the distended tube,

and the chronic **“beads-on-a-string”** appearance caused by fibrotic remnants of the tubal folds.

A 2023 systematic review and meta-analysis of almost 4,000 women found pooled transvaginal-ultrasound sensitivity of approximately **84%** and specificity around **99%** for hydrosalpinx in the included studies. [PubMed Central \(PMC\)](#)

This makes ultrasound highly useful.

But a normal ultrasound does not prove both tubes are healthy or open.

Smaller or non-distended tubal disease can be missed.

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### Hysterosalpingography — HSG

HSG is one of the most established fertility investigations for fallopian-tube patency.

A thin catheter is placed through the cervix.

Contrast medium is introduced into the uterine cavity.

X-ray imaging then shows whether contrast moves through the fallopian tubes and spills into the pelvis.

With hydrosalpinx, the HSG may show:

a distended tube,

distal obstruction,

and absence or abnormality of free peritoneal spill.



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The **2025 WHO infertility guideline recommends either HSG or HyCoSy for women with infertility in whom tubal disease is suspected.** [NCBI](#)

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### **Hysterosalpingo-Contrast Sonography — HyCoSy**

HyCoSy evaluates tubal patency using ultrasound and a contrast medium introduced through the cervix.

An advantage is that it avoids conventional X-ray radiation.

WHO's 2025 assessment found no compelling overall diagnostic advantage of HSG over HyCoSy and recommends either depending on:

availability,

operator expertise,

patient preference,

and factors such as contrast allergy. [NCBI](#)

The best test therefore depends on the clinical situation and local expertise.

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### **Can HSG Give a False Diagnosis?**

Yes.

Tubal testing is not perfect.

Spasm near the uterine end of the tube can occasionally mimic proximal obstruction.

Mucus or technical factors can alter appearances.

Conversely, contrast passage does not prove the microscopic tubal cilia are healthy.

This is why a fertility specialist interprets the HSG together with history, ultrasound and other findings rather than treating one image as the complete diagnosis.

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### **Laparoscopy With Dye**

Laparoscopy allows the surgeon to see the pelvis directly.

Dye can be introduced through the cervix to observe whether it exits through the fimbrial ends.

Laparoscopy can also identify:



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pelvic adhesions,  
endometriosis,  
the external appearance of hydrosalpinges,  
tubo-ovarian relationships,  
and other pelvic pathology.

WHO describes laparoscopy with chromopertubation as the reference standard for confirming tubal disease. [NCBI](#)

However, because it is an operation requiring anesthesia, it is not necessary for every woman simply to screen for tubal patency.

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### **When Is Laparoscopy Particularly Useful?**

NICE recommends HSG as a less-invasive screening test in women without known major pelvic comorbidities.

For women thought to have associated conditions such as:

previous PID,  
previous ectopic pregnancy,  
or endometriosis,

NICE recommends laparoscopy and dye because pelvic and tubal pathology can be assessed simultaneously. [Nice](#)

This is a useful practical distinction.

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### **MRI**

MRI is not usually the first-line investigation for hydrosalpinx.

It can sometimes help when:

ultrasound findings are uncertain,  
complex adnexal pathology exists,  
endometriosis is suspected,  
or another pelvic mass needs better characterization.

For routine tubal-patency assessment, HSG or HyCoSy is more relevant.



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## Hydrosalpinx Versus Ovarian Cyst

A hydrosalpinx can sometimes resemble an ovarian or paraovarian cyst.

Expert ultrasound looks for whether the structure is separate from the ovary and whether it has a tubular folded morphology.

This distinction matters because:

an ovarian cyst and a hydrosalpinx have very different implications for fertility treatment.

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## Hydrosalpinx Versus Pyosalpinx

A **hydrosalpinx** contains relatively clear serous fluid and generally represents chronic distal tubal obstruction.

A **pyosalpinx** is a fallopian tube filled with pus, usually related to active severe infection.

A patient with pyosalpinx may have:

fever,

significant pelvic pain,

tenderness,

systemic illness,

and inflammatory laboratory abnormalities.

That can require urgent antibiotic and gynecological management.

Chronic hydrosalpinx and acute pyosalpinx should not be treated as the same condition.

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## Hydrosalpinx Versus Hematosalpinx

A hematosalpinx is a fallopian tube distended with blood.

Possible causes include:

ectopic pregnancy,

endometriosis,



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torsion,

or other pathology.

Again, the imaging appearance and clinical situation determine the diagnosis.

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### **Can Antibiotics Cure Hydrosalpinx?**

This question is extremely common.

If a woman currently has an active bacterial pelvic infection, **appropriate antibiotics are essential.**

But once the fallopian tube has developed extensive fibrosis, loss of cilia and a permanently sealed distal end, antibiotics do not mechanically reconstruct the tube.

ASRM notes that irreversible damage to tubal cilia after salpingitis helps explain why a tube can become technically patent after reconstructive surgery yet still have reduced reproductive function. [ASRM Integration](#)

Therefore:

**Treating infection and repairing structural tubal damage are two different things.**

Likewise, confirmed genital tuberculosis requires appropriate anti-tuberculosis treatment—but antitubercular therapy cannot guarantee that a tube already destroyed by fibrosis will regain normal reproductive function.

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### **Can Hydrosalpinx Be Treated Without Surgery?**

It depends on the objective.

If the patient is not seeking pregnancy, has no symptoms and no active disease requiring treatment, observation may be appropriate in selected situations.

If IVF is planned, however, treatment of a communicating hydrosalpinx usually becomes much more important.

Possible approaches include:

salpingectomy,

proximal tubal occlusion,

salpingostomy in selected repairable disease,

aspiration in limited circumstances,



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and some emerging procedures such as sclerotherapy.

The correct treatment depends on:

age,

severity,

unilateral versus bilateral disease,

adhesions,

ovarian reserve,

desire for natural conception,

and whether IVF is already required.

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### **Fertility-Preserving Tubal Surgery**

Some hydrosalpinges can potentially be repaired.

This is particularly relevant in a younger patient who:

has mild tubal damage,

has no major male infertility,

has no severe additional infertility factor,

has favorable reproductive anatomy,

and strongly desires natural conception.

Procedures can include:

#### **Fimbrioplasty**

The fimbrial end of the tube is surgically reconstructed.

#### **Neosalpingostomy**

A new opening is created at the distal end of the obstructed tube.

ASRM recommends considering laparoscopic fimbrioplasty or neosalpingostomy for **mild hydrosalpinges in young women with no other significant infertility factor.**

[ASRM](#)

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### **Natural Pregnancy After Tubal Repair**

Pregnancy after tubal reconstructive surgery is possible.



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But success depends heavily on the severity of the tubal damage.

A 2023 systematic review found an overall natural intrauterine-pregnancy rate of about **27% after fertility-preserving hydrosalpinx surgery.**

More importantly, outcomes differed greatly by disease severity:

mild disease had substantially better pregnancy outcomes,

while severe hydrosalpinx had poor natural-conception results. [PubMed](#)

These numbers come mainly from observational studies and should not be interpreted as guaranteed personal probabilities.

The experience of the surgeon and condition of the tubal mucosa matter enormously.

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### **The Risk of Re-Obstruction**

Opening a hydrosalpinx does not necessarily restore a normal tube permanently.

The original problem often involved severe inflammation and fibrosis.

The new opening may scar closed again.

Fluid can reaccumulate.

This is called **recurrent hydrosalpinx**.

ASRM specifically advises counselling women that re-occlusion can occur after reconstructive surgery and that later salpingectomy may ultimately be needed. [ASRM Integration](#)

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### **Who Is a Poor Candidate for Tubal Repair?**

Tubal reconstruction is much less attractive when there are:

large hydrosalpinges,

thick fibrotic tubal walls,

extensive dense adhesions,

severely damaged or absent internal mucosa,

combined proximal and distal obstruction,

older reproductive age,

poor ovarian reserve,



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significant male-factor infertility,

or other reasons IVF is already required.

ASRM describes these features as **poor-prognosis hydrosalpinx** and favors salpingectomy followed by IVF. [ASRM](#)

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### What Does the New WHO Guideline Say About Tubal Surgery Versus IVF?

The 2025 WHO guideline provides useful age- and severity-based guidance for tubal infertility.

For women **younger than 35 with mild-to-moderate tubal disease**, WHO conditionally suggests surgery rather than immediately proceeding to IVF.

For women under 35 with **severe tubal disease**, WHO favors IVF.

For women **35 or older with tubal disease**, WHO generally suggests IVF rather than reconstructive tubal surgery.

These recommendations are conditional and supported by very-low-certainty evidence, so they should guide—not mechanically determine—individual treatment. [NCBI](#)

WHO suggests that after fertility-preserving surgery for appropriate mild-to-moderate disease in younger women, around one year can be a reasonable period for attempting pregnancy before considering another intervention such as IVF. [NCBI](#)

That does not mean every patient should wait one year. Age, reserve and other fertility factors can justify moving faster.

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### Salpingectomy

**Salpingectomy means surgical removal of the affected fallopian tube.**

It is usually performed laparoscopically.

Importantly:

**Salpingectomy removes the tube—not the ovary.**

The ovary remains in place and can continue producing eggs and hormones.

If one tube is removed but the opposite tube is healthy, natural conception can still occur through the remaining tube.

If **both fallopian tubes are removed**, natural fertilization through intercourse is no longer possible because sperm and egg cannot meet through the tubal pathway.



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However, IVF remains possible because IVF bypasses the tubes.

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### **Why Would We Remove a Tube in Someone Trying to Become Pregnant?**

This can initially sound contradictory.

The reason is that a severely damaged hydrosalpinx may be doing more harm than good.

A nonfunctional tube may:

prevent natural conception,

increase ectopic-pregnancy risk,

and reduce IVF implantation by allowing hydrosalpinx fluid to enter the uterus.

In that situation, removing the diseased tube can improve the reproductive environment for IVF.

---

### **Hydrosalpinx Treatment Before IVF: What WHO Says in 2025**

The newest WHO infertility guideline specifically recommends:

**salpingectomy or tubal occlusion before IVF for women with hydrosalpinx.**

WHO states that either method can be selected according to:

surgical feasibility,

availability of trained clinicians,

presence of adhesions,

and patient circumstances. [NCBI](#)

The certainty of evidence is classified as **very low**, an important limitation that should be disclosed.

The recommendation nevertheless reflects the consistent clinical concern that untreated hydrosalpinx reduces IVF success.

---

### **What Does NICE Say in 2026?**

The March 2026 NICE fertility guideline gives a very clear recommendation:

**Offer laparoscopic salpingectomy or tubal occlusion to treat hydrosalpinges before IVF. [Nice](#)**

This is one of the most important current recommendations for fertility clinics.

If surgery carries a particularly high risk of complications, NICE says **aspiration close to the time of oocyte retrieval can be considered**. [Nice](#)

This provides an alternative for carefully selected women in whom laparoscopy is not considered safe or practical.

---

### Proximal Tubal Occlusion

Instead of removing the hydrosalpinx, a surgeon may disconnect it from the uterine cavity.

This is called **proximal tubal occlusion**.

The objective is to prevent hydrosalpinx fluid from flowing back into the uterus.

The tube remains physically present but no longer communicates normally with the uterine cavity.

Randomized and meta-analytic evidence suggests that proximal occlusion and salpingectomy can both improve IVF outcomes, without convincing evidence that one is universally superior. [PubMed](#)

WHO therefore allows either strategy. [NCBI](#)

---

### Why Might Tubal Occlusion Be Chosen Instead of Salpingectomy?

In some women, the hydrosalpinx is surrounded by severe pelvic adhesions.

Completely removing the tube may then increase the risk of:

bleeding,

damage to the ovary,

damage to the bowel,

or injury to nearby structures.

Proximal occlusion may sometimes be technically safer.

But leaving the tube also means the hydrosalpinx remains physically present, and ASRM notes a theoretical possibility that it can enlarge after proximal occlusion because fluid can no longer drain toward the uterus. [ASRM](#)

The decision therefore requires surgical judgement.



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## Aspiration of Hydrosalpinx Fluid

Under ultrasound guidance, fluid can be aspirated from the tube.

This is much less invasive than laparoscopy.

However, the damaged tube is still present and can refill.

WHO's newest evidence assessment therefore favors **salpingectomy or occlusion over aspiration before IVF**, while allowing aspiration where those procedures are unavailable or not feasible. [NCBI](#)

NICE 2026 similarly reserves aspiration primarily for situations in which laparoscopic surgery carries a high risk of complications. [Nice](#)

Thus aspiration should generally be viewed as a **selected alternative rather than the preferred permanent solution**.

---

## Sclerotherapy

Sclerotherapy involves aspirating hydrosalpinx fluid and introducing an agent intended to reduce secretion and encourage the tube to scar down.

It is being studied as a minimally invasive alternative.

A 2024 network meta-analysis of nine randomized trials plus observational data found that salpingectomy and laparoscopic tubal occlusion clearly improved clinical-pregnancy outcomes compared with no intervention; sclerotherapy also showed potentially promising results in aggregated analyses. However, the randomized evidence did not establish a significant difference between methods for live birth. [PubMed](#)

Therefore, sclerotherapy remains a **selected or evolving alternative**, not something I would present as superior to current guideline-supported surgery.

---

## What Does the 2024 Network Meta-Analysis Add?

The 2024 systematic review and network meta-analysis is useful because it compared several approaches:

salpingectomy,

proximal tubal occlusion,

aspiration,



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sclerotherapy,

and expectant management.

It found that salpingectomy and proximal occlusion improved clinical-pregnancy rates compared with no treatment, while no clear live-birth superiority between treatment methods could be established from the randomized evidence. [PubMed](#)

This is an important reminder that:

**Current recommendations are clinically strong, but the comparative evidence between individual procedures is still imperfect.**

Patient anatomy and surgical risk remain central.

---

### **Does Salpingectomy Reduce the Number of Eggs Retrieved During IVF?**

This remains an important concern.

A systematic review and meta-analysis found no significant difference in the number of retrieved eggs after salpingectomy in randomized or observational comparisons and found improved pregnancy and live-birth outcomes in randomized trials. [PubMed](#)

However, another meta-analysis focusing specifically on ovarian-reserve markers found conflicting findings, with some comparisons suggesting modestly lower AMH or AFC after surgery. [PubMed](#)

For this reason I would not tell patients either:

**“Salpingectomy definitely damages the ovary,”**

or

**“There is absolutely no ovarian risk.”**

The more accurate statement is:

**the overall IVF evidence is reassuring, but careful surgical technique is important—especially when operating close to ovarian blood vessels.**

WHO explicitly makes the same caution. [NCBI](#)

---

### **Should Eggs Be Retrieved Before Salpingectomy?**

Not routinely.

But in selected women with:



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very low ovarian reserve,  
extensive bilateral adhesions,  
high surgical risk,  
or concern that surgery could compromise ovarian access or blood supply,  
a reproductive-medicine team may consider the sequence of egg retrieval and tubal treatment carefully.

There is no universal rule that every woman should freeze eggs or embryos before salpingectomy.

The timing should be individualized.

---

### **IVF After Bilateral Salpingectomy**

This question worries many women.

If both hydrosalpinges are removed, the ovaries still remain.

They continue producing eggs.

During IVF, those eggs are collected directly from the ovaries.

Fertilization occurs in the laboratory.

The embryo is then placed inside the uterus.

Therefore:

### **Fallopian tubes are not required for IVF.**

For severe bilateral hydrosalpinx, removing or isolating the damaged tubes can actually improve the uterine environment for embryo transfer.

---

### **Does Hydrosalpinx Automatically Require ICSI?**

No.

This is an important distinction.

Hydrosalpinx is a **female tubal-factor infertility problem**.

ICSI is primarily a fertilization technique used when there is:

significant male-factor infertility,

previous fertilization failure,



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very limited sperm availability,

or another specific indication.

If the male partner's semen is appropriate, conventional IVF may be possible.

Hydrosalpinx itself does not automatically require sperm injection into the egg.

---

### **Can IUI Treat Hydrosalpinx?**

IUI does not bypass the fallopian tubes.

It places prepared sperm into the uterus, but the sperm and egg still need a functional tube to meet.

Therefore, bilateral severe hydrosalpinx is generally a poor situation for IUI.

In unilateral disease with a healthy opposite tube, the situation is more complicated. Some pregnancy may still be possible naturally or with IUI, but distal tubal pathology tends to have poorer outcomes than proximal obstruction.

A 2023 systematic review found that evidence for IUI after unilateral tubal disease is limited and heterogeneous, with distal tubal disease having less favorable outcomes.

[PubMed](#)

A personalized fertility plan is therefore preferable to repeated low-probability IUI cycles.

---

### **What If Only One Tube Has Hydrosalpinx?**

This depends strongly on the opposite tube.

If the other tube is healthy and the patient is young, natural conception may still occur.

But there are several questions:

Is the hydrosalpinx large?

Does it communicate with the uterine cavity?

Is the patient experiencing pain?

How long has infertility continued?

Is the other tube genuinely healthy?

Is there male infertility?

Is IVF already required for another reason?



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In selected women, treating the unilateral hydrosalpinx can improve fertility.

ASRM reports observational evidence showing improved IVF outcomes after unilateral salpingectomy and even spontaneous conceptions in some women once the diseased unilateral tube was removed. [ASRM](#)

---

### **What If Both Tubes Have Hydrosalpinx?**

The first question is whether either tube has a realistic chance of functional reconstruction.

If both are severely damaged, natural conception is unlikely.

In that situation, IVF is usually the more effective reproductive strategy, after appropriate management of the hydrosalpinges.

The WHO guideline favors IVF rather than reconstructive surgery for severe tubal disease in women under 35, and for tubal disease generally in women aged 35 and older. [NCBI](#)

---

### **The Importance of Female Age**

This is one of the most important treatment decisions.

A 26-year-old woman with mild unilateral hydrosalpinx and excellent ovarian reserve has a very different situation from a 39-year-old woman with bilateral severe disease.

The younger woman may reasonably consider fertility-preserving tubal surgery.

For the older patient, spending a year or more attempting to restore severely damaged tubes may use reproductive time during which egg quantity and quality continue to decline.

This is why WHO incorporates age into its tubal-infertility recommendations. [NCBI](#)

---

### **Ovarian Reserve Matters Too**

Age is central, but AMH and antral follicle count can help predict ovarian response when IVF is being considered.

A woman with diminished ovarian reserve may need a different sequence of:

surgery,

egg retrieval,

embryo creation,

and hydrosalpinx treatment

than a woman with excellent ovarian reserve.

The hydrosalpinx report cannot make this decision by itself.

---

### **The Male Partner Must Be Evaluated**

This is particularly important at Saira Health Care because my focused practice covers both sexual disorders and infertility.

Suppose we perform technically successful reconstructive tubal surgery so that the woman can attempt natural pregnancy.

Then we discover that her husband has severe oligozoospermia requiring ICSI.

The main reason for preserving the tube may no longer apply.

Therefore, semen analysis should form part of the couple's fertility assessment before major fertility-directed surgery.

WHO's 2025 infertility guideline consistently frames infertility evaluation and treatment around both female and male reproductive factors rather than treating one partner in isolation. [World Health Organization](https://www.who.int/news-room/fact-sheets/detail/infertility)

---

### **Hydrosalpinx and Recurrent IVF Failure**

If a woman has experienced failed embryo transfers and subsequently a hydrosalpinx is identified, the finding deserves serious attention.

However, not every failed transfer should automatically be blamed on the hydrosalpinx.

Other factors include:

embryo quality,

female age,

uterine cavity abnormalities,

endometrial pathology,

laboratory factors,

and additional reproductive conditions.



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Still, because hydrosalpinx is a **potentially treatable factor with established negative association with IVF outcomes**, it is one of the structural problems that should generally be addressed before further embryo transfer. [NCBI](#)

---

### **Hydrosalpinx and Recurrent Pregnancy Loss**

Untreated hydrosalpinx has been associated with increased early pregnancy loss.

But recurrent miscarriage requires a broader evaluation.

Embryonic chromosome abnormalities, uterine conditions, antiphospholipid syndrome and other factors may also contribute.

Treating hydrosalpinx should therefore be part of a comprehensive reproductive strategy rather than assuming it explains every previous loss.

---

### **Can Hydrosalpinx Come Back?**

After salpingostomy or other tubal-conserving surgery, yes.

The original tubal tissue remains.

Scarring can recur.

The tube can close again.

Fluid can reaccumulate.

After complete salpingectomy, the removed tube itself obviously cannot redevelop a hydrosalpinx, although disease could theoretically affect the opposite tube if it remains.

This is another factor when choosing between preservation and removal.

---

### **Can Hydrosalpinx Be Prevented?**

Not every case is preventable.

But some major causes of tubal damage can be reduced through:

prompt diagnosis and treatment of pelvic infections,

appropriate STI prevention and treatment,

partner treatment where indicated,

avoiding unnecessary pelvic infection risk,



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and timely assessment of suspected genital tuberculosis or endometriosis.

The most important prevention principle is to protect the fallopian tubes **before irreversible fibrosis develops**.

Once the delicate tubal lining has been destroyed, restoring true biological function becomes much harder than simply opening the tube.

---

### **Hydrosalpinx and the Unani System of Medicine**

As a physician trained in the **Unani System of Medicine**, I believe hydrosalpinx is a condition where traditional principles can be useful—but only when they are applied with a clear understanding of modern reproductive anatomy.

A hydrosalpinx is a structural disease of the fallopian tube.

Therefore:

**It should not be claimed that one traditional medicine, herb or diet can reliably reopen a severely scarred fallopian tube.**

This is an important limitation.

At the same time, Unani medicine places considerable emphasis on treating the **cause**, supporting general health and selecting dietary, lifestyle, pharmacological or procedural treatment according to the actual condition.

That framework can be highly useful when applied responsibly.

---

### **Is There an Exact Classical Unani Term for Hydrosalpinx?**

Classical Unani physicians described infertility—'**Uqr**'—as well as pelvic, uterine and inflammatory disorders that may produce symptoms overlapping with modern tubal disease.

But hydrosalpinx is a modern anatomical diagnosis based on:

ultrasound,

HSG,

HyCoSy,

laparoscopy,

and modern understanding of the fallopian tube.



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Therefore, I do not believe it is scientifically appropriate to state that hydrosalpinx is exactly equivalent to one classical Unani diagnosis.

The modern anatomical diagnosis should first be established.

---

### **Izala-i-Sabab — Treating the Cause**

CCRUM's official description of Unani medicine identifies **Izala-i-Sabab**, or correction/removal of the causative factor, as a fundamental principle of treatment.

[CCRUM](#)

I consider this particularly relevant to hydrosalpinx.

If active infection is present, the infection needs evidence-based treatment.

If genital tuberculosis is present, it requires appropriate anti-tuberculosis treatment.

If endometriosis is contributing to adhesions, that condition requires appropriate evaluation.

If the tube is severely fibrotic and filled with fluid, the structural damage must be acknowledged.

If IVF is planned, the hydrosalpinx may need to be removed or isolated.

This is a much stronger clinical interpretation of **Izala-i-Sabab** than simply giving the same “female fertility tonic” to every patient.

---

### **The Four Major Unani Treatment Modalities**

CCRUM describes the principal modes of Unani treatment as:

**Ilaj-bil-Tadbir — Regimental Therapy**

**Ilaj-bil-Ghiza — Dietotherapy**

**Ilaj-bil-Dawa — Pharmacotherapy**

**Ilaj-bil-Yad — Surgery** [CCRUM](#)

These concepts can be integrated into contemporary care according to what the patient actually needs.

---

### **Ilaj-bil-Ghiza — Dietotherapy**

Good nutrition supports:

healthy body weight,



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metabolic health,  
adequate micronutrient intake,  
preconception health,  
and general recovery.

This can be especially useful when infertility coexists with:

PCOS/PMOS,  
obesity,  
anemia,  
diabetes,  
or poor nutritional habits.

However:

**No specific diet has been proven to reopen a blocked hydrosalpinx.**

Diet should therefore support the patient, not replace structural treatment.

---

### **Ilaj-bil-Tadbir — Regimental and Lifestyle Care**

The Unani emphasis on healthy routine can be integrated through:

appropriate physical activity,  
sleep,  
weight optimization,  
stress management,  
general pelvic and reproductive health,  
and avoidance of unhealthy exposures.

These measures may improve overall fertility health.

But they cannot mechanically reconstruct destroyed tubal fimbriae.

The distinction between **supportive care** and **anatomical repair** needs to remain clear.

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### **Ilaj-bil-Dawa — Unani Pharmacotherapy**



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Unani medicine contains traditional pharmacological approaches used for gynecological, inflammatory and fertility-related complaints.

However, there is presently **no high-quality clinical evidence demonstrating that a specific Unani formulation reliably reverses established hydrosalpinx, restores destroyed tubal cilia or produces live-birth rates comparable with guideline-directed surgery or IVF.**

Therefore, in my practice, Unani pharmacotherapy is best used as:

**individualized supportive treatment alongside appropriate fertility management.**

A patient should not spend several reproductive years taking different herbal or Unani preparations while bilateral severe tubal disease remains untreated.

---

### Why “Anti-Inflammatory” Does Not Mean “Tube-Opening”

This is an important concept.

A medicine can potentially help an inflammatory symptom.

That does not mean it can reverse mature scar tissue.

Once inflammation has caused:

fibrosis,

tubal sealing,

loss of fimbrial architecture,

and destruction of cilia,

the clinical problem becomes partly structural.

This is why active infection and chronic hydrosalpinx require different treatment strategies.

---

### Ilaj-bil-Yad — When Surgery Is the Appropriate Treatment

Perhaps the most relevant Unani therapeutic concept in hydrosalpinx is **Ilaj-bil-Yad**, or procedural/surgical treatment.

CCRUM officially includes surgery among the accepted treatment modalities of Unani medicine. [CCRUM](#)



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If a structural blockage is preventing pregnancy or hydrosalpinx fluid is compromising IVF, modern laparoscopic treatment can be entirely consistent with a cause-oriented integrative philosophy.

Depending on the patient, that may involve:

fimbrioplasty,

neosalpingostomy,

salpingectomy,

or proximal tubal occlusion.

Using surgery where surgery is appropriate does not contradict integrative medicine.

It is part of treating the disease according to its nature.

---

### **Unani Support Before and After Surgery**

Unani supportive care may be useful around fertility treatment for:

diet,

general health,

sleep,

stress,

bowel health,

sexual well-being,

and individualized symptom support.

However, all herbal and Unani medicines should be disclosed before surgery or IVF.

Some preparations can potentially affect:

bleeding,

blood sugar,

blood pressure,

liver metabolism,

or interactions with conventional medicines.



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CCRUM itself maintains formal drug-standardization programmes addressing manufacturing standards and testing for contaminants including heavy metals, microorganisms, aflatoxins and pesticide residues. [CCRUM](#)

Quality-controlled medicines and professional supervision therefore matter.

---

### **The Saira Health Care Approach to Hydrosalpinx**

At **Saira Health Care**, I do not approach hydrosalpinx simply as:

**“tube blocked—give fertility medicine.”**

My approach is to understand the **entire reproductive mechanism**.

The first question is:

**Is this really a hydrosalpinx, and how severe is it?**

A one-line HSG report is only the beginning.

---

### **Step 1: Confirm the Tubal Diagnosis**

I review:

HSG or HyCoSy,

expert pelvic ultrasound,

whether one or both tubes are affected,

whether the hydrosalpinx is large enough to be visible sonographically,

and whether additional laparoscopy is clinically justified.

A large ultrasound-visible hydrosalpinx is particularly important before IVF. [ASRM](#)

---

### **Step 2: Investigate Why the Tube Became Damaged**

The history may point toward:

previous PID,

previous STI,

genital tuberculosis risk,

endometriosis,

ectopic pregnancy,



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pelvic surgery,

or previous severe pelvic inflammation.

Treating the underlying active disease remains important even when the structural damage cannot be fully reversed.

---

### **Step 3: Determine Whether Disease Is Mild and Potentially Repairable or Severe and Nonfunctional**

This is one of the most important decisions.

A thin-walled mildly damaged tube with preserved fimbrial anatomy is different from a massively distended fibrotic hydrosalpinx with dense adhesions.

ASRM specifically distinguishes **good-prognosis hydrosalpinges suitable for selected reconstruction from poor-prognosis tubes better treated with salpingectomy and IVF.** [ASRM](#)

---

### **Step 4: Consider the Woman's Age**

Age may determine whether there is enough reproductive time to attempt tubal reconstruction.

WHO's newest recommendations distinguish younger women with mild disease from older women or patients with severe disease for exactly this reason. [NCBI](#)

---

### **Step 5: Evaluate Ovarian Reserve Where Relevant**

AMH and AFC can help guide treatment, particularly when IVF or potentially difficult tubal surgery is being considered.

A woman with low ovarian reserve may benefit from a different sequence of treatment from a woman with excellent reserve.

---

### **Step 6: Evaluate the Other Fallopian Tube**

In unilateral hydrosalpinx, the condition of the opposite tube can completely change the plan.

If the opposite tube is healthy, natural conception may remain realistic.

If both are damaged, IVF becomes much more likely.



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### Step 7: Evaluate the Male Partner

I consider semen analysis essential before major fertility-directed decisions.

If severe male-factor infertility already requires ICSI, prolonged efforts to preserve damaged tubes may provide little benefit.

This is where Saira Health Care's focused work across **sexual disorders, male infertility and female infertility** can be particularly useful in couple-based counselling.

---

### Step 8: Evaluate Ovulation and Other Female Fertility Factors

Hydrosalpinx may not be the only condition present.

A woman may simultaneously have:

PCOS/PMOS,

endometriosis,

adenomyosis,

low ovarian reserve,

fibroids,

or an ovulatory disorder.

The treatment plan should address the complete fertility picture.

---

### Step 9: Decide Between Tubal Repair and IVF

The decision considers:

age,

disease severity,

ovarian reserve,

male-factor findings,

number of children desired,

duration of infertility,

risk of ectopic pregnancy,

surgical expertise,



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IVF availability,

cost,

and patient preference.

ASRM emphasizes essentially the same variables when counselling between tubal surgery and IVF. [ASRM](#)

---

### **Step 10: Treat Hydrosalpinx Before IVF When Indicated**

When a clinically relevant hydrosalpinx is present before IVF, current WHO 2025 and NICE 2026 guidance supports:

**salpingectomy or proximal tubal occlusion.** [NCBI](#)

Aspiration is reserved more for cases in which surgery is unsafe, unavailable or impractical.

---

### **Step 11: Integrate Unani Support Responsibly**

At this stage I may integrate appropriate Unani principles for:

nutrition,

metabolic health,

lifestyle,

sleep,

stress,

general reproductive health,

and selected associated symptoms.

But supportive treatment does not replace correction or bypass of a severely damaged tube.

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### **Step 12: Monitor Objectively**

Treatment success should not be judged simply by:

less pain,

improved energy,



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or a subjective feeling that the tubes have become stronger.

We need objective reproductive outcomes.

After reconstructive surgery:

Is the tube still patent?

Has hydrosalpinx recurred?

Has natural pregnancy occurred?

After salpingectomy or occlusion:

Is IVF proceeding appropriately?

Objective monitoring keeps treatment scientifically grounded.

---

### **Saira Health Care's Contribution to Sexual Disorders and Infertility**

One of the most important contributions a focused infertility clinic can make is to prevent different conditions from being treated as though they are identical.

A woman with:

bilateral severe hydrosalpinx,

a woman with one mildly damaged tube,

a woman with genital tuberculosis,

and a woman with PCOS

can all present with the same complaint:

**“We are not getting pregnant.”**

But they require very different treatment.

At **Saira Health Care**, the intended clinical contribution is therefore a **cause-oriented and couple-oriented approach**.

The patient should understand:

what is damaged,

whether it is reversible,

which treatment has meaningful evidence,

where Unani supportive care can contribute,

and when modern surgery or assisted reproduction is more appropriate.



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## Why Sexual-Health Assessment Also Matters

Infertility treatment can place major stress on intimate relationships.

A woman with previous PID, endometriosis or pelvic surgery may also have painful intercourse.

Long fertility treatment can reduce sexual desire.

The male partner may develop performance anxiety or erectile difficulties when intercourse becomes scheduled.

Therefore, treating hydrosalpinx should not mean ignoring the sexual well-being of the couple.

This is particularly relevant in a clinic with focused practice in both **sexual disorders and infertility**.

---

## Natural Pregnancy After One Tube Is Removed

Yes, pregnancy can occur naturally after unilateral salpingectomy if:

the remaining tube is open and functional,

ovulation occurs,

the male partner's sperm is adequate,

and no major additional infertility factor exists.

The egg released from either ovary can sometimes be captured by the remaining tube because the ovaries and tubes are not rigidly isolated on two separate sides.

However, this should not be used to promise natural conception in every patient.

The condition of the remaining tube is more important than simply knowing that it exists.

---

## Natural Pregnancy After Both Tubes Are Removed

If both fallopian tubes are completely removed, egg and sperm cannot meet through the normal reproductive tract.

Natural conception is therefore not expected.

But the uterus and ovaries can remain fully present.



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IVF can collect eggs directly from the ovaries, create embryos in the laboratory and transfer an embryo into the uterus.

Thus:

**Bilateral salpingectomy does not mean a woman cannot have her own biological child—it means conception requires IVF if she wishes to use her own eggs and carry the pregnancy.**

---

### **Does Salpingectomy Cause Early Menopause?**

Removing the fallopian tubes does not directly remove the ovaries and should not itself be equated with menopause.

However, because ovarian and tubal blood supplies are anatomically close, surgeons need to preserve ovarian vascularization.

Current data about long-term ovarian-reserve effects are not completely uniform, which is why careful technique is particularly important in bilateral surgery or women with reduced reserve. [PubMed](#)

---

### **Can Hydrosalpinx Fluid Disappear on Its Own?**

The amount of fluid may fluctuate.

A hydrosalpinx can look larger on one scan and smaller on another.

Fluid can sometimes intermittently drain into the uterus.

But disappearance of visible fluid does not necessarily mean that the damaged tube has returned to normal function.

The underlying fibrosis and loss of cilia may remain.

Therefore, treatment decisions should not be based only on whether the tube happened to look less distended on one particular day.

---

### **Pregnancy After Tubal Surgery: Early Monitoring Matters**

Because tubal disease and reconstructive tubal surgery increase the risk of ectopic pregnancy, a positive pregnancy test deserves timely follow-up.

This may include:

serial pregnancy hormone testing where clinically required

and

early transvaginal ultrasound to document an intrauterine gestational sac.

Symptoms such as:

severe one-sided pelvic pain,

shoulder-tip pain,

fainting,

dizziness,

or significant bleeding

during early pregnancy require urgent medical assessment because ruptured ectopic pregnancy can be life-threatening.

---

## **Common Mistakes I Encourage Patients to Avoid**

### **Assuming “blocked tube” always means IVF**

Mild disease in selected younger patients may sometimes be surgically repairable.

### **Assuming every hydrosalpinx should be repaired**

Severely damaged tubes often have poor natural-fertility potential and can reduce IVF success.

### **Doing repeated IUI despite bilateral severe hydrosalpinx**

IUI still requires functional tubes.

### **Beginning IVF embryo transfer while ignoring a significant hydrosalpinx**

Current WHO and NICE guidance recommends treating hydrosalpinx before IVF. [NCBI](#)

### **Assuming antibiotics can reopen chronic scarred tubes**

Antibiotics treat active bacterial infection; established tubal fibrosis is a structural problem.

### **Taking anti-tuberculosis medicines simply because an HSG looks abnormal**

Genital TB requires appropriate diagnostic evaluation.

### **Taking fertility medicines only for the woman without semen testing**

Male-factor infertility can completely change the treatment plan.

### **Waiting years for herbal medicine to “dissolve” a severely damaged hydrosalpinx**



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Current evidence does not support such a claim, and reproductive age continues advancing during the delay.

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## **Frequently Asked Questions About Hydrosalpinx**

### **What exactly is hydrosalpinx?**

It is a fallopian tube that has become blocked and distended with fluid, usually as a result of previous inflammation and scarring.

### **Is hydrosalpinx the same as a blocked tube?**

Hydrosalpinx is a type of tubal blockage, usually involving the distal end, but it also implies fluid accumulation and often more extensive structural damage.

### **What is the most common cause?**

Previous pelvic inflammatory disease is one of the most common causes. Previous infection, genital tuberculosis in appropriate settings, endometriosis and pelvic surgery can also contribute. [PubMed Central \(PMC\)](#)

### **Can hydrosalpinx exist without symptoms?**

Yes. Infertility may be the only clue.

### **Can one hydrosalpinx cause infertility?**

Yes, although spontaneous conception may remain possible if the opposite tube is healthy.

### **Can both hydrosalpinges cause complete infertility?**

Severe bilateral hydrosalpinx makes natural conception extremely difficult because both tubal pathways are damaged. IVF often becomes the appropriate reproductive option.

### **Can ultrasound detect hydrosalpinx?**

Yes. A 2023 meta-analysis found pooled sensitivity around 84% and specificity around 99% for transvaginal ultrasound in the included studies. [PubMed Central \(PMC\)](#)

### **Which is better for checking tubes—HSG or HyCoSy?**

WHO 2025 considers either appropriate for suspected tubal disease; selection depends on availability, expertise, allergy considerations and patient preference. [NCBI](#)

### **Do I always need laparoscopy?**



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No. Laparoscopy is invasive and is not necessary merely to screen every infertility patient. It becomes particularly useful when significant pelvic disease such as endometriosis, previous PID or ectopic pregnancy is suspected. [Nice](#)

### **Can antibiotics cure hydrosalpinx?**

Antibiotics can treat an active bacterial infection but cannot reliably reconstruct a tube already damaged by mature fibrosis and loss of cilia.

### **Can Unani medicine open hydrosalpinx?**

Unani medicine can provide individualized supportive care for nutrition, general health, lifestyle and associated symptoms. However, there is no high-quality evidence that a Unani formulation can reliably reopen a severely scarred hydrosalpinx.

### **Can a hydrosalpinx be repaired?**

Yes, selected mild hydrosalpinges can be treated with procedures such as fimbrioplasty or neosalpingostomy, particularly in younger women without other major infertility factors. [ASRM](#)

### **What is the chance of pregnancy after tubal repair?**

Published observational meta-analysis suggests an overall intrauterine-pregnancy rate around 27%, with much better outcomes in mild disease and substantially poorer results in severe disease. [PubMed](#)

### **Can pregnancy after tubal repair be ectopic?**

Yes. The risk is elevated because the tube remains damaged. Early pregnancy location should therefore be confirmed.

### **Why remove a tube before IVF?**

Hydrosalpinx fluid can reach the uterus and reduce implantation and pregnancy rates. Treating the tube improves IVF outcomes. [ASRM](#)

### **What does WHO currently recommend?**

WHO's 2025 infertility guideline suggests **salpingectomy or tubal occlusion before IVF** for hydrosalpinx. [NCBI](#)

### **What does NICE recommend?**

NICE 2026 recommends offering laparoscopic salpingectomy or tubal occlusion before IVF. Aspiration can be considered when laparoscopic surgery has a high risk of complications. [Nice](#)

### **Is salpingectomy better than tubal occlusion?**



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Both are accepted. Current evidence has not established one as universally superior for pregnancy or live birth. Anatomy, adhesions and surgical risk help determine the choice. [PubMed](#)

### **Can hydrosalpinx return after surgery?**

It can recur after salpingostomy or other tubal-conserving procedures because the tube may scar closed again. A completely removed tube cannot redevelop hydrosalpinx.

### **Can I conceive naturally after one tube is removed?**

Yes, if the remaining tube is healthy and no other major infertility factor exists.

### **Can I become pregnant after both tubes are removed?**

Yes through IVF, because the ovaries and uterus remain and IVF bypasses the fallopian tubes.

### **Does bilateral salpingectomy require ICSI?**

Not necessarily. ICSI depends mainly on sperm and fertilization factors, not on the absence of fallopian tubes.

### **Can genital tuberculosis cause hydrosalpinx?**

Yes. FGTB can cause tubal scarring and infertility, particularly in TB-endemic settings, but hydrosalpinx by itself does not prove tuberculosis. [PubMed](#)

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## **A Message to My Patients**

When a patient says:

**“Doctor, my HSG shows hydrosalpinx. Does this mean my hope of pregnancy is finished?”**

my answer is:

**No. But we need to choose treatment according to the condition of the tubes and the complete fertility situation.**

If only one tube is mildly affected and the other is healthy, pregnancy may still occur naturally.

If a young woman has mild repairable tubal disease, fertility-preserving surgery may sometimes be reasonable.

If both tubes are severely damaged, IVF may provide a much more effective pathway.



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And if IVF is planned while a communicating hydrosalpinx remains present, we should not simply ignore it because the newest WHO and NICE guidelines recommend treating it before embryo transfer.

Another patient asks me:

**“Doctor, can you give medicine first so I do not have to remove my tube?”**

I explain that the answer depends on what is wrong.

If there is active infection, medicine is necessary.

If there is a nutritional or metabolic problem, supportive treatment can help general reproductive health.

But if the tube has become a large fibrotic fluid-filled structure whose inner lining is severely destroyed, medicine cannot be promised to reconstruct normal tubal cilia.

The most important aim is not to “save the tube” at any cost.

**The aim is to protect the patient's best realistic chance of becoming pregnant.**

Sometimes that means preserving a tube.

Sometimes it means repairing it.

Sometimes it means removing or disconnecting a nonfunctional tube so that IVF has a better opportunity to succeed.

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## 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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The professional profile supplied for this article reflects Dr. Nizamuddin Qasmi's focused clinical work and additional training in infertility, sexual and reproductive health and male infertility.

At **Saira Health Care**, the objective in hydrosalpinx-associated infertility is to assess the woman and the couple comprehensively rather than treating one abnormal scan in isolation.

The assessment may include:

tubal-factor evaluation,

ovulation and ovarian-reserve assessment,

male-partner semen evaluation,

sexual-health concerns,

identification of possible infection or genital tuberculosis where clinically indicated,

and counselling regarding natural conception, tubal surgery, IVF or ICSI.

When laparoscopic tubal reconstruction, salpingectomy, advanced gynecological surgery, IVF or complex tuberculosis/pelvic-infection management is required, appropriate specialist collaboration and referral should form part of comprehensive care.

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### The Special Contribution of Saira Health Care

For hydrosalpinx, I consider one of Saira Health Care's most useful contributions to be **connecting female tubal disease with the couple's complete infertility and sexual-health picture.**

A woman should not undergo major surgery before anyone has examined her partner's semen.

A man should not receive fertility medicines because his wife has tubal infertility.

A patient with severe bilateral hydrosalpinx should not spend years taking empirical medicines while her ovarian age advances.

And a patient with mild potentially repairable disease should not automatically be told that IVF is her only option without individualized assessment.

That balance—between preserving natural fertility when realistic and using modern assisted reproduction when necessary—is central to responsible infertility care.



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## How I Integrate Modern Fertility Care and Unani Medicine at Saira Health Care

My preferred approach is not to ask:

**“Should we use modern medicine or Unani medicine?”**

The more useful question is:

**“What aspect of this patient's problem requires which type of treatment?”**

Modern imaging can show whether the tube is blocked and enlarged.

Laparoscopy can define adhesions and tubal anatomy.

Surgery can repair, remove or disconnect a severely diseased tube.

IVF can bypass destroyed tubes.

Evidence-based antimicrobial therapy can treat active infection.

At the same time, individualized Unani care can support:

nutrition,

metabolic health,

lifestyle,

sleep,

stress,

general reproductive health,

and associated menstrual or sexual-health concerns.

This is meaningful integration because each approach is being used for what it can realistically achieve.

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## What the Latest 2025–2026 Evidence Changes

The most important current development is the publication of the **WHO's first global infertility guideline in November 2025**.

For hydrosalpinx specifically, WHO now advises **salpingectomy or tubal occlusion before IVF**, while recognizing that the evidence certainty remains very low and treatment should consider adhesions, feasibility and surgical expertise. [NCBI](#)

WHO also takes a broader age-based approach to tubal infertility:

younger women with mild-to-moderate disease may reasonably consider surgery,



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whereas severe disease and older reproductive age generally favor IVF. [NCBI](#)

The second major current update is the **NICE guideline published March 31, 2026**, which directly recommends offering laparoscopic salpingectomy or tubal occlusion before IVF and allows aspiration near egg retrieval when laparoscopic complications are considered particularly likely. [Nice](#)

The newest comparative meta-analytic evidence also reminds us that although treating hydrosalpinx clearly improves clinical-pregnancy outcomes compared with no treatment, evidence is insufficient to declare one intervention universally best for live birth. [PubMed](#)

Thus the modern direction is clear:

**Treat clinically important hydrosalpinx—but personalize how it is treated.**

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## Conclusion

**Hydrosalpinx is one of the most important structural causes of female tubal-factor infertility.**

It develops when a fallopian tube becomes blocked, damaged and distended with fluid, usually following inflammation and scarring.

The most common clinical background is previous pelvic inflammatory disease, but hydrosalpinx can also occur with genital tuberculosis, endometriosis, previous pelvic surgery and other causes of tubal injury. [PubMed Central \(PMC\)](#)

Hydrosalpinx can impair natural fertility by:

preventing normal egg pickup,

blocking sperm passage,

destroying tubal cilia,

distorting pelvic anatomy,

and increasing the risk of ectopic pregnancy.

It can also reduce fertility **even during IVF** because hydrosalpinx fluid may reflux into the uterine cavity and interfere with implantation through mechanical, inflammatory and endometrial mechanisms. [ASRM](#)

Diagnosis can involve expert transvaginal ultrasound, HSG or HyCoSy.

WHO's 2025 guideline considers **HSG and HyCoSy both appropriate choices for assessing suspected tubal disease.** [NCBI](#)



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Laparoscopy with dye remains particularly useful when associated pelvic disease is suspected or when surgery itself is being considered. [Nice](#)

Treatment depends on the reproductive goal.

For selected young women with mild disease and otherwise favorable fertility, tubal reconstruction may preserve the possibility of natural conception.

For severe disease, extensive fibrosis, older reproductive age or significant additional infertility, IVF is usually more appropriate.

And when IVF is planned:

**the newest WHO 2025 and NICE 2026 guidelines support treating hydrosalpinx with salpingectomy or tubal occlusion before embryo transfer.** [NCBI](#)

Aspiration has a more limited role because the fluid can recur.

Sclerotherapy remains an evolving alternative.

From the **Unani perspective**, the principle of **Izala-i-Sabab—identify and address the causative factor—** is particularly relevant. CCRUM formally describes **Ilaj-bil-Ghiza, Ilaj-bil-Tadbir, Ilaj-bil-Dawa and Ilaj-bil-Yad** as recognized treatment modalities.

[CCRUM](#)

In a modern fertility setting, Unani treatment can therefore provide meaningful support for:

diet,

lifestyle,

general health,

metabolic well-being,

stress,

sleep,

and associated reproductive or sexual-health complaints.

But scientific responsibility requires one clear limitation:

**No Unani, herbal or oral medicine has been proven to reliably reconstruct a severely scarred fallopian tube or permanently eliminate an established hydrosalpinx.**

A structural problem sometimes requires structural treatment.

At **Saira Health Care**, my preferred approach is therefore:

**confirm the diagnosis, determine why the tube was damaged, establish whether one or both tubes are affected, assess the severity of disease, evaluate ovarian reserve and reproductive age, assess the male partner, preserve natural fertility when realistic, treat hydrosalpinx before IVF when indicated, and integrate appropriate Unani supportive care without delaying necessary surgery or assisted reproduction.**

When a patient asks me:

**“Doctor, can I become pregnant with hydrosalpinx?”**

my answer is:

**Yes, pregnancy is possible for many women with hydrosalpinx—but the best path depends on whether the tube can still function, whether the other tube is healthy and what the complete fertility evaluation shows.**

The correct objective is not simply to keep every fallopian tube.

It is:

**to preserve every realistic opportunity for a healthy pregnancy.**

**Saira Health Care**

**Dr. Nizamuddin Qasmi — Founder & Chief Physician**

**Focused Practice in Sexual Disorders & Infertility**

**Medical Disclaimer:** This article is intended for medical education and general patient awareness. Hydrosalpinx and tubal-factor infertility require individualized evaluation. Patients should not begin antibiotics, anti-tuberculosis medicines, fertility medicines, herbal products or Unani formulations solely because an ultrasound or HSG reports hydrosalpinx. Active pelvic infection and genital tuberculosis require specific diagnostic and medical treatment. Tubal reconstructive surgery, salpingectomy, tubal occlusion, IVF and ICSI should be selected according to age, tubal severity, ovarian reserve, male fertility, surgical risk and patient preference. Pregnancy after significant tubal disease may carry an increased risk of ectopic pregnancy and should receive appropriate early assessment. No conventional, surgical, Unani, herbal or assisted-reproductive treatment can guarantee conception, pregnancy or live birth.



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