

Adenomyosis and Fertility

Causes of Infertility, Symptoms, Diagnosis, Ovarian Reserve, Implantation, Miscarriage, Natural Conception, IVF, Fertility-Preserving Treatment and an Integrative Unani Approach

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

When a woman comes to me with a scan report saying “**adenomyosis**”, one of her first concerns is often:

“Doctor, will I be able to become pregnant?”

Another woman may say:

“My periods are very painful and heavy, but my main concern is that we have been trying for pregnancy for a long time.”

Some women have already undergone several cycles of fertility treatment. Others have adenomyosis together with endometriosis, fibroids, a reduced ovarian reserve, sexual pain or a male-factor infertility problem in their partner.

My first message is therefore very important:

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

Many women with adenomyosis conceive naturally. Others achieve pregnancy with appropriately selected fertility treatment such as ovulation-based treatment, intrauterine insemination in selected circumstances, or IVF/ICSI. Some women benefit from fertility-preserving treatment of the adenomyosis itself, while others are better served by avoiding unnecessary surgery and proceeding directly with reproductive treatment.



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The newest 2026 reviews emphasize that adenomyosis is **highly heterogeneous**. Its reproductive effect appears to depend on factors such as whether disease is focal or diffuse, the amount of uterine involvement, uterine volume, junctional-zone disturbance, symptoms, age, coexisting endometriosis and other fertility factors. There is still no one universally accepted fertility-treatment protocol that is best for every woman with adenomyosis.

For this reason, my approach is not simply:

“Adenomyosis is present, so give one medicine.”

I prefer to ask:

How much is adenomyosis actually affecting this woman's reproductive system, and what is the safest and most time-efficient route toward pregnancy for this particular couple?

What Is Adenomyosis?

Adenomyosis is a **benign, estrogen-responsive disorder of the uterus** in which tissue resembling the endometrium—the tissue that normally lines the inside of the uterus—is present within the muscular wall of the uterus, called the **myometrium**.

The surrounding muscle responds to this abnormal tissue with changes that can include inflammation, enlargement, fibrosis and abnormal uterine architecture.

Adenomyosis may therefore cause a uterus that is enlarged, tender or more globular than usual.

The Society of Obstetricians and Gynaecologists of Canada guideline recognizes adenomyosis as a condition affecting people of reproductive age and identifies **transvaginal ultrasound and MRI** as the principal modern imaging methods used in diagnosis.

Adenomyosis was historically diagnosed mainly after hysterectomy, when the uterus could be examined under a microscope.

That is no longer how we need to approach most reproductive-age women.

Modern ultrasound and MRI have made it possible to identify adenomyosis without removing the uterus, which is particularly important for women who wish to preserve fertility.

Adenomyosis Is Not the Same as Endometriosis



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Patients frequently confuse these two conditions.

They are related and can occur together, but they are not identical.

Feature	Adenomyosis	Endometriosis
Main location	Within the muscular wall of the uterus	Outside the uterus
Common sites	Myometrium	Ovaries, tubes, pelvic lining, bowel, bladder and other pelvic areas
Typical symptoms	Heavy bleeding, painful periods, pelvic pain, infertility	Painful periods, pelvic pain, painful intercourse, bowel/bladder symptoms, infertility
Uterine enlargement	Common in more extensive disease	Not a defining feature
Endometrioma	No	May occur in ovary
Definitive removal	Hysterectomy removes uterine adenomyosis	Hysterectomy does not necessarily remove all endometriosis

A woman can have **both adenomyosis and endometriosis**, and combined disease may further complicate fertility evaluation.

Adenomyosis Is Also Different From Fibroids

Fibroids, or leiomyomas, are benign tumors arising from uterine smooth muscle.

Adenomyosis is not a fibroid.

A fibroid often forms a reasonably defined mass.

Diffuse adenomyosis can infiltrate the uterine muscle much less distinctly, making complete surgical removal more difficult.

A localized adenomyotic lesion may sometimes form an **adenomyoma**, which can resemble a fibroid on imaging.

This is another reason why expert ultrasound or MRI can be important before fertility-related surgery.

Types of Adenomyosis



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Adenomyosis is not one uniform condition.

Modern imaging allows us to describe different patterns.

Diffuse Adenomyosis

In diffuse adenomyosis, abnormal tissue and secondary muscular changes involve a broader area of the uterine wall.

The uterus can become globally enlarged.

This form may be more difficult to remove surgically because there may not be one clear boundary between abnormal and healthy myometrium.

Focal Adenomyosis

In focal adenomyosis, the disease is concentrated in a more localized region.

A more distinct mass-like focal lesion is sometimes called an **adenomyoma**.

Focal disease can occasionally be more suitable for fertility-preserving excisional surgery than extensive diffuse disease.

Internal and External Adenomyosis

Increasingly, researchers are studying adenomyosis according to whether disease is predominantly located closer to the endometrial cavity and junctional zone or toward the outer myometrium.

A 2026 review suggests that internal and external phenotypes may have different associations with implantation failure, pregnancy loss, endometriosis and infertility, although these phenotype-specific findings still require better prospective validation.

This is a rapidly evolving field.

Symptoms of Adenomyosis

Some women have obvious symptoms.

Others have none and discover adenomyosis during a fertility ultrasound.

Common symptoms can include **painful menstruation, heavy or prolonged menstrual bleeding, chronic pelvic pain, pressure or heaviness in the pelvis, pain during intercourse and infertility**. Adenomyosis may also coexist with fibroids or endometriosis, making it difficult to determine which condition is responsible for which symptom. Current clinical guidelines therefore recommend tailoring management to the patient's predominant problems—pain, bleeding, infertility or combinations of these.



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The severity of symptoms does not always tell us how much adenomyosis is present.

A woman with extensive ultrasound findings can sometimes have relatively mild symptoms.

Another woman with more limited disease may have severe dysmenorrhea.

Does Adenomyosis Cause Infertility?

Increasing evidence suggests that adenomyosis can **contribute to reduced fertility**, but the relationship is complex.

Not every woman with adenomyosis is infertile, and a diagnosis of adenomyosis does not prove that adenomyosis is the only reason pregnancy has not occurred.

The latest 2026 fertility review describes several mechanisms linking adenomyosis with reduced implantation and abnormal placentation, including **junctional-zone disruption, hyperestrogenism, progesterone resistance, immune dysregulation and chronic inflammation**.

Another 2026 review emphasizes inflammation, abnormal uterine contractility and impaired endometrial receptivity as important reproductive mechanisms.

In most patients, several mechanisms probably overlap.

Understanding the Junctional Zone

One of the most important structures in adenomyosis-related fertility is the **junctional zone**, often abbreviated **JZ**.

This is the inner portion of the uterine muscle immediately underneath the endometrium.

The junctional zone is not simply structural.

It participates in normal uterine contractions and reproductive function.

During different phases of the menstrual cycle, carefully coordinated uterine contractions help:

- move sperm through the uterus,
- support reproductive-tract transport,
- prepare the uterus for implantation,
- and participate in placentation.



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In adenomyosis, the junctional zone can become thickened, irregular or structurally disrupted.

A 2026 review of fertility in adenomyosis highlights junctional-zone remodeling and abnormal uterine contractility among the leading proposed mechanisms of infertility.

Abnormal Uterine Contractions May Interfere With Fertility

The uterus is not a motionless organ.

It generates organized contractions known as **uterine peristalsis**.

These contractions vary during the menstrual cycle.

Around ovulation they may help facilitate sperm transport toward the fallopian tubes.

Research now suggests that adenomyosis can produce abnormal uterine contraction patterns.

A 2025 systematic review specifically examining uterine peristalsis in adenomyosis found evidence that altered uterine architecture may disturb contraction patterns, potentially affecting both sperm transport and embryo implantation.

This may help explain why infertility can occur even if both fallopian tubes are technically open.

Chronic Inflammation

Adenomyosis is associated with a chronically altered inflammatory environment.

Inflammatory cells and signalling molecules can affect the endometrium, myometrium and endometrial-myometrial interface.

Modern molecular research describes interactions between inflammation, immune cells, abnormal hormone signalling, fibrosis, angiogenesis and altered uterine tissue repair.

From a fertility perspective, this inflammatory environment may interfere with several processes:

normal sperm transport,

embryo-endometrial communication,

implantation,

placental development,



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and potentially early pregnancy maintenance.

But these mechanisms remain areas of active research and should not be interpreted as meaning every woman has the same inflammatory abnormality.

Progesterone Resistance

Progesterone is essential for transforming the endometrium into a receptive environment for implantation.

In adenomyosis, researchers have identified abnormalities in progesterone signalling, sometimes described as **progesterone resistance**.

This does not simply mean that a patient's blood progesterone is low.

It refers to altered response of uterine tissues to progesterone at a molecular level.

The 2026 fertility review identifies progesterone resistance together with local hyperestrogenism as important proposed contributors to impaired implantation.

This distinction is important because measuring a single serum progesterone level cannot diagnose adenomyosis-associated progesterone resistance.

Local Estrogen Activity

Adenomyosis is considered an estrogen-dependent condition.

The adenomyotic tissue and surrounding uterine environment can demonstrate altered local estrogen metabolism.

This may contribute to:

lesion activity,

uterine enlargement,

inflammation,

abnormal tissue growth,

and progesterone resistance.

This hormonal biology explains why many effective symptom-control therapies work by reducing or modifying estrogenic stimulation.

However, treatments that suppress ovarian estrogen also commonly suppress ovulation.



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That creates an important difference between:

treating adenomyosis symptoms and **trying to achieve pregnancy immediately.**

Adenomyosis and Endometrial Receptivity

For implantation to succeed, a healthy embryo and a receptive endometrium must communicate correctly.

Research in adenomyosis has identified changes involving:

inflammatory signalling,

implantation-related genes,

progesterone signalling,

cell adhesion,

vascular development,

and immune regulation.

A 2026 review of adenomyosis and maternal-fetal outcomes concludes that defective endometrial receptivity is one plausible contributor to infertility and recurrent pregnancy loss.

But endometrial receptivity is only one part of fertility.

Adenomyosis does not mean that implantation can never happen.

Does Adenomyosis Affect Egg Quality?

Adenomyosis primarily involves the **uterus**, not the ovary.

This is different from ovarian endometriosis, which directly involves ovarian tissue.

For that reason, adenomyosis should not automatically be described as a disease of poor egg quality.

A woman's egg quantity and quality remain strongly influenced by **age and ovarian biology.**

However, adenomyosis often coexists with endometriosis or other reproductive disorders, and these additional conditions can affect ovarian reserve or oocyte quality.

This is why AMH or antral follicle count may still be useful during fertility planning—but they are not tests for adenomyosis itself.



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Adenomyosis and Ovarian Reserve

Adenomyosis by itself is not generally considered a direct ovarian-reserve disease in the same way that an ovarian endometrioma or ovarian surgery can be.

A woman with adenomyosis can have:

excellent ovarian reserve,

average ovarian reserve,

or diminished ovarian reserve.

Age remains one of the strongest determinants.

Therefore, if a patient has low AMH, we should not automatically blame adenomyosis.

Other causes need to be considered.

Can Adenomyosis Affect Sperm Transport?

Possibly.

Changes in junctional-zone structure and uterine peristalsis may alter the way sperm are transported from the cervix toward the fallopian tubes.

This is one proposed explanation for infertility even when:

ovulation is occurring,

the tubes appear patent,

and semen analysis is satisfactory.

However, this mechanism is difficult to measure routinely in an individual patient.

It remains part of the biological explanation rather than a standard clinical test.

Adenomyosis and Implantation Failure

Women with adenomyosis undergoing IVF have, on average, shown lower implantation and pregnancy outcomes in several observational studies and meta-analyses.

A 2024 systematic review and meta-analysis found that compared with women without adenomyosis, those with adenomyosis had a pooled **26% reduction in clinical pregnancy**, a **35% reduction in live birth**, and approximately **1.9 times the**



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miscarriage rate. These results represent group averages from available studies and cannot be converted into a personal prediction for an individual woman.

Differences in how adenomyosis was diagnosed, disease severity, patient age and treatment protocols contribute to uncertainty.

Does the Type of Adenomyosis Matter?

Probably.

A meta-analysis examining ultrasound-defined subtypes found poorer IVF outcomes particularly in **symptomatic and diffuse adenomyosis**, whereas findings for asymptomatic disease were less clear. The authors graded much of the evidence as low or very low certainty.

This supports an important clinical principle:

A scan should describe the disease phenotype rather than simply writing “adenomyosis present.”

A focal lesion in a younger woman may have different reproductive implications from a very enlarged uterus with diffuse adenomyosis.

Does Uterine Size Matter?

Emerging evidence suggests it may.

Larger uterine volume and more extensive junctional-zone involvement have been associated with poorer reproductive outcomes in some IVF populations.

A 2026 review suggests that uterine volume, junctional-zone thickness and direct MUSA imaging features may contribute to fertility prognosis, although it explicitly notes that proposed treatment thresholds are based mainly on observational evidence and are **not formal guideline recommendations**.

This is important.

A particular uterine-volume number should not become an automatic indication for surgery or IVF.

It can be one factor in individualized counselling.

Adenomyosis and Miscarriage

One of the more consistent findings in modern literature is an association between adenomyosis and miscarriage.

This does not mean that adenomyosis causes every miscarriage.

Miscarriage can result from:

embryonic chromosome abnormalities,

maternal age,

uterine abnormalities,

endocrine factors,

genetic factors,

antiphospholipid syndrome,

and many other causes.

However, the increased miscarriage association remains after pooling many adenomyosis studies.

The large 2026 ADELIN meta-analysis found an approximately **61% relative increase in miscarriage risk** among women with adenomyosis, while also emphasizing that certainty of evidence for many obstetric outcomes was low.

Therefore, recurrent miscarriage in a woman with adenomyosis deserves a complete recurrent-pregnancy-loss evaluation rather than automatically attributing every loss to the adenomyosis.

Adenomyosis and Pregnancy Complications

Once pregnancy occurs, many women with adenomyosis will still have successful pregnancies.

Nevertheless, adenomyosis has been associated in observational research with increased risks of several pregnancy and obstetric complications.

The 2026 ADELIN meta-analysis included 39 studies and more than 5.5 million pregnancies. Adenomyosis was associated with higher relative risks of outcomes including **preeclampsia, postpartum hemorrhage, small-for-gestational-age birth, malpresentation, miscarriage, preterm premature rupture of membranes, placental malposition and low birth weight**. Importantly, the certainty of evidence was generally low or very low, so these figures should be used for counselling rather than to predict an individual pregnancy.



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A separate 2026 meta-analysis of more than 24,000 women with adenomyosis similarly found lower clinical pregnancy and live-birth rates and higher risks of miscarriage, preterm birth and several obstetric complications.

For me, the practical message is:

once pregnancy is achieved, the obstetric team should know that adenomyosis is present.

The monitoring plan should then be individualized according to the woman's full risk profile.

How Is Adenomyosis Diagnosed?

Modern diagnosis is usually based on:

clinical history,

pelvic examination where appropriate,

transvaginal ultrasound,

and MRI when additional clarification is required.

Histopathological examination after hysterectomy remains definitive in a strict pathological sense, but hysterectomy is clearly inappropriate merely to establish the diagnosis in a woman wishing to preserve fertility.

Current clinical guidelines recognize ultrasound and MRI as appropriate diagnostic tools.

Transvaginal Ultrasound

A high-quality **transvaginal ultrasound (TVS)** is generally the most practical first-line imaging investigation.

Ultrasound specialists now use standardized terminology developed by the **Morphological Uterus Sonographic Assessment—MUSA—group.**

The revised MUSA consensus separates ultrasound findings into **direct signs** and **indirect signs**.

Direct signs are features thought to represent adenomyotic tissue more directly.

These include:

myometrial cysts,



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hyperechoic islands,
and echogenic subendometrial lines or buds.
Indirect signs include changes resulting from the disease, such as:
globular uterine shape,
asymmetrical myometrial thickening,
fan-shaped shadowing,
translesional vascularity,
and an irregular or interrupted junctional zone.

What Does the Latest 2026 Ultrasound Evidence Show?

A large prospective 2026 study comparing ultrasound findings with hysterectomy pathology found that individual adenomyosis features generally had **high specificity but limited sensitivity**.

Direct ultrasound signs provided the most consistent diagnostic information, while indirect findings were better considered supportive rather than definitive.

In simple language:

when characteristic direct findings are seen, they can be quite helpful, but a normal-looking scan does not completely exclude adenomyosis.

The skill and experience of the sonographer also matter.

MRI for Adenomyosis

MRI can be particularly helpful when:

ultrasound is uncertain,
the uterus is very enlarged,
focal adenomyosis needs to be distinguished from a fibroid,
deep endometriosis coexists,
junctional-zone anatomy needs clarification,
or fertility-preserving surgery is being considered.

MRI provides excellent visualization of the uterine wall and junctional zone.



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It is not automatically required in every woman with convincing ultrasound evidence.

Is There a Blood Test for Adenomyosis?

No blood test currently provides a reliable standalone diagnosis.

Markers such as CA-125 may be elevated in some women with adenomyosis or endometriosis, but they are nonspecific.

Diagnosis should therefore not be made from one tumor-marker result.

Does Every Woman With Adenomyosis Need Fertility Testing?

No.

If a woman is not currently trying to conceive, management may focus mainly on symptoms and future fertility planning.

But if pregnancy is desired, I believe the fertility assessment should answer questions beyond the adenomyosis itself.

The woman may need evaluation of:

ovulation,

ovarian reserve where relevant,

tubal function,

uterine cavity,

coexisting endometriosis or fibroids,

and reproductive age.

At the same time, the male partner should usually undergo appropriate fertility evaluation.

Why the Male Partner Must Be Assessed

This is particularly important at Saira Health Care because my clinical work focuses on both sexual disorders and infertility.

A woman may have adenomyosis, but her partner may simultaneously have:

low sperm concentration,



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poor motility,
abnormal morphology,
severe male-factor infertility,
ejaculatory difficulty,
or sexual-performance anxiety that reduces intercourse during the fertile window.

If we assume adenomyosis explains everything, we can waste months or years treating the wrong problem.

Infertility belongs to the **couple's reproductive situation**.

Adenomyosis and Painful Intercourse

Adenomyosis can cause deep pelvic pain during intercourse.

Some women also have endometriosis or pelvic-floor muscle overactivity.

When intercourse repeatedly causes pain, the body may begin anticipating the discomfort.

Pelvic muscles tighten.

The woman begins avoiding penetration.

The couple has intercourse less frequently.

Fertility pressure makes the problem worse.

Thus, sexual pain can become an **additional functional barrier to conception**.

In these cases, asking only about ovulation and tubes is not enough.

Adenomyosis Treatment Depends on the Patient's Goal

This is one of the most important principles.

The treatment of a woman who wants relief from heavy bleeding and **does not currently want pregnancy** is very different from treatment of a woman who wants to conceive immediately.

The 2023 evidence-based adenomyosis guideline specifically recommends tailoring treatment to predominant symptoms and reproductive goals. Options can include anti-inflammatory medicines, tranexamic acid, hormonal therapies, GnRH analogues, uterine-sparing interventions and surgery.



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For infertility patients, however, every treatment must be considered in relation to **time to pregnancy**.

Symptom Treatment When Pregnancy Is Not Immediately Desired

Hormonal therapies such as combined contraceptives, progestins, dienogest, the levonorgestrel-releasing intrauterine system and GnRH analogues can be effective for pain or heavy bleeding in selected women.

But many of these treatments suppress ovulation or prevent pregnancy while being used.

Therefore:

A treatment can be excellent for adenomyosis pain and simultaneously unsuitable for a woman trying to conceive naturally that month.

The therapeutic goal must be clear.

Non-Steroidal Anti-Inflammatory Drugs

NSAIDs can help control dysmenorrhea and pelvic pain.

They do not remove adenomyosis.

If pregnancy is being attempted, prolonged or intensive use around ovulation may need individual discussion with the treating clinician rather than indiscriminate self-medication.

The main role is symptomatic relief.

Tranexamic Acid

Tranexamic acid can reduce heavy menstrual bleeding in appropriate patients.

It does not treat the underlying adenomyotic tissue or directly improve fertility.

It is therefore a symptom-control treatment rather than fertility therapy.

Progestins and Dienogest

Progestin treatment can reduce adenomyosis-associated pain and bleeding.

Dienogest is also used for endometriosis-related symptoms and increasingly in adenomyosis management.

But continuous progestin therapy generally suppresses reproductive cycling, so it is not a treatment for immediate natural conception.

Its role around IVF or before fertility treatment remains an area of ongoing study rather than an established universal protocol.

Levonorgestrel Intrauterine System

The levonorgestrel-releasing intrauterine system can be highly useful for heavy menstrual bleeding and pain.

However, it is also a contraceptive.

It therefore has no role as an immediate conception treatment while it remains in the uterus.

It may be useful in a woman who wants symptom control now and pregnancy later.

GnRH Agonist Treatment

GnRH agonists temporarily produce profound suppression of ovarian hormonal stimulation.

This can reduce uterine volume and adenomyosis activity.

Because the medication suppresses ovarian function, a woman generally cannot pursue natural conception during the treatment period.

The more interesting question is whether temporary GnRH agonist treatment **before IVF or embryo transfer** improves reproductive outcomes.

And here, current evidence is mixed.

Does GnRH Agonist Pretreatment Improve IVF Outcomes?

Earlier observational research suggested that prolonged GnRH suppression might improve implantation in adenomyosis.

More recent systematic reviews have produced inconsistent results.



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A 2025 systematic review and meta-analysis found that long-term GnRH agonist pretreatment improved **clinical pregnancy rate** in some fresh IVF/ICSI comparisons but did not demonstrate a clear benefit for live birth or miscarriage.

Another recent systematic review found **no convincing evidence that long or ultra-long GnRH agonist protocols or GnRH pretreatment before frozen embryo transfer improve live-birth outcomes consistently.**

Meanwhile, 2026 reviews argue that prolonged hormonal suppression may still be useful in selected women, particularly those with more extensive disease, but emphasize that most supporting data remain observational.

Therefore:

GnRH agonist pretreatment should not be presented as mandatory for every woman with adenomyosis undergoing IVF.

It is an individualized reproductive-medicine decision.

Fresh Embryo Transfer or Frozen Embryo Transfer?

A common belief is that every woman with adenomyosis must undergo a freeze-all IVF strategy.

Current evidence does not justify such a universal rule.

A 2025 systematic review found that, among women with adenomyosis, IVF/ICSI outcomes were broadly comparable between frozen and fresh embryo-transfer strategies.

A freeze-all strategy may still be appropriate for many reasons—including ovarian response, progesterone level, genetic testing, planned hormonal suppression or clinic protocol—but adenomyosis alone does not automatically prove that frozen transfer is always superior.

IVF Outcomes in Women With Adenomyosis

Adenomyosis is associated at the population level with lower IVF success.

In a modern meta-analysis, clinical pregnancy occurred in approximately **42.5% of women with adenomyosis versus 55.9% without adenomyosis**, while live birth was approximately **30.7% versus 47.8%** in the included studies. Miscarriage was also higher.

These figures should be interpreted cautiously.

They are pooled study populations.

They do not account perfectly for:

age,

embryo quality,

adenomyosis phenotype,

coexisting endometriosis,

uterine size,

previous treatment,

or differences between fertility centres.

They should therefore inform counselling—not determine an individual prognosis.

Does Adenomyosis Mean IVF Is Required?

No.

Some women with adenomyosis will conceive naturally.

Whether natural conception should be attempted depends on the complete fertility profile.

A younger woman with:

good ovarian reserve,

apparently normal tubes,

limited adenomyosis,

regular ovulation,

normal semen analysis,

and a short duration of infertility

may reasonably have a period of natural attempts.

A woman aged 39 with:

several years of infertility,

diffuse adenomyosis,

diminished ovarian reserve,



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and severe male-factor infertility

may gain very little from spending another year waiting.

The disease name may be identical.

The reproductive strategy is not.

Is IUI Useful?

IUI may be considered in appropriately selected couples when:

at least one tube is functional,

ovulation can occur,

sperm numbers after preparation are suitable,

female age is favorable,

and there is no other major fertility factor requiring IVF.

However, evidence specific to adenomyosis and IUI is much less developed than IVF evidence.

Therefore, IUI should not be offered simply because it is less expensive than IVF.

It should have a reasonable biological chance of success.

Is ICSI Necessary Because of Adenomyosis?

No.

ICSI addresses fertilization involving sperm.

It does not treat adenomyosis.

If the male partner has a significant sperm abnormality or another recognized ICSI indication, ICSI may be appropriate.

But adenomyosis by itself does not automatically require sperm injection.

This is another example of why male and female fertility need to be assessed together.

Fertility-Preserving Surgery



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For women who wish to preserve the uterus, the main fertility-preserving surgical procedure for significant adenomyosis is broadly called **adenomyomectomy** or conservative excision.

The surgeon removes as much abnormal adenomyotic tissue as reasonably possible while reconstructing the uterus.

This can be much more difficult than removing a fibroid because adenomyosis often lacks a clean surgical boundary.

Who Might Be Considered for Adenomyomectomy?

Surgery may be considered in carefully selected women with factors such as:

severe symptoms despite medical treatment,

a large focal adenomyoma,

extensive disease causing marked uterine distortion,

repeated reproductive failure in which adenomyosis is believed to be clinically important,

or circumstances where the patient wishes to preserve the uterus despite significant disease.

But there is no universally accepted fertility-based surgical threshold.

A 2026 review specifically states that the choice between uterus-sparing surgery and direct IVF remains an area of debate.

Focal Versus Diffuse Adenomyomectomy

Focal disease may sometimes be easier to excise because the surgeon has a more definable target.

Diffuse disease can require complex reconstruction of the uterine muscle.

A 2026 systematic review of published adenomyomectomy studies included more than 3,000 patients and showed reproductive success after both focal and diffuse procedures, but the evidence came from heterogeneous surgical series rather than randomized trials.

The operation should therefore be performed by surgeons with experience in fertility-preserving adenomyosis surgery when pregnancy is desired.



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The Major Concern After Adenomyomectomy: Uterine Integrity

Removing adenomyosis and reconstructing the myometrium can leave a uterine scar.

During pregnancy, the uterus expands dramatically.

A weakened scar creates a risk of **uterine rupture**.

Other possible concerns include:

placenta accreta spectrum,

preterm birth,

hemorrhage,

and the need for planned cesarean delivery in some patients.

A 2025 review emphasizes that although adenomyomectomy can improve fertility in selected patients, subsequent pregnancy carries potentially serious obstetric risks including uterine rupture, placenta accreta spectrum and severe hemorrhage.

Therefore, fertility-preserving surgery should never be promoted as a simple “remove adenomyosis and everything becomes normal” procedure.

Pregnancy After Adenomyomectomy Requires Specialist Obstetric Planning

A woman who becomes pregnant after significant uterine reconstructive surgery should inform her obstetric team from the beginning.

The treating obstetrician needs to understand:

what procedure was performed,

where the uterine incision was made,

how much muscle was removed,

and how the uterus was reconstructed.

This information may influence pregnancy surveillance and delivery planning.

Is Hysterectomy a Treatment?

Hysterectomy—removal of the uterus—is the definitive surgical treatment for uterine adenomyosis.

But it permanently ends the possibility of carrying a pregnancy.



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Therefore, it is **not a fertility-preserving treatment**.

In a woman seeking pregnancy, management should focus on conservative medical, reproductive or surgical approaches appropriate to her condition.

High-Intensity Focused Ultrasound — HIFU

HIFU is a non-incisional technique that uses focused energy to thermally ablate adenomyotic tissue.

It has attracted attention because it may reduce symptoms while preserving the uterus.

A 2025 systematic review and meta-analysis reported encouraging pregnancy outcomes after HIFU, but most available studies were observational and patient selection varied considerably.

This means HIFU is promising but should not yet be presented as a proven fertility treatment equivalent to established ART or as superior to surgery.

Women desiring pregnancy need careful counselling about the quality of evidence and local expertise.

Radiofrequency Ablation and Other Minimally Invasive Treatments

Other uterus-preserving approaches under investigation include radiofrequency ablation and related image-guided techniques.

Early reproductive outcomes are encouraging in selected cohorts.

However, the 2025–2026 literature continues to emphasize the need for better prospective comparative studies, particularly regarding:

future fertility,

pregnancy complications,

uterine integrity,

and long-term recurrence.

These options should therefore be discussed as **selected or evolving treatments**, not as universally established infertility therapy.

What About Uterine Artery Embolization?

Uterine artery embolization can reduce bleeding and uterine volume in some women with adenomyosis.

However, when future pregnancy is a high priority, reproductive implications need particularly careful consideration.

Current adenomyosis guidelines recognize UAE as a treatment option in general management, but fertility-focused decisions require individualized counselling because evidence regarding reproductive outcomes is less established than for standard fertility treatments.

Adenomyosis, Age and the “Fertility Clock”

One of the most important mistakes in adenomyosis management is focusing so much on the uterus that we forget **age**.

Suppose one woman is 26 and another is 40.

Both have adenomyosis.

The same six-month medical treatment means something very different for their overall reproductive potential.

Oocyte quantity and chromosomal competence decline with reproductive age regardless of adenomyosis.

Therefore, the time spent on suppression, surgery or repeated low-probability treatment must always be balanced against the woman's remaining reproductive window.

Adenomyosis and AMH: Do Not Treat One Number

AMH can help estimate how strongly the ovaries may respond to fertility stimulation.

It does not measure whether implantation can occur.

A woman can have low AMH and still conceive naturally.

A woman can have high AMH and still have infertility from another cause.

Therefore, neither adenomyosis nor fertility treatment should be planned from AMH alone.

The useful question is:

What does her ovarian reserve mean in combination with her age and the rest of the couple's fertility evaluation?

Can Adenomyosis Be Completely Cured?

If the uterus is retained, adenomyosis should generally be thought of as a **chronic condition that can be managed**, rather than a disease for which one medicine reliably guarantees permanent elimination.

Hormonal treatment can suppress disease activity.

Surgery can remove or reduce abnormal tissue.

Symptoms may improve substantially.

Pregnancy can occur.

But adenomyosis can persist or recur.

A hysterectomy removes the adenomyotic uterus but obviously eliminates the ability to carry pregnancy.

Therefore, fertility-focused medicine emphasizes **control, reproductive planning and individualized treatment**, not unrealistic promises of permanent cure.

Adenomyosis and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine**, I believe adenomyosis and infertility should be approached in a way that respects traditional clinical principles while remaining scientifically accurate about a modern imaging-defined uterine disease.

The first important point is this:

Adenomyosis is a modern pathological and imaging diagnosis, and it should not automatically be declared identical to one classical Unani disease term.

Classical Unani physicians described women with painful menstruation, excessive uterine bleeding, pelvic discomfort and infertility.

Those descriptions may overlap with symptoms seen today in adenomyosis.

But classical medicine developed before modern histopathology, transvaginal ultrasound, MRI and contemporary reproductive endocrinology.

Therefore, in my practice, the modern diagnosis comes first.

Izala-i-Sabab — Addressing the Causative and Aggravating Factors



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CCRUM describes **Izala-i-Sabab**, or removal/correction of causative factors, as an important Unani principle of treatment. It also describes Unani medicine as taking a holistic view of the patient's constitution, lifestyle and affected organs.

This principle can be applied thoughtfully in adenomyosis.

For example, if a patient has severe anemia because of heavy bleeding, the anemia needs treatment.

If obesity or metabolic disease is affecting her reproductive health, those factors need attention.

If painful intercourse is preventing regular sexual activity, that needs its own treatment.

If IVF is required because the male partner has severe infertility, we should not spend years trying to treat the woman alone.

If the uterus has a major structural abnormality requiring specialist intervention, medicine should not be used to postpone necessary care.

That is how I interpret cause-oriented integrative medicine.

The Four Major Unani Therapeutic Approaches

Official CCRUM material describes four broad therapeutic modalities:

Ilaj-bil-Tadbir — Regimental therapy

Ilaj-bil-Ghiza — Dietotherapy

Ilaj-bil-Dawa — Pharmacotherapy

Ilaj-bil-Yad — Surgery

This framework can be useful when adenomyosis is treated as a whole-person reproductive-health problem rather than simply as one ultrasound finding.

Ilaj-bil-Ghiza — Dietotherapy

Diet should support the woman's general and reproductive health.

Depending on the patient, I pay attention to:

healthy body weight,

adequate protein and micronutrient intake,

iron status when bleeding is heavy,

blood glucose and metabolic health,



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bowel function,

and an overall balanced diet.

But scientific transparency is necessary.

No specific Unani diet has been proven in high-quality clinical trials to remove adenomyosis or guarantee pregnancy.

A dietary programme may improve general health and correct nutritional problems.

It does not physically reconstruct a severely abnormal junctional zone or guarantee embryo implantation.

Heavy Menstrual Bleeding and Iron Deficiency

Adenomyosis can produce heavy menstrual bleeding.

Over time, this may cause iron deficiency or iron-deficiency anemia.

A patient may complain of:

fatigue,

weakness,

shortness of breath,

palpitations,

or reduced physical stamina.

When this occurs, treatment should include proper blood testing and appropriate correction of the deficiency.

Restoring hemoglobin and iron status can improve the woman's health while her fertility plan is being developed.

This is an example of an area in which supportive nutritional treatment is genuinely important.

Ilaj-bil-Tadbir — Lifestyle and Regimental Treatment

CCRUM recognizes regimental therapy as an established component of Unani medicine.



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In a modern integrative fertility setting, useful supportive measures can include appropriate exercise, adequate sleep, weight management, stress reduction and attention to general physical well-being.

These measures are not substitutes for IVF or surgery when those treatments are required.

But a woman living with chronic pain and infertility benefits from being treated as a whole person.

Stress and Fertility

Stress does not mean adenomyosis is “psychological.”

Adenomyosis is a real uterine disease.

However, chronic pain, repeated unsuccessful pregnancy attempts and fertility treatment can cause substantial psychological distress.

Stress can affect:

sleep,

sexual desire,

relationships,

treatment adherence,

and overall quality of life.

Therefore, psychological support can form a legitimate part of infertility treatment without implying that stress caused the disease.

Ilaj-bil-Dawa — Unani Pharmacotherapy

Unani pharmacotherapy contains medicines historically used for gynecological symptoms including painful menstruation, abnormal uterine bleeding and reproductive complaints.

But I believe an important scientific limit must be stated openly:

High-quality clinical evidence does not currently establish a specific Unani formulation as a proven cure for adenomyosis or as a treatment proven to increase live-birth rates in women with adenomyosis-related infertility.



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This means Unani medicine should be used **supportively and individually**, rather than marketed as a guaranteed method of dissolving adenomyosis.

The strength of evidence for a traditional formulation may differ greatly from the evidence supporting IVF, imaging or established hormonal treatments.

Patients deserve to know that difference.

Herbal Medicine During Fertility Treatment

This is particularly important during:

ovulation induction,

IUI,

IVF stimulation,

egg retrieval,

embryo transfer,

and early pregnancy.

A herbal medicine used for pelvic symptoms before fertility treatment may not automatically be suitable during an IVF cycle or pregnancy.

Some plant products can influence:

bleeding,

blood pressure,

liver enzymes,

glucose,

hormonal pathways,

or conventional-drug metabolism.

All medicines and supplements should therefore be disclosed to the fertility team.

Ilaj-bil-Yad — The Role of Procedures and Surgery

CCRUM includes **Ilaj-bil-Yad**, or surgical/procedural treatment, within the Unani therapeutic framework.

This is particularly relevant to a structural uterine condition.



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If a highly selected patient has a focal adenomyoma requiring conservative excision, surgery may be the appropriate treatment.

If hysteroscopy is needed for a separate intracavitary problem, that should be performed appropriately.

If IVF is needed because natural conception has become unlikely, assisted reproductive treatment should not be postponed simply to continue oral therapy.

For me, recommending modern reproductive procedures when they are indicated is fully compatible with responsible integrative practice.

Where Unani Medicine May Be Most Useful in Adenomyosis and Fertility

I consider Unani medicine most useful as part of an **individualized supportive programme** addressing the patient rather than promising to erase adenomyosis.

The useful areas can include:

general nutrition,

correction of unhealthy lifestyle factors,

support during painful menstruation,

general health optimization,

stress and sleep,

sexual well-being,

and appropriate traditional pharmacotherapy when safe and compatible with the reproductive plan.

Its role should be integrated with objective monitoring.

If the woman's reproductive circumstances indicate surgery or ART, those treatments should not be delayed.

The Saira Health Care Approach to Adenomyosis and Fertility

At **Saira Health Care**, my approach begins with a question:

Is adenomyosis truly the major fertility problem in this couple?

That question prevents unnecessary treatment.



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Saira Health Care's current physician profile lists my work as a focused practice in sexual disorders and infertility and lists the professional education and additional training shown in the byline of this article.

For adenomyosis-related fertility concerns, I use an integrative framework rather than offering one medicine to every patient.

First: Confirm the Diagnosis Properly

I want to know:

Was adenomyosis diagnosed by expert transvaginal ultrasound?

What features were present?

Is the disease focal or diffuse?

How large is the uterus?

Is the junctional zone significantly affected?

Is MRI needed?

Could the lesion actually be a fibroid?

Does the woman also have endometriosis?

A one-line report saying:

“Bulky uterus with adenomyosis”

does not always provide enough information for fertility planning.

Second: Understand the Patient's Symptoms

Is the main problem infertility?

Or does she also have:

heavy menstrual bleeding,

severe dysmenorrhea,

chronic pelvic pain,

painful intercourse,

or anemia?

Symptoms matter because treatment may need to achieve more than pregnancy alone.



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Third: Understand the Fertility Timeline

I ask:

How old is the woman?

How long has the couple been trying?

Has she ever conceived?

Have miscarriages occurred?

Has IVF already failed?

How many embryos were transferred?

Were genetically tested embryos used?

These details affect how strongly adenomyosis should influence the next treatment decision.

Fourth: Assess Ovarian Reserve When Appropriate

AMH and antral follicle count can be especially useful when reproductive age is advancing or ART is being considered.

A woman with diminished reserve may not have the same time available for prolonged suppression or repeated surgery as someone with excellent reserve.

Fifth: Evaluate the Tubes and Uterine Cavity

Adenomyosis primarily affects the uterine muscle, but infertility evaluation still needs to identify:

tubal blockage,

hydrosalpinx,

endometrial polyps,

submucosal fibroids,

uterine septum,

or other structural problems.



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Treating adenomyosis while missing a hydrosalpinx, for example, would produce an incomplete fertility plan.

Sixth: Evaluate the Male Partner Early

This is particularly important in my practice because I work extensively with sexual disorders and male infertility.

A semen analysis can change the entire treatment strategy.

If the male partner has severe oligozoospermia or azoospermia, direct IVF/ICSI planning may become more relevant than prolonged natural-conception treatment for mild adenomyosis.

The couple should be assessed together.

Seventh: Address Sexual Pain and Intimacy

If deep intercourse is painful, I ask about it directly.

Some women need:

pelvic-floor assessment,

pain management,

sexual counselling,

better lubrication,

treatment of coexisting endometriosis,

or psychological support.

Fertility advice that simply says “have intercourse around ovulation” is not useful when intercourse itself causes severe pain.

Eighth: Decide Whether Natural Conception Is Reasonable

For selected younger couples with relatively favorable fertility findings, a defined period of natural conception may be appropriate.

But the duration should be deliberate rather than indefinite.

If pregnancy does not occur, the plan should progress.



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Ninth: Use Medical Suppression Only for a Clear Reason

Hormonal suppression can be useful for symptom control or as part of a selected ART protocol.

But I do not believe every woman seeking pregnancy should lose many months to hormonal suppression without a clearly defined fertility objective.

Current evidence regarding GnRH agonist pretreatment remains inconsistent, especially for live birth.

Tenth: Consider Surgery Only When Its Potential Benefit Justifies Its Risk

Conservative adenomyosis surgery can help selected patients.

But it creates a uterine scar and can carry future pregnancy risks.

Therefore, a woman should understand why surgery is being recommended, what alternative options exist and how the surgery may affect a future pregnancy.

Eleventh: Move to IVF at the Appropriate Time

IVF should neither be presented as a failure nor avoided simply because a patient prefers “natural” treatment.

For certain couples, IVF may be the most rational fertility strategy.

This is especially true when adenomyosis is accompanied by:

advanced reproductive age,

low ovarian reserve,

significant tubal disease,

male-factor infertility,

long-standing infertility,

or previous treatment failure.

Twelfth: Use Unani Treatment as an Integrated Support, Not a Delay

At Saira Health Care, the Unani component can be used to support:

diet,



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general health,
lifestyle,
sleep,
stress,
menstrual well-being,
and selected symptoms.

But objective fertility markers and reproductive timing remain central.

If the patient needs reproductive endocrinology, advanced ultrasound, hysteroscopic or laparoscopic surgery, IVF or high-risk obstetric care, timely referral should be part of responsible treatment.

Adenomyosis and Recurrent IVF Failure

When implantation fails repeatedly, it is tempting to blame adenomyosis immediately.

But recurrent IVF failure requires a careful review of:

embryo quality,
maternal age,
uterine cavity,
adenomyosis phenotype,
endometrial factors,
laboratory factors,
sperm factors,
and the exact stage at which previous cycles failed.

Adenomyosis may be an important contributor, but it should not become a convenient explanation for every unsuccessful embryo transfer.

Adenomyosis and a Euploid Embryo

Even when a chromosomally screened embryo is available, uterine factors still matter.

Research suggests adenomyosis can affect implantation and miscarriage independently of some embryo factors.



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However, the magnitude of the effect varies among studies.

Therefore, a euploid embryo does not completely remove adenomyosis-related risk—but adenomyosis also does not mean a euploid embryo cannot implant.

Does Adenomyosis Always Get Worse With Time?

Not predictably.

Adenomyosis can remain stable in some women and progress in others.

Its symptoms and imaging appearance may change with age, hormonal environment, pregnancy and treatment.

Because of this variability, fertility planning should be based on the patient's **current reproductive situation**, not assumptions that the disease will definitely progress at a particular rate.

Can Pregnancy Improve Adenomyosis?

Pregnancy creates a prolonged progesterone-dominant and non-menstruating hormonal environment.

Some women experience temporary improvement in adenomyosis-related symptoms.

However:

pregnancy should not be described as a cure for adenomyosis.

The condition may remain or symptoms may return later.

A woman should pursue pregnancy because she wants a child—not because pregnancy has been prescribed as treatment for a uterine disorder.

Adenomyosis and Delivery

Most women with adenomyosis who become pregnant do not automatically require one particular mode of delivery.

The delivery plan depends on obstetric circumstances.

The situation is different after extensive adenomyomectomy, where uterine-wall reconstruction may affect delivery recommendations because of the risk of uterine rupture.

The operating surgeon's report becomes very important.



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Common Mistakes I Encourage Patients to Avoid

One of the most common mistakes is assuming that **adenomyosis means infertility is permanent**.

Another is assuming every ultrasound-diagnosed adenomyosis needs surgery.

The opposite mistake is assuming surgery should never be performed.

Patients may also spend many months taking hormonal suppressive treatment even though their immediate goal is pregnancy and no clear ART plan exists.

Another frequent problem is repeatedly treating only the woman without performing a semen analysis in the male partner.

Some women undergo several ovarian or uterine procedures without considering reproductive age and ovarian reserve.

And patients sometimes believe that herbal medicines can “dissolve” extensive adenomyosis with certainty.

Responsible fertility treatment avoids all of these extremes.

Frequently Asked Questions About Adenomyosis and Fertility

Can adenomyosis cause infertility?

Yes. Adenomyosis is associated with reduced fertility and may interfere with reproduction through abnormal uterine contractility, junctional-zone changes, chronic inflammation, progesterone resistance and impaired endometrial receptivity.

Does every woman with adenomyosis have infertility?

No. Many women with adenomyosis conceive naturally.

Can adenomyosis cause miscarriage?

Adenomyosis is associated with a higher miscarriage rate at the population level, but it does not prove that adenomyosis caused an individual miscarriage.

How is adenomyosis diagnosed?

Expert transvaginal ultrasound is generally the main imaging test. MRI can be useful when ultrasound is unclear or detailed mapping is required.

What are the MUSA criteria?



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MUSA terminology standardizes ultrasound findings. Direct features include myometrial cysts, hyperechogenic islands and subendometrial lines or buds. Indirect features include globular uterus, asymmetrical wall thickening, fan-shaped shadowing and junctional-zone abnormalities.

Can ultrasound miss adenomyosis?

Yes. Even with modern criteria, sensitivity is imperfect. A 2026 prospective study found that direct ultrasound signs were highly specific but not sufficiently sensitive to detect every histologically confirmed case.

Does adenomyosis reduce IVF success?

On average, yes. Meta-analyses show lower clinical pregnancy and live-birth rates and higher miscarriage rates among women with adenomyosis, although individual outcomes vary greatly.

Can women with adenomyosis still have successful IVF?

Yes. Many do.

Does everyone need GnRH agonist treatment before IVF?

No. Evidence is mixed. Some studies suggest improvement in selected patients, but recent meta-analyses have not shown a consistent live-birth benefit for every woman.

Is frozen embryo transfer always better?

No. Recent pooled evidence found broadly comparable outcomes between fresh and frozen transfer in adenomyosis, so treatment should be individualized.

Does adenomyosis require ICSI?

No. ICSI is primarily used for male-factor or fertilization-related indications. Adenomyosis itself does not automatically require ICSI.

Can adenomyosis be removed surgically?

Selected focal or diffuse disease can be treated with fertility-preserving adenomyomectomy, but surgery can be complex and future pregnancy can carry risks including uterine rupture and abnormal placentation.

Should every woman have adenomyosis surgery before IVF?

No. There is no evidence supporting routine adenomyomectomy before IVF for every woman.

Can HIFU improve fertility?

Pregnancies have been reported after HIFU and recent meta-analysis is encouraging, but evidence is predominantly observational. It should be discussed as a selected fertility-preserving option rather than a proven universal treatment.

Can adenomyosis affect pregnancy after conception?

Yes. Observational research has associated adenomyosis with higher risks of miscarriage, preterm delivery, hypertensive disorders, placental abnormalities and postpartum hemorrhage, although certainty for several outcomes is low.

Can adenomyosis be permanently cured without removing the uterus?

No conservative therapy can currently guarantee permanent elimination. Disease activity and symptoms can often be controlled, and pregnancy can be achieved, but recurrence or persistence is possible.

Can Unani medicine help?

Unani medicine can provide an **individualized supportive and integrative approach**, particularly for diet, lifestyle, menstrual well-being, stress, general health and selected symptoms. CCRUM formally recognizes dietotherapy, regimental therapy, pharmacotherapy and surgical/procedural care within Unani treatment.

However, current clinical evidence does not establish a specific Unani formulation as a proven cure for adenomyosis or as a treatment guaranteed to improve live-birth rates.

A Message to My Patients

When a woman says to me:

“Doctor, my ultrasound says adenomyosis. Is my uterus unable to carry a baby?”

I explain:

No. Adenomyosis does not mean your uterus can never support a pregnancy.

But we need to understand your individual condition.

I want to know whether your adenomyosis is focal or diffuse.

I want to know whether your uterus is mildly or significantly enlarged.

I want to know your age and ovarian reserve.

I want to know whether your tubes are functional.

I want to know whether you also have endometriosis.

And I want to see your partner's semen analysis.



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Only then can we decide whether you should:

continue trying naturally,

consider IUI,

undergo selected treatment of adenomyosis,

or move toward IVF.

Another patient may ask:

“Can you give me medicine first so that the adenomyosis completely disappears?”

I explain that adenomyosis is a chronic structural and hormonal uterine condition. Medicines can suppress activity and improve symptoms, but we should not lose valuable reproductive time chasing a promise that the uterus will become completely normal.

And when a patient says:

“I want only natural treatment and never IVF,”

I respect her preference—but I also believe she deserves accurate information about what delay might mean for her age and fertility.

The purpose of counselling is not to pressure a couple toward one treatment.

It is to allow them to make an informed decision.

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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Saira Health Care's current public physician profile identifies Dr. Nizamuddin Qasmi as Founder and Chief Physician with focused clinical practice in sexual disorders and infertility and lists the above professional education and additional training.

This combination of infertility and sexual-health work is relevant to adenomyosis because successful reproductive care may require simultaneous attention to:

female fertility,

male fertility,

painful intercourse,

relationship stress,

sexual frequency,

and reproductive timing.

At Saira Health Care, the goal of integrative care is therefore not simply to prescribe a medicine for adenomyosis, but to understand the complete reproductive situation and coordinate modern fertility care with responsible individualized Unani supportive treatment where appropriate.

Saira Health Care's Contribution to Adenomyosis-Related Infertility

The contribution of a focused fertility clinic should be measured by the quality of its clinical reasoning, not by making the strongest cure claim.

For adenomyosis, I consider several areas especially important.

First, helping a patient understand that adenomyosis is different from endometriosis and fibroids.

Second, interpreting ultrasound findings in the context of age, symptoms and fertility.

Third, ensuring that the male partner is assessed rather than repeatedly treating only the woman.

Fourth, protecting reproductive time and avoiding unnecessary prolonged treatment.

Fifth, helping women understand the difference between **symptom-control treatment** and **fertility treatment**.

Sixth, integrating diet, lifestyle, general health and Unani principles responsibly while recognizing when reproductive endocrinology, specialist gynecologic surgery or IVF is required.

This approach is also consistent with Saira Health Care's publicly described patient-centered model combining traditional knowledge, lifestyle guidance and contemporary reproductive understanding.

What the Latest 2026 Evidence Adds

Several important developments have become clearer in recent literature.

Modern research increasingly sees adenomyosis as a collection of different **phenotypes** rather than one uniform disease.

Imaging characteristics such as junctional-zone involvement, uterine volume and direct MUSA signs may eventually help predict reproductive prognosis more accurately.

At the same time, investigators remain cautious because most treatment studies are observational.

There is still no high-quality evidence establishing one universal sequence of:

suppression → surgery → IVF

that is correct for every woman.

The use of prolonged GnRH agonist treatment before embryo transfer remains controversial.

Fertility-preserving surgery and HIFU show promise but require careful selection and better comparative evidence.

And the pregnancy literature increasingly suggests that adenomyosis has consequences extending beyond conception into placentation and obstetric outcomes.

In other words:

Personalized treatment is becoming more important, not less.

Conclusion

Adenomyosis and Fertility is a complex reproductive-health problem because adenomyosis can affect much more than menstrual pain.

The disease may alter the uterine muscular wall, junctional zone, uterine contractions, inflammatory environment, hormonal responsiveness and endometrial receptivity.

These mechanisms can contribute to:

difficulty conceiving,



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implantation problems,
miscarriage,
and adverse pregnancy outcomes.

The newest 2026 evidence continues to support an association between adenomyosis and poorer reproductive outcomes while emphasizing that the disease is heterogeneous and that the optimal fertility strategy remains individualized.

Modern diagnosis increasingly relies on **expert transvaginal ultrasound using standardized MUSA terminology**, with MRI providing additional anatomical information when needed. Direct ultrasound signs appear particularly specific, but even current imaging cannot identify every case perfectly.

Women undergoing IVF should be counselled that adenomyosis is associated on average with lower clinical-pregnancy and live-birth rates and higher miscarriage rates—but these are population-level associations, not predictions that pregnancy will fail.

Hormonal treatment can be highly useful for adenomyosis symptoms, but suppressing ovulation is obviously different from actively trying for natural pregnancy.

GnRH agonist pretreatment before IVF may help selected patients, but the newest systematic reviews remain inconsistent, particularly regarding live birth. It should therefore be individualized rather than automatically prescribed.

Fertility-preserving surgery can be useful in carefully selected patients, especially with substantial focal disease, but adenomyomectomy is major uterine surgery and future pregnancy can carry risks including uterine rupture, placenta accreta spectrum and hemorrhage.

From the **Unani perspective**, the principles of **Izala-i-Sabab, Ilaj-bil-Ghiza, Ilaj-bil-Tadbir, Ilaj-bil-Dawa and Ilaj-bil-Yad** provide a useful framework for individualized whole-person care. Official CCRUM material recognizes these cause-oriented, dietary, regimental, pharmacological and surgical approaches.

However, responsible integrative medicine must acknowledge that **no Unani medicine has currently been proven in high-quality trials to permanently eradicate adenomyosis or guarantee conception or live birth.**

The best role of Unani medicine is therefore to support the woman's overall health, diet, lifestyle, menstrual and sexual well-being and other modifiable factors while appropriate modern imaging, fertility assessment, surgery or assisted reproduction addresses the structural and reproductive aspects of the disease.

At **Saira Health Care**, my preferred principle is:

Do not treat the ultrasound report alone. Treat the woman and the couple.



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We should understand:

her age,
her ovarian reserve,
the adenomyosis phenotype,
the condition of her uterus and tubes,
her symptoms,
her sexual comfort,
her previous treatment,
and her partner's fertility.

Then we should choose the safest, most realistic route toward pregnancy without wasting reproductive time.

When a woman asks:

“Doctor, can I become pregnant with adenomyosis?”

my answer is:

Yes, pregnancy is certainly possible for many women with adenomyosis—but the right pathway depends on your individual reproductive situation.

The purpose of good treatment is not to create fear from the diagnosis and not to make unrealistic promises.

It is to identify **what can be improved, what should be monitored, what should not be unnecessarily treated, and when modern fertility treatment should be used.**

That is the foundation of responsible, patient-centered and integrative fertility care.

Medical Disclaimer: This article is intended for medical education and general patient awareness. Adenomyosis, infertility, recurrent miscarriage and abnormal uterine bleeding require individualized assessment. Patients should not begin, stop or delay hormonal treatment, fertility medicines, Unani medicines, herbal preparations, surgery, IUI or IVF solely on the basis of online information. Women considering fertility-preserving adenomyosis surgery should receive counselling about uterine scarring and future obstetric risks. Herbal and traditional medicines should be reviewed carefully during ovarian stimulation, embryo transfer and pregnancy. No conventional, surgical, Unani, herbal or assisted-reproductive treatment can guarantee conception, pregnancy or live birth.



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