Varicocele: Causes, Symptoms, Diagnosis, Treatment, Male Infertility and the Role of Unani Medicine

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Introduction: "Doctor, I Have Varicocele. Do I Need Surgery, or Can It Be Treated Without an Operation?"

Varicocele is one of the conditions I discuss very frequently with men who come to me for:

- infertility,
- low sperm count,
- poor sperm motility,
- abnormal sperm morphology,
- scrotal heaviness,
- testicular discomfort,
- or an ultrasound report showing enlarged veins around the testicle.

A patient may ask me:

"Doctor, my ultrasound says Grade 2 varicocele. Is this why we are not getting pregnancy?"

Another may say:

"I do not have pain, but the veins are enlarged. Do I need surgery?"

A younger man may be frightened after searching online:

"Will varicocele permanently destroy my testicle?"

And many patients ask:

“Can I first try Unani treatment such as Dr. Qasmi's Nuskha No. 145?”

My answer begins with an important principle:

Not every varicocele requires treatment.

Varicocele is common.

Current European Association of Urology guidance reports that it occurs in approximately **15% of the general male population**, but is considerably more common among men undergoing fertility evaluation. It is found in approximately 25% of men with abnormal semen analysis and in around 35–40% of men presenting with infertility.

Many men with varicocele:

- have no pain,
- have normal sperm,
- have normal testosterone,
- and father children naturally.

At the same time, in selected men a clinically important varicocele can contribute to:

- reduced sperm production,
- impaired motility,
- abnormal morphology,
- increased sperm DNA fragmentation,
- testicular growth problems,
- pain,
- and possibly reduced testosterone production.

Therefore, when a patient comes to me at **Saira Health Care**, I do not treat the ultrasound report alone.

I ask:

Is the varicocele actually palpable?

What grade is it?

Does it cause pain?

What does the semen analysis show?

Is the testicle becoming smaller?

Is testosterone low?

Is the couple experiencing infertility?

How old is the female partner and what is her ovarian reserve?

Would conservative treatment be reasonable, or would repair offer a meaningful advantage?

This is the basis of individualized varicocele care.

What Is a Varicocele?

A varicocele is an abnormal enlargement and tortuosity of veins within the scrotum, particularly the veins of the:

Pampiniform Venous Plexus

These veins normally carry blood away from the testicle.

A simple comparison is helpful.

Varicocele can be thought of as somewhat similar to:

varicose veins of the legs—but occurring around the testicle.

However, the reproductive consequences can be different because normal testicular function depends on a carefully regulated environment.

The testes work best at a temperature slightly below the body's core temperature.

The pampiniform plexus contributes to:

- venous drainage,
- heat exchange,
- and temperature regulation around the testes.

When these veins become enlarged and blood refluxes abnormally, the local testicular environment may change.

The Unani Name for Varicocele

Official standardized terminology published by the **Central Council for Research in Unani Medicine (CCRUM), Ministry of AYUSH**, identifies the traditional Unani term:

for varicocele.

CCRUM describes it as a condition involving dilatation of veins in and around the scrotum.

This is important because it shows that dilated scrotal veins were recognized within traditional Unani medical literature long before modern Doppler ultrasound became available.

Modern medicine, however, can now investigate:

- venous diameter,
- direction and duration of reflux,
- testicular volume,
- semen parameters,
- hormones,
- and sperm DNA integrity

with much greater precision.

My preferred approach is therefore to combine:

the individualized principles of Unani medicine with contemporary reproductive-urological diagnosis.

Why Does Varicocele Usually Occur on the Left Side?

Most clinically evident varicoceles occur predominantly on the:

left side.

This is related largely to anatomy.

The left testicular vein drains into the:

- left renal vein,

while the right testicular vein usually drains more directly into the:

- inferior vena cava.

The left side also has differences in:

- venous length,
- pressure,

- drainage angle,
- and surrounding vascular anatomy.

These factors can make venous pressure and reflux more likely on the left.

However, varicocele can also be:

- bilateral,
- or occasionally isolated on the right.

Why Is an Isolated Right-Sided Varicocele Important?

A right-sided varicocele does not automatically mean something dangerous.

However, current EAU guidance advises further evaluation of a **clinically isolated right-sided varicocele** for possible:

- abdominal,
- retroperitoneal,
- or congenital abnormalities.

This becomes especially important when a varicocele:

- appears suddenly,
- cannot be reduced when lying down,
- develops in an older man,
- or is associated with other unusual symptoms.

Therefore, unusual presentations deserve proper evaluation rather than simply being labelled ordinary varicocele.

Why Does a Varicocele Develop?

There is not one single mechanism in every patient.

The traditional explanation that varicocele is simply:

“excess fluid collecting in the scrotum”

is not the modern anatomical definition.

Modern medicine understands varicocele primarily as:

abnormal dilation of testicular veins with impaired venous drainage and reflux.

Potential contributors include:

- incompetent venous valves,
- increased venous pressure,
- anatomical differences,
- compression of venous drainage,
- and individual vascular characteristics.

What Happens to the Testicle in Varicocele?

Not every testis with varicocele becomes damaged.

But in susceptible men, several mechanisms may contribute to impaired testicular function.

These include:

- increased scrotal temperature,
- oxidative stress,
- reduced oxygen supply or hypoxia,
- accumulation or reflux of metabolites,
- altered testicular blood flow,
- inflammatory changes,
- and possible hormonal effects.

Current EAU guidance recognizes increased temperature, hypoxia and reflux of potentially harmful metabolites among mechanisms proposed to explain testicular dysfunction in varicocele.

Varicocele and Testicular Temperature

Sperm production requires a temperature slightly lower than normal core body temperature.

This is one reason the testes are located outside the abdomen.

Enlarged scrotal veins may interfere with the normal heat-exchange mechanism.

Chronically increased local temperature can potentially interfere with:

- germ-cell development,

- sperm concentration,
- motility,
- morphology,
- and testicular function.

However, this effect varies substantially between men.

Varicocele and Oxidative Stress

One of the most important modern theories is:

Oxidative Stress

Reactive oxygen species—or ROS—are normal in small amounts.

Excessive ROS, however, can damage:

- sperm-cell membranes,
- mitochondria,
- proteins,
- and DNA.

Varicocele has been associated with increased oxidative stress and sperm DNA fragmentation.

A large 2025 systematic review and meta-analysis found that varicocele repair was associated with reductions in sperm DNA fragmentation, with the pooled reduction becoming particularly evident several months after treatment.

This provides a biological explanation for why a varicocele may impair sperm even when the sperm count alone does not tell the entire story.

Varicocele and Sperm DNA Fragmentation

Sperm DNA fragmentation—or SDF—refers to damage within sperm genetic material.

Men with clinical varicocele may have increased SDF.

Current EAU guidance recognizes this association and states that varicocele intervention has been shown to reduce SDF in selected men.

However:

Every man with varicocele does not need a sperm DNA fragmentation test.

SDF testing becomes more relevant in selected situations such as:

- unexplained infertility,
- recurrent pregnancy loss,
- repeated IVF/ICSI failure,
- or other specific fertility concerns.

It should not automatically replace standard semen analysis.

Varicocele and Male Infertility

Varicocele is one of the most recognized potentially correctable conditions associated with male-factor infertility.

But the word:

associated

is very important.

Varicocele does not cause infertility in every affected man.

Many fertile men have varicocele.

Therefore:

Varicocele + infertility does not automatically prove that the varicocele is the only cause.

A complete male-fertility assessment is still necessary.

How Can Varicocele Affect Semen Quality?

Varicocele may be associated with abnormalities in:

Sperm Concentration

The number of sperm per millilitre may fall.

Total Sperm Number

The total number in the ejaculate may be reduced.

Progressive Motility

The percentage of sperm moving effectively forward may decline.

Morphology

The proportion of normally shaped sperm may decrease.

DNA Integrity

Sperm DNA fragmentation can increase in some men.

Current EAU evidence indicates that varicocele repair in appropriately selected men can improve several semen parameters, although the magnitude of improvement varies considerably between patients.

Does Varicocele Always Lower the Sperm Count?

No.

Some men with varicocele have:

- excellent sperm concentration,
- normal motility,
- normal morphology.

Another man may have:

- low sperm concentration only.

Another may have:

- poor motility.

Another may have:

- oligo-astheno-teratozoospermia.

Therefore, I never predict fertility simply from varicocele grade.

Can Varicocele Cause Azoospermia?

Severe testicular dysfunction associated with varicocele may coexist with:

Non-Obstructive Azoospermia – NOA

but this is a very different situation from ordinary varicocele-associated oligozoospermia.

Current AUA/ASRM guidance specifically cautions that in men with:

clinical varicocele + non-obstructive azoospermia

there is **no definitive evidence** establishing that varicocele repair before assisted reproduction will reliably restore sperm production.

Therefore:

Azoospermia should never be managed merely by saying, "Operate the varicocele and sperm will definitely return."

These patients need specialist male-infertility evaluation.

Varicocele and Testosterone

The testes produce both:

- sperm,
- and testosterone.

Varicocele may affect Leydig-cell function in some men.

This has led to research into whether varicocele repair can improve testosterone levels.

A 2026 systematic review and meta-analysis involving **18 studies and 1,225 hypogonadal men** reported an average increase in serum testosterone of approximately **114 ng/dL** after varicocelectomy, with improvement observed during follow-up.

This is clinically interesting.

However:

Varicocele should not automatically be blamed for every case of low testosterone.

Low testosterone can also result from:

- obesity,
- diabetes,
- pituitary disease,
- medication,
- sleep disorders,
- aging,
- chronic illness,
- and other endocrine conditions.

A proper hormonal evaluation is necessary.

Does Varicocele Cause Erectile Dysfunction?

Not directly in most men.

Varicocele is primarily a:

- venous,
- testicular,
- and fertility-related condition.

Erectile dysfunction is mainly related to:

- blood vessels,
- nerves,
- hormones,
- psychological factors,
- medications,
- and metabolic health.

However, if varicocele is associated with:

- significant pain,
- low testosterone,
- infertility stress,

sexual health may be affected indirectly.

A 2026 meta-analysis in hypogonadal men found improvement in erectile-function scores after varicocelectomy, but these findings should not be interpreted to mean that varicocele is a universal cause of erectile dysfunction.

Symptoms of Varicocele

Many varicoceles cause:

No symptoms.

They may be discovered during:

- routine examination,
- infertility investigation,

- or ultrasound performed for another reason.

When symptoms occur, they may include:

- dull scrotal ache,
- dragging sensation,
- heaviness,
- discomfort after prolonged standing,
- discomfort after exercise,
- visible enlarged veins,
- a “bag of worms” sensation,
- testicular asymmetry,
- reduced testicular volume,
- or infertility.

What Does Varicocele Pain Usually Feel Like?

Typical pain is often:

- dull,
- aching,
- dragging,
- or heavy

rather than sharp.

It may become worse:

- later in the day,
- after prolonged standing,
- after strenuous activity,
- or in hot weather.

It may improve when:

- lying down,
- supporting the scrotum,

- or resting.

But:

Sudden severe testicular pain is not typical varicocele pain.

Sudden severe pain should receive urgent evaluation for conditions such as:

- testicular torsion,
- acute infection,
- trauma,
- or another acute scrotal disorder.

Does Masturbation Cause Varicocele?

No reliable evidence shows that normal masturbation causes varicocele.

Varicocele is not caused by:

- semen loss,
- masturbation,
- nocturnal emission,
- or frequency of ejaculation.

Patients should not develop unnecessary guilt over normal sexual behavior.

Does Frequent Sexual Intercourse Cause Varicocele?

No.

Normal sexual intercourse is not considered a cause of varicocele.

A painful existing varicocele may sometimes become more noticeable after activity, but sexual activity itself is not considered its primary cause.

Does Weightlifting Cause Varicocele?

Heavy straining can transiently increase intra-abdominal and venous pressure and may make an existing varicocele:

- more visible,
- or more uncomfortable.

However, it would be inaccurate to say that ordinary exercise or gym activity alone causes every varicocele.

If heavy lifting consistently produces significant pain, activity can be modified while the patient is evaluated.

Varicocele Grading

Clinical varicoceles are commonly classified into grades.

Current EAU guidance uses the following practical classification:

Subclinical Varicocele

Not visible or palpable during physical examination.

Detected only by:

- Doppler ultrasound,
- or another imaging method.

Grade 1

Palpable only during:

Valsalva manoeuvre

when the patient bears down.

Grade 2

Palpable while standing without Valsalva but not obviously visible.

Grade 3

Visible and palpable at rest.

Is Grade 3 Always Worse Than Grade 1?

A higher grade may be associated with a greater chance of testicular effects, and EAU evidence notes that deterioration in semen parameters can correlate with higher grade.

But:

Grade alone does not decide treatment.

A man with Grade 3 varicocele may have:

- normal sperm,

- no pain,
- and proven fertility.

Another man with Grade 2 disease may have:

- significant infertility,
- abnormal semen,
- and testicular dysfunction.

The whole picture matters.

What Is a Subclinical Varicocele?

A subclinical varicocele is:

- not palpable,
- not visible,

but is detected on ultrasound.

This is a very important distinction because:

An ultrasound finding alone does not automatically need treatment.

Current EAU guidance strongly advises against treating infertile men solely for a subclinical varicocele when semen analysis is normal or when the varicocele is not clinically palpable.

AUA/ASRM guidance likewise states that clinicians should **not recommend varicocelectomy for a non-palpable varicocele detected solely by imaging**.

Diagnosis of Varicocele

The diagnosis begins with:

Physical Examination

—not ultrasound alone.

The patient is generally examined:

- standing,
- and sometimes lying down.

The physician may ask him to perform:

Valsalva manoeuvre

to make smaller varicoceles more obvious.

Role of Doppler Ultrasound

Doppler ultrasound becomes especially useful when:

- physical examination is uncertain,
- obesity makes examination difficult,
- recurrence after surgery is suspected,
- another scrotal abnormality may exist,
- or testicular size needs objective assessment.

Current EAU guidance notes that ultrasound findings associated with a clinically significant varicocele include approximately:

- vein diameter greater than **3 mm**
- while upright and performing Valsalva,
- and venous reflux lasting more than **2 seconds**.

These measurements are useful, but ultrasound should be interpreted together with examination and fertility findings.

Semen Analysis

For a man with varicocele who wants children, semen analysis is one of the most important investigations.

It evaluates:

- sperm concentration,
- total sperm number,
- progressive motility,
- total motility,
- morphology,
- semen volume,
- and other parameters.

Current EAU guidance recommends at least **two semen analyses when the baseline result is abnormal**.

One abnormal sample should not always determine major treatment decisions.

Hormone Testing

Hormonal evaluation becomes especially relevant when there is:

- severe oligozoospermia,
- azoospermia,
- reduced testicular volume,
- low libido,
- erectile symptoms,
- or suspected testosterone deficiency.

Tests may include:

- FSH,
- LH,
- morning testosterone,
- prolactin,
- and other hormones when appropriate.

Testicular Volume

Testicular size can be assessed using:

- an orchidometer,
- or ultrasound.

Varicocele is associated with testicular growth impairment in some adolescents and testicular dysfunction in selected adults.

Serial testicular-volume measurements can therefore be particularly important in adolescents.

Varicocele in Adolescents

Adolescent varicocele requires careful management because:

not every teenager with varicocele will develop infertility.

Overtreatment should be avoided.

Current EAU guidance recommends offering surgery when varicocele is associated with a **persistent smaller testis**, defined approximately as:

- more than **2 mL**
- or **20% difference in volume**,

confirmed at repeated assessments approximately six months apart.

Other factors such as:

- pain,
- abnormal semen in older adolescents,
- bilateral disease,
- and progressive testicular changes

may also influence specialist decisions.

When Does Varicocele Need Treatment?

This is the most important practical question.

Treatment may be considered when varicocele is associated with:

1. Male infertility with abnormal semen

Particularly when the varicocele is:

- clinical,
- palpable,
- and the female partner has reasonable reproductive potential.

2. Persistent scrotal pain

When conservative treatment fails.

3. Progressive testicular growth impairment

Especially in adolescents.

4. Selected men with elevated sperm DNA fragmentation

Particularly with:

- unexplained infertility,
- repeated ART failure,
- or recurrent pregnancy loss,

after appropriate evaluation.

5. Selected hypogonadal men

When a clinically important varicocele and low testosterone coexist and other factors have been considered.

Current WHO 2025 Recommendation

The **World Health Organization's first global infertility guideline**, published on **28 November 2025**, specifically addressed clinical varicocele.

WHO suggests:

surgical or radiological treatment rather than expectant management for men with infertility and a clinical varicocele.

Men whose semen parameters are outside WHO reference ranges are considered more likely to benefit.

WHO describes this as a **conditional recommendation**, reflecting limitations in the certainty of evidence.

This is important because it shows that modern guidelines support treatment in:

selected patients—not every man with enlarged scrotal veins.

Current EAU Recommendation

Current EAU guidance strongly recommends treating infertile men when all of the following are present:

- **clinical varicocele**
- **abnormal semen parameters**
- **otherwise unexplained male-factor infertility**
- and a female partner with good ovarian reserve.

EAU strongly advises against routine treatment when:

- semen is normal,
- or the varicocele is subclinical.

AUA/ASRM Recommendation

AUA/ASRM guidance recommends considering surgical varicocelectomy in men:

- attempting conception,
- with a palpable varicocele,
- infertility,
- and abnormal semen parameters,

with specific caution in azoospermic men.

The agreement between these major guidelines is clinically useful:

Clinical findings + fertility problem + abnormal semen matter much more than an ultrasound label alone.

When Varicocele Usually Does Not Need Treatment

Treatment is generally unnecessary merely because:

- ultrasound shows mildly enlarged veins,
- the patient has no pain,
- semen analysis is normal,
- fertility is normal,
- testicular size is stable.

In such situations, observation may be completely reasonable.

Conservative Treatment for Varicocele

Conservative treatment does not physically close the abnormal veins.

Its purpose is mainly to manage:

symptoms

in men who do not currently require intervention.

Measures may include:

- scrotal support,
- supportive underwear,
- avoiding activities that repeatedly provoke pain,
- appropriate pain medication,
- lifestyle management,
- and follow-up.

Scrotal Support

Supportive underwear may reduce:

- pulling,
- heaviness,
- and movement-related discomfort.

For mild symptomatic varicocele, this is a simple and often useful measure.

Pain Relief

When medically appropriate, analgesic or anti-inflammatory medication may help control discomfort.

However:

Pain medicine does not repair venous reflux.

If persistent significant pain continues despite appropriate conservative treatment, surgical or radiological treatment may be discussed.

Modern Definitive Treatment

The major established methods are:

Varicocelectomy

Surgical interruption of abnormal veins.

Percutaneous Embolization

A radiological procedure that blocks abnormal venous flow from within the vessel.

Microsurgical Varicocelectomy

Microsurgical repair can be performed through:

- inguinal,
- or subinguinal

approaches.

The surgeon identifies and ligates abnormal veins while attempting to preserve:

- testicular artery,
- lymphatic vessels,
- vas deferens,
- and other important structures.

WHO's 2025 infertility guideline suggests **microscopic surgery over other surgical approaches** when surgical treatment has been chosen.

EAU evidence likewise indicates that microscopic inguinal or subinguinal approaches may have lower:

- recurrence,
- and complication rates

than some non-microscopic techniques.

Why Microsurgery Is Often Preferred

The operating microscope helps the surgeon distinguish:

- veins,
- arteries,
- lymphatics.

This can reduce risks such as:

- recurrent varicocele,
- hydrocele,
- accidental arterial damage.

However, results still depend on:

- surgeon expertise,
- anatomy,
- varicocele characteristics,
- and patient factors.

Laparoscopic Varicocelectomy

Laparoscopic repair is another surgical option.

It involves accessing the veins through small abdominal incisions.

It may be useful in selected situations, although microsurgical approaches are generally preferred when expertise is available.

Open Non-Microsurgical Varicocelectomy

Traditional inguinal or retroperitoneal operations remain available in some settings.

WHO recognizes these as acceptable alternatives when:

- microsurgical expertise is unavailable.

Varicocele Embolization

Varicocele embolization is performed by an interventional radiologist.

A catheter is guided into the abnormal veins, which are then blocked using:

- coils,
- plugs,
- or sclerosant agents.

Advantages may include:

- no scrotal incision,
- relatively quick recovery,
- and usefulness in selected recurrent varicoceles.

Potential disadvantages include:

- technical failure,

- recurrence,
- contrast exposure,
- vascular complications,
- and radiation exposure.

WHO's 2025 guideline considers both **surgical and radiological treatment** acceptable when treatment of infertility-associated clinical varicocele has been chosen.

Does Varicocele Surgery Improve Sperm Count?

In appropriately selected men:

often, yes—but not always.

Current EAU evidence shows significant improvement in sperm concentration and other semen parameters following treatment in many infertile men with clinical varicocele and abnormal baseline semen.

A 2025 meta-analysis examining factors associated with treatment response included 1,498 patients and reported an overall semen-response rate of approximately **63%**, while emphasizing that not every man improves.

Therefore:

Varicocelectomy should never be sold as a guaranteed sperm-count operation.

Does Surgery Improve Sperm Motility and Morphology?

Many before-and-after studies show improvement in:

- progressive motility,
- total motility,
- and morphology.

However, trials comparing treated and untreated men have sometimes produced less consistent results for motility and morphology than for sperm concentration and pregnancy.

Current EAU guidance therefore describes the evidence as favorable overall while recognizing uncertainty in the size of benefit for individual semen parameters.

How Long Does Semen Improvement Take?

This is important for patient counselling.

Sperm development takes several weeks.

Therefore, I do not expect a meaningful new semen pattern a few days after treatment.

EAU guidance notes that improvement may require up to approximately:

two spermatogenic cycles.

Spontaneous pregnancies after successful varicocele treatment commonly occur within approximately:

6–12 months

in couples who are otherwise suitable for natural conception.

This timeline must also be balanced against:

- the female partner's age,
- ovarian reserve,
- infertility duration.

Does Varicocele Repair Improve Pregnancy Rates?

Evidence suggests a benefit in appropriately selected infertile couples.

Current EAU evidence reports improved pregnancy rates compared with observation in men with:

- clinical varicocele,
- abnormal semen,
- and male-factor infertility.

The 2025 WHO guideline also concluded that clinical varicocele was sufficiently important to warrant a conditional recommendation for surgical or radiological treatment in selected infertile men.

But:

Pregnancy can never be guaranteed by correcting a varicocele.

Pregnancy also depends on the female partner.

Varicocelectomy Before IVF or ICSI

This is an increasingly important area of research.

A 2025 systematic review and meta-analysis involving **1,705 patients** found a statistically higher clinical pregnancy rate among infertile men who underwent varicocelectomy before ART compared with those who did not.

Other analyses have also reported possible improvements in:

- pregnancy,
- and live-birth outcomes

following repair before ART.

However, these data include many observational studies.

The decision must consider:

- female age,
- ovarian reserve,
- semen severity,
- ART history,
- and the time required after surgery.

Why Female Age Matters Before Varicocele Surgery

Suppose two men have the same:

- Grade 3 clinical varicocele,
- low sperm count.

Couple A

The wife is:

- 26,
- with excellent ovarian reserve.

Waiting several months to assess semen improvement after repair may be reasonable.

Couple B

The wife is:

- 40,
- with significantly diminished ovarian reserve.

Waiting 6–12 months simply to improve the semen report may reduce the couple's overall reproductive opportunity.

This is why infertility treatment should always be:

couple-centered.

Varicocele and Non-Obstructive Azoospermia

This area requires particular caution.

Some studies have reported sperm appearing in the ejaculate after varicocele repair in selected NOA patients.

However:

there are no sufficiently strong randomized data to guarantee benefit.

AUA/ASRM specifically recommends counselling couples that definitive evidence supporting varicocele repair before ART in NOA is lacking.

Therefore, NOA should receive a complete specialist evaluation rather than relying solely on varicocele treatment.

Varicocele and Pain: How Successful Is Surgery?

When a patient has:

- a clinical varicocele,
- typical varicocele pain,
- and persistent symptoms despite conservative measures,

repair may help.

EAU reports pain resolution after varicocelectomy in approximately:

48–90%

of patients across available studies.

This broad range illustrates that:

pain relief is common but not guaranteed.

If the pain has another cause, surgery may not resolve it.

Risks of Varicocele Surgery

Possible complications include:

- recurrent or persistent varicocele,
- hydrocele,
- hematoma,
- infection,
- chronic discomfort,
- lymphatic injury,
- testicular artery injury,
- testicular atrophy in rare severe vascular injury,
- anesthesia-related risks.

Microsurgical techniques aim to reduce several of these complications.

Can Varicocele Return?

Yes.

Recurrence can occur after:

- surgery,
- or embolization.

The risk depends partly on:

- technique,
- anatomy,
- and operator experience.

Microsurgical approaches generally have lower recurrence rates than some older non-microscopic procedures.

Antioxidants and Varicocele

Because oxidative stress is implicated in varicocele-associated sperm dysfunction, many men are prescribed:

- vitamins,

- antioxidants,
- CoQ10,
- carnitine,
- zinc,
- selenium,
- and other fertility supplements.

Some studies report improvements in semen parameters or oxidative markers.

However, the **2025 WHO infertility guideline did not make a recommendation for or against antioxidant supplementation in male infertility with abnormal semen parameters**, because the evidence remains insufficient and heterogeneous.

Therefore:

antioxidants should not be presented as a proven replacement for clinically indicated varicocele repair.

The Unani Concept of Varicocele

As I mentioned earlier, CCRUM standardized Unani terminology recognizes:

Dawālī al-Safan

as the traditional equivalent of varicocele.

Classical Unani medicine traditionally understands disease through concepts involving:

- Mizaj,
- Akhlat,
- organ function,
- diet,
- lifestyle,
- and systemic balance.

Some traditional descriptions discuss altered movement or accumulation of humoral material and weakness of tissues or vessels.

However, I do not equate these directly with:

- defective venous valves,

- Doppler reflux,
- venous diameter,
- or oxidative stress.

These are different explanatory frameworks.

Mizaj and Individualized Varicocele Care

Mizaj, or temperament, is an important traditional Unani concept.

In my clinical practice, an individualized assessment may consider:

- body constitution,
- digestion,
- physical activity,
- sleep,
- nutrition,
- bowel habits,
- weight,
- psychological state,
- sexual function,
- and general reproductive health.

This can be useful for whole-person care.

But:

Mizaj assessment does not replace physical examination, semen analysis or Doppler ultrasound when these are medically required.

Akhlat and the Traditional Humoral Framework

Classical Unani medicine describes four traditional humors:

- Dam,
- Balgham,
- Safra,

- Sauda.

Alterations in their balance form part of traditional Unani disease theory.

However, these concepts should not be presented as if they were modern laboratory variables.

For example:

Balgham is not sperm count.

Safra is not testosterone.

Humoral imbalance is not Doppler reflux.

Maintaining this distinction makes integrative medicine more scientifically credible.

Four Major Modes of Treatment in Unani Medicine

CCRUM recognizes four broad approaches in Unani medicine:

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bit-Tadbir

Regimenal therapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical treatment

This is an important point.

Authentic Unani treatment does not mean:

“Surgery must never be used.”

Ilaj-bil-Yad itself recognizes the role of surgical intervention where the nature of disease requires it.

Ilaj-bil-Ghiza in Varicocele

Diet cannot physically ligate an incompetent testicular vein.

However, nutrition can support:

- sperm production,
- metabolic health,
- healthy weight,
- antioxidant balance,
- testosterone health,
- and general well-being.

I may therefore advise a fertility-oriented diet containing appropriate:

- protein,
- vegetables,
- fruits,
- whole grains,
- healthy fats,
- micronutrients.

I also consider:

- obesity,
- diabetes,
- smoking,
- alcohol,
- processed foods,
- and nutritional deficiency.

My message is:

Healthy diet supports testicular function; it does not mechanically close an enlarged vein.

Ilaj-bit-Tadbir in Varicocele

Regimenal treatment may focus on:

- appropriate exercise,
- healthy body weight,

- avoiding prolonged activities that consistently provoke pain,
- adequate sleep,
- stress management,
- scrotal support where needed,
- and general reproductive-health optimization.

These approaches can be useful particularly in:

- mild symptomatic disease,
- fertility optimization,
- or conservative management.

What About Hijama for Varicocele?

Hijama has an established historical place within Unani regimenal therapy.

However:

There is currently insufficient high-quality evidence showing that Hijama permanently eliminates pathological spermatic-vein reflux or replaces varicocelectomy in an infertile man who meets surgical criteria.

Therefore, if used as part of selected traditional care, it should be considered:

- supportive,

rather than a proven anatomical repair of the abnormal veins.

Should the Enlarged Veins Be Massaged?

I do not recommend aggressive massage directly over a varicocele.

Enlarged scrotal veins are delicate structures.

Massage has not been proven to repair venous valve dysfunction and may:

- aggravate pain,
- cause unnecessary manipulation,
- or distract from proper diagnosis.

Ilaj-bid-Dawa: Unani Pharmacotherapy

Unani pharmacotherapy is one of the areas in which Saira Health Care offers individualized management.

The objective may include supporting:

- general vascular health,
- scrotal comfort,
- reproductive health,
- semen quality,
- nutrition,
- and associated male-fertility problems.

However, medicines should be selected according to:

- symptoms,
- varicocele grade,
- semen profile,
- fertility goals,
- testicular volume,
- hormones,
- Mizaj,
- and associated medical conditions.

This is why I do not believe every varicocele patient should automatically receive the same fertility package.

Dr. Qasmi's Nuskha No. 145 – Varico Relief

A formulation specifically used within Saira Health Care's traditional varicocele programme is:

Dr. Qasmi's Nuskha No. 145 – Varico Relief

The current Saira Health Care Pharmacy listing describes it as a Dr. Qasmi herbal formulation and lists each 500 mg tablet as containing traditional ingredients including:

- Mazu Sabz,
- Rasaut Zard,

- Kateera Safaid,
- Sange Jarahat,
- Geru,
- and excipients.

Within my clinical approach, Nuskha No. 145 may be considered in selected patients as part of:

- conservative traditional management,
- symptom-support treatment,
- reproductive-health support,
- and an individualized Unani programme.

What I Do Not Claim About Nuskha No. 145

I believe this distinction is extremely important.

Although Saira Health Care uses Nuskha No. 145 within its varicocele practice:

I do not consider it scientifically appropriate to promise that one tablet will permanently eliminate every clinical varicocele.

A varicocele is an anatomical venous abnormality.

At present, I do not identify high-quality independent randomized controlled evidence showing that Nuskha No. 145:

- permanently closes incompetent spermatic veins,
- eliminates Doppler reflux in every patient,
- replaces microsurgical repair in men meeting surgical criteria,
- or guarantees pregnancy.

Therefore, I prefer to describe it accurately as:

an individualized traditional supportive formulation used within Saira Health Care's integrative varicocele programme.

Who May Be Suitable for an Initial Conservative Unani Approach?

A conservative individualized programme may be particularly reasonable when:

- the varicocele is mild,
- discomfort is limited,
- semen parameters are normal or only mildly altered,
- surgery is not currently indicated,
- the patient is being observed,
- fertility is not immediately time-sensitive,
- and there are no concerning testicular changes.

The patient should still be monitored appropriately.

When Nuskha No. 145 Should Not Delay Other Treatment

Traditional treatment should not delay appropriate urological management when there is:

- persistent disabling pain,
- progressive testicular shrinkage,
- significant infertility with abnormal semen and clinical varicocele,
- an unusual isolated right-sided varicocele requiring investigation,
- suspected testicular disease,
- or another clear indication for intervention.

In such patients, treatment should remain open to:

- microsurgical varicocelectomy,
- embolization,
- or appropriate specialist fertility care.

What About Spermogenic and Other Fertility Medicines?

Some varicocele patients also have:

- oligozoospermia,
- asthenozoospermia,
- teratozoospermia,
- or other semen abnormalities.

In such cases, the treatment plan may include separate fertility-support measures.

Saira Health Care's pharmacy currently groups several reproductive-health formulations within its varicocele and male-infertility sections, including Nuskha No. 145 and Spermogenic.

However:

treating poor sperm quality is not exactly the same as treating the abnormal vein.

These two objectives should be assessed separately.

My Special Individualized Approach to Varicocele at Saira Health Care

When a man comes to me with a varicocele report, I prefer a structured assessment.

Step 1: Confirm That the Varicocele Is Clinically Relevant

I ask:

- Is it palpable?
- Is it visible?
- What grade is it?
- Is it only an ultrasound finding?

This prevents overtreatment of subclinical disease.

Step 2: Assess Symptoms

I ask about:

- pain,
- heaviness,
- standing-related discomfort,
- exercise-related symptoms,
- duration,
- side involved.

I also make sure the pain is not actually caused by:

- epididymitis,

- epididymal cyst,
- hernia,
- testicular disease,
- or another scrotal condition.

Step 3: Assess Testicular Size

I evaluate whether:

- both testes are similar,
- one is becoming smaller,
- there is significant testicular hypotrophy.

This is especially important in adolescents and young adults.

Step 4: Understand the Patient's Fertility Goals

I ask:

“Are you trying to have a child now?”

This single question can completely change management.

A painless varicocele in a man who has completed his family is a different clinical situation from a man with:

- infertility,
- abnormal sperm,
- and a wife with limited reproductive time.

Step 5: Review Semen Analysis

I assess:

- sperm concentration,
- total count,
- motility,
- morphology,

- semen volume.

If abnormal, repeat analysis is often appropriate.

Step 6: Evaluate Hormones When Indicated

Depending on the patient, I consider:

- FSH,
- LH,
- testosterone,
- prolactin,
- and other endocrine investigations.

Step 7: Look Beyond the Varicocele

This is extremely important.

I assess other causes of male infertility such as:

- smoking,
- obesity,
- diabetes,
- hormonal disorders,
- infection,
- anabolic steroids,
- genetic disorders,
- previous undescended testes,
- testicular injury,
- chemotherapy,
- and age-related reproductive factors.

A varicocele may be present but may not be the entire explanation.

Step 8: Assess the Female Partner

I consider:

- female age,
- ovarian reserve,
- ovulation,
- tubal health,
- infertility duration.

This helps determine whether waiting for varicocele treatment to improve semen is sensible.

Step 9: Correct Lifestyle Factors

I advise:

- no smoking,
- healthy body weight,
- regular moderate exercise,
- diabetes control,
- good sleep,
- limiting heavy alcohol,
- avoiding anabolic steroids,
- and maintaining appropriate nutrition.

Step 10: Use Unani Care Where Appropriate

When conservative treatment is suitable, an individualized Unani plan may include:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- and Nuskha No. 145 where clinically appropriate.

My goal is not simply:

“Give a varicocele tablet.”

The goal is to support the patient's:

- comfort,
- fertility,
- general health,
- and reproductive environment.

Step 11: Monitor Objectively

I review:

- pain,
- testicular size,
- semen parameters,
- reproductive outcomes,
- and ultrasound findings when clinically necessary.

Treatment should not be declared successful only because:

“I can feel the veins less today.”

Objective fertility outcomes matter.

Step 12: Recommend Surgery or Embolization When It Offers More Benefit

If the patient clearly meets evidence-based criteria for intervention, I do not believe prolonged empirical treatment should prevent him from receiving:

- microsurgical repair,
- or radiological embolization.

Current WHO guidance specifically supports surgical or radiological treatment for selected infertile men with clinical varicocele.

Step 13: Reassess Fertility After Treatment

Following repair, semen analysis is generally assessed after sufficient time for new sperm development.

Improvement should be evaluated over:

months rather than days.

Step 14: Move to ART When Necessary

If infertility persists despite appropriate management, options may include:

- IUI,
- IVF,
- ICSI.

The decision depends on:

- post-treatment semen quality,
- female fertility,
- age,
- and duration of infertility.

A responsible fertility clinic should know when to stop waiting.

The Importance of Avoiding Unnecessary Surgery

Just as I do not support exaggerated claims about herbal treatment, I also do not support operating on every ultrasound-detected varicocele.

Current international guidelines are clear:

Subclinical varicocele should not routinely be treated for infertility.

Good medicine avoids both:

- unnecessary surgery,
- and unnecessary prolonged medication.

The Importance of Avoiding Unnecessary Delay

The opposite mistake also occurs.

A patient may have:

- Grade 3 clinical varicocele,
- consistently abnormal sperm,

- progressive testicular dysfunction,
- years of infertility,

but continue conservative treatment indefinitely.

This can also be inappropriate.

The purpose of integrative treatment is not to defend one system of medicine.

It is to select what gives the patient the best realistic reproductive outcome.

Latest Research: Varicocelectomy Response Is Not Universal

A 2025 meta-analysis involving **11 studies and 1,498 patients** found an overall response rate of around **62.8%** based on the included studies' definitions of improvement.

Microsurgical and subinguinal approaches showed comparatively favorable results, while better pre-operative sperm concentration and total motile sperm count were associated with better postoperative response.

The most important practical lesson is:

Some men improve substantially, some improve modestly, and some do not improve.

Latest Research: Sperm DNA Fragmentation

A large 2025 meta-analysis examining multiple interventions found that varicocelectomy was associated with a reduction in sperm DNA fragmentation of approximately:

- **6.7 percentage points at three months**
- and approximately **12.4 percentage points at six months**

in the pooled before-and-after analyses.

This supports the concept that treatment may improve sperm quality beyond conventional sperm count alone.

But improved DNA fragmentation is still:

a biological marker—not a guaranteed pregnancy.

Latest Research: Testosterone in Hypogonadal Men

The 2026 meta-analysis involving 1,225 hypogonadal men found an average testosterone increase of approximately 114 ng/dL after repair and an improvement in erectile-function scores.

This is promising.

But these results primarily concern men with low testosterone and should not be generalized to every man with varicocele.

Latest Research: ART Outcomes

A 2025 systematic review and meta-analysis involving 1,705 infertile men reported higher clinical pregnancy rates in couples undergoing ART when the male partner had undergone varicocelectomy compared with untreated controls.

This may become increasingly important in selected ART planning.

However, because much of the evidence is observational, treatment should remain individualized.

Common Myths About Varicocele

Myth 1: Every varicocele causes infertility.

Fact: Many fertile men have varicocele.

Myth 2: Every varicocele requires surgery.

Fact: Treatment depends on symptoms, semen parameters, testicular health and fertility goals.

Myth 3: Every ultrasound varicocele should be operated upon.

Fact: Current EAU and AUA/ASRM guidance advises against routine repair of non-palpable subclinical varicocele.

Myth 4: Varicocele Grade 3 automatically means infertility.

Fact: Grade helps describe the examination, but fertility must be evaluated separately.

Myth 5: Masturbation causes varicocele.

Fact: There is no established evidence that normal masturbation causes varicocele.

Myth 6: Frequent sex worsens varicocele.

Fact: Normal sexual activity is not recognized as a cause.

Myth 7: Varicocele always causes erectile dysfunction.

Fact: Varicocele primarily affects scrotal venous and testicular function. Erectile dysfunction has many other causes.

Myth 8: Varicocele always lowers testosterone.

Fact: Some men with varicocele have normal testosterone.

Myth 9: Varicocele surgery guarantees normal sperm.

Fact: Many men improve, but response is not universal. A 2025 meta-analysis found an overall response around 63% using the included studies' outcome definitions.

Myth 10: Varicocele surgery guarantees pregnancy.

Fact: Fertility depends on both partners.

Myth 11: Antioxidants can replace varicocele repair.

Fact: WHO currently makes no recommendation for or against antioxidant supplements for male infertility because evidence remains uncertain.

Myth 12: Herbal medicine is scientifically proven to eliminate every varicocele.

Fact: High-quality evidence demonstrating universal anatomical resolution of varicocele with an oral herbal formulation is currently lacking.

Myth 13: Unani medicine has no role in varicocele.

Fact: Unani medicine can contribute meaningfully through individualized diet, lifestyle, reproductive-health support and supervised traditional pharmacotherapy. Its role should be matched to disease severity and should not delay intervention when repair is indicated.

Frequently Asked Questions

Is varicocele dangerous?

Usually it is not dangerous to life.

The main potential concerns are:

- pain,
- reduced testicular growth,
- impaired sperm production,
- infertility,
- and possibly reduced testosterone in selected men.

Can I live normally with varicocele?

Yes.

Many men with asymptomatic varicocele require no active treatment.

Can a man with varicocele become a father naturally?

Absolutely.

Many men with varicocele have normal fertility.

Even some men with mildly abnormal semen can achieve natural pregnancy.

Does Grade 1 varicocele require treatment?

Not automatically.

Treatment depends on:

- fertility,
- semen,
- pain,

- testicular health.

Does Grade 2 require surgery?

Not automatically.

A Grade 2 varicocele with:

- abnormal semen,
- infertility,

may be considered for repair.

But a painless Grade 2 varicocele with normal fertility may simply be observed.

Does Grade 3 require surgery?

Grade 3 alone does not make surgery compulsory.

However, higher grade together with:

- pain,
- abnormal semen,
- testicular changes,
- infertility

makes treatment more relevant.

Can a varicocele become smaller naturally?

Symptoms may fluctuate, and veins may appear less prominent when lying down.

A true established clinical varicocele generally does not reliably disappear through lifestyle changes alone.

Can medicines permanently close the varicocele veins?

There is currently no standard oral medicine proven to permanently close incompetent spermatic veins in the way surgical ligation or embolization does.

Can Unani medicine be tried first?

In selected mild or conservatively managed cases, individualized Unani treatment may reasonably be incorporated under supervision.

However, the patient should not delay indicated urological treatment when there is:

- significant infertility,
- persistent pain,
- progressive testicular damage,
- or another clear intervention indication.

What is Dr. Qasmi's Nuskha No. 145?

Dr. Qasmi's Nuskha No. 145—Varico Relief—is a herbal formulation currently listed by Saira Health Care Pharmacy within its varicocele programme.

At Saira Health Care, it may be used as part of individualized traditional supportive care.

It should not be interpreted as a guaranteed replacement for varicocelectomy.

Can Nuskha No. 145 improve sperm count?

A patient with varicocele may simultaneously receive a broader fertility-support programme according to semen findings.

However, I do not identify high-quality product-specific controlled evidence proving a predictable sperm-count increase from Nuskha No. 145 alone.

Progress should therefore be assessed objectively through semen analysis.

Can varicocele reduce sperm motility?

Yes.

Varicocele is associated with reduced motility in some infertile men.

Can varicocele affect sperm morphology?

Yes.

Abnormal morphology may coexist with clinical varicocele, and some studies report improvement after repair.

Can varicocele increase sperm DNA fragmentation?

Yes.

Varicocele is associated with elevated SDF in selected infertile men, and repair has been shown to reduce SDF on average.

How soon after surgery should semen be tested?

Treatment effects should be judged over months rather than days.

Follow-up commonly begins around one spermatogenic cycle after repair, with further reassessment according to the couple's fertility plan.

When can pregnancy happen after repair?

EAU literature reports spontaneous pregnancies commonly occurring during approximately the first **6–12 months** after repair in suitable couples.

Is microsurgery the best technique?

When surgery is selected and expertise is available, WHO suggests microscopic surgery over other surgical approaches.

Microsurgical inguinal or subinguinal techniques are associated with relatively low recurrence and complication rates.

Is embolization effective?

It is an established alternative in selected patients.

WHO recognizes both surgical and radiological treatment options for infertility-associated clinical varicocele.

Can surgery increase testosterone?

It may particularly in hypogonadal men.

A 2026 meta-analysis reported an average testosterone increase of approximately 114 ng/dL after varicocelectomy.

Individual results vary.

Can surgery improve erectile function?

The same 2026 meta-analysis reported improvement in erectile-function scores in hypogonadal men, but varicocelectomy should not be considered a universal ED treatment.

Can varicocele recur after treatment?

Yes.

Recurrence is possible after both:

- surgery,
- and embolization.

Microsurgical methods generally have relatively low recurrence.

When Should You Seek Specialist Evaluation?

I recommend proper evaluation if you have:

- infertility,
- a palpable varicocele,
- abnormal sperm count,
- reduced sperm motility,
- abnormal morphology,
- persistent scrotal pain,
- testicular asymmetry,
- shrinking testicle,
- low testosterone symptoms,
- azoospermia,
- recurrent pregnancy loss with elevated sperm DNA fragmentation,
- repeated ART failure,
- an unusual isolated right-sided varicocele,

- or rapidly changing scrotal findings.

When Should Scrotal Pain Be Treated Urgently?

Seek urgent medical care for:

- sudden severe testicular pain,
- acute swelling,
- nausea or vomiting with testicular pain,
- major testicular trauma,
- fever with severe scrotal inflammation.

These symptoms may indicate another condition such as:

testicular torsion

and should not simply be blamed on varicocele.

Dr. Nizamuddin Qasmi and Saira Health Care

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with focused clinical practice in:

Sexual Disorders & Infertility

My professional education and training listed for this work include:

- **BUMS – Hamdard University, Delhi**
- **MD**
- **CGO**
- **Certificate in Infertility – MGBIMS, Delhi**
- **Certificate in Urology – London, UK**
- **Masters in Male Infertility – MasterHealthPro (HealthPro)**
- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**

Saira Health Care's public physician profile identifies my focused work in sexual disorders and infertility and specifically includes **varicocele** among the male reproductive-health disorders addressed within the practice.

Current Saira Health Care educational material additionally lists the **Masters in Male Infertility – MasterHealthPro (HealthPro)** within my professional profile.

This combination of:

- Unani medicine,
- infertility practice,
- male reproductive-health training,
- and urological education

is particularly useful in varicocele because treatment requires understanding both:

the enlarged veins

and

their possible effect on fertility and testicular function.

Saira Health Care's Contribution to Sexual Disorders and Infertility

One of the most important contributions I believe Saira Health Care can make is helping patients avoid the two extremes surrounding varicocele.

The first extreme is:

“Varicocele is harmless in everyone. Never treat it.”

The second extreme is:

“Every varicocele will destroy fertility and must be operated upon immediately.”

Neither statement is medically correct.

Saira Health Care publicly describes its model as patient-centered and focused on combining traditional knowledge, individualized care, lifestyle guidance and contemporary medical understanding.

For varicocele, this means helping patients understand:

- clinical versus subclinical disease,
- varicocele grade,
- semen findings,
- testicular volume,
- fertility potential,

- female-partner factors,
- Unani supportive options,
- surgical indications,
- and ART options.

What Makes Saira Health Care's Approach Different?

My objective is not simply:

“Treat the visible vein.”

Nor is it simply:

“Increase sperm count.”

I look at:

- the patient's reproductive goal,
- semen quality,
- sexual health,
- testicular function,
- hormones,
- lifestyle,
- general health,
- and the couple's fertility.

For one patient, the correct treatment may be:

observation.

For another:

Nuskha No. 145 with individualized conservative care.

For another:

broader infertility treatment.

For another:

microsurgical varicocelectomy.

For another:

embolization.

And for another:

IVF/ICSI without unnecessary delay.

That is what individualized treatment means.

Latest Scientific Perspective: 2025–2026

The scientific approach to varicocele has become increasingly selective rather than simply treating every enlarged vein.

WHO 2025 Infertility Guideline

WHO issued its first global infertility guideline on **28 November 2025**.

For infertile men with a **clinical varicocele**, WHO suggests:

- surgical or radiological treatment over observation,

particularly when semen parameters are outside WHO reference ranges.

WHO also suggests:

- microscopic surgery when surgical treatment is chosen.

Current 2026 EAU Guidance

Current EAU guidance emphasizes:

- physical examination as the basis of diagnosis,
- treatment of clinical rather than merely subclinical varicocele,
- semen testing,
- attention to female ovarian reserve,
- fertility-oriented patient selection,
- and microsurgical techniques where appropriate.

2025 Varicocelectomy Outcome Research

A 2025 meta-analysis involving 1,498 men reported that approximately **62.8%** met the included studies' definitions of treatment efficacy, while microsurgical subinguinal repair had comparatively favorable outcomes.

This highlights both:

- the effectiveness of properly selected treatment,
- and the reality that not everybody responds.

2025 Sperm DNA Research

A large 2025 meta-analysis found significant reductions in sperm DNA fragmentation following varicocele repair, with improvement particularly evident several months after treatment.

2025 ART Research

A 2025 systematic review and meta-analysis involving 1,705 men found higher clinical pregnancy rates after varicocelectomy among couples proceeding to assisted reproduction, though much of the evidence remains observational.

2026 Testosterone Research

A March 2026 systematic review and meta-analysis involving 1,225 hypogonadal men found significant improvement in testosterone and erectile-function scores after varicocelectomy.

These findings broaden our understanding of varicocele beyond sperm count alone.

My Final Message to Patients

If an ultrasound report says:

“Varicocele”

please do not immediately assume:

“I need surgery.”

But do not automatically assume:

“It can never affect my fertility.”

Instead ask:

Is it clinical or only visible on ultrasound?

What grade is it?

Is it causing pain?

What is my testicular volume?

What does my semen analysis show?

Is sperm count low?

Is motility reduced?

Is morphology abnormal?

Do I need sperm DNA fragmentation testing?

Is testosterone low?

Are we currently trying for pregnancy?

How is my wife's fertility and ovarian reserve?

Would observation be reasonable?

Would individualized Unani treatment be appropriate?

Would microsurgical repair or embolization give me a better chance?

These are the questions that guide good treatment.

At Saira Health Care, my philosophy is:

Do not operate on an ultrasound report—and do not allow an herbal prescription to delay a necessary operation.

Both mistakes can be avoided through correct diagnosis and individualized care.

Conclusion

Varicocele is an abnormal dilation of the veins of the pampiniform plexus surrounding the testicle.

In Unani terminology, CCRUM recognizes the condition as:

Dawālī al-Safan.

Varicocele is common and does not automatically cause disease.

Many affected men have:

- no pain,
- normal sperm,
- normal testosterone,

- and normal fertility.

However, clinically important varicocele can contribute to:

- scrotal pain,
- impaired testicular growth,
- low sperm concentration,
- reduced motility,
- abnormal morphology,
- increased sperm DNA fragmentation,
- infertility,
- and possibly reduced testosterone in selected men.

The diagnosis is primarily clinical.

Doppler ultrasound is particularly useful when examination is uncertain, when recurrence is suspected, or when other scrotal abnormalities require evaluation.

Current EAU criteria associate clinically significant Doppler findings with approximately:

- venous diameter greater than 3 mm,
- and reflux lasting more than two seconds

in the appropriate examination setting.

Treatment should be individualized.

Men with:

- subclinical varicocele,
- normal semen,
- no symptoms

generally do not require repair.

By contrast, current EAU guidance strongly supports treatment in appropriately selected infertile men with:

- a clinical varicocele,
- abnormal semen parameters,
- otherwise unexplained male-factor infertility,
- and a female partner with good ovarian reserve.

WHO's 2025 infertility guideline similarly suggests surgical or radiological treatment rather than observation in infertile men with a clinical varicocele, particularly when semen parameters are abnormal.

When surgery is selected, WHO suggests:

microscopic surgery

over other surgical approaches when expertise is available.

Varicocelectomy may improve:

- sperm concentration,
- sperm motility,
- morphology,
- sperm DNA fragmentation,
- pregnancy opportunities,
- and testosterone in selected hypogonadal men.

But:

no treatment guarantees normal sperm or pregnancy.

The **Unani system of medicine** can make a useful contribution through:

- individualized Mizaj assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- nutritional improvement,
- lifestyle management,
- fertility support,
- general reproductive-health optimization,
- and supervised traditional pharmacotherapy.

At **Saira Health Care**, **Dr. Qasmi's Nuskha No. 145 – Varico Relief** is used within selected individualized traditional varicocele programmes. Its current pharmacy formulation includes Mazu Sabz, Rasaut Zard, Kateera Safaid, Sange Jarahat and Geru.

However:

Nuskha No. 145 should be regarded as an individualized traditional supportive formulation—not as a scientifically proven universal replacement for varicocelectomy or embolization.

The role of Unani treatment is particularly valuable when it is integrated responsibly with:

- accurate examination,
- semen analysis,
- hormone assessment,
- lifestyle correction,
- fertility counselling,
- and appropriate urological intervention.

My approach at **Saira Health Care** can therefore be summarized as:

Confirm whether the varicocele is clinically significant.

Do not treat an ultrasound finding alone.

Assess pain and testicular size.

Evaluate semen quality when fertility matters.

Evaluate hormones when appropriate.

Consider the female partner's fertility and ovarian reserve.

Correct smoking, obesity, metabolic disease and other reversible factors.

Use Nuskha No. 145 and other Unani measures individually where conservative treatment is appropriate.

Monitor results objectively.

Recommend microsurgical repair or embolization when intervention offers a meaningful advantage.

Do not make guaranteed sperm or pregnancy claims.

And move to assisted reproduction without unnecessary delay when the couple's situation requires it.

For every patient who asks me:

“Doctor, can my varicocele be treated?”

my answer is:

Yes, varicocele can be managed very effectively—but the right treatment depends on what the varicocele is actually doing to your testicle, your sperm, your comfort and your fertility.

The goal is not simply to remove enlarged veins.

The goal is to protect testicular health, preserve fertility, relieve symptoms and choose the least unnecessary—but most effective—treatment for the individual patient.

About the Author

Dr. Nizamuddin Qasmi

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

Professional Education & Training

- **BUMS – Hamdard University, Delhi**
- **MD**
- **CGO**
- **Certificate in Infertility – MGBIMS, Delhi**
- **Certificate in Urology – London, UK**
- **Masters in Male Infertility – MasterHealthPro (HealthPro)**
- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**

Saira Health Care's current public professional profile identifies Dr. Nizamuddin Qasmi's focused clinical work in sexual disorders and infertility and specifically includes **varicocele, azoospermia, oligospermia, asthenospermia, abnormal sperm morphology and other male-fertility conditions** within his clinical area of practice.

Saira Health Care's current educational material additionally lists **Masters in Male Infertility – MasterHealthPro (HealthPro)** within the professional profile used for its sexual- and reproductive-health publications.

His clinical philosophy combines individualized Unani assessment with contemporary knowledge of:

- semen analysis,
- male infertility,
- varicocele,

- testicular function,
- reproductive hormones,
- lifestyle,
- microsurgical treatment,
- and assisted reproduction.

Medical Disclaimer

This article is intended for general medical education and male reproductive-health awareness.

It is not a substitute for:

- individual consultation,
- physical examination,
- semen analysis,
- scrotal Doppler ultrasound,
- hormone testing,
- reproductive-urology consultation,
- or personalized infertility treatment.

A varicocele found only on ultrasound does not automatically require treatment.

Do not independently start or stop:

- prescription medicines,
- hormones,
- fertility supplements,
- Unani medicines,
- Ayurvedic medicines,
- herbal preparations,
- or pain medicines

without appropriate professional guidance.

Dr. Qasmi's Nuskha No. 145 – Varico Relief should not be interpreted as a guaranteed method of permanently eliminating every varicocele, reversing every semen abnormality, avoiding surgery in every patient, or guaranteeing pregnancy.

Where:

- microsurgical varicocelectomy,
- radiological embolization,
- IUI,
- IVF,
- ICSI,
- or another specialist intervention

offers the more appropriate treatment, timely referral should form part of responsible integrative care.

Sudden severe testicular pain is not typical simple varicocele pain and requires urgent medical evaluation to exclude testicular torsion and other acute scrotal emergencies.