Primary Ovarian Insufficiency (POI): Causes, Symptoms, Fertility, Modern Treatment and the Role of Unani Medicine

Premature Ovarian Insufficiency, Early Loss of Ovarian Function and Female Infertility

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Introduction: "Doctor, My AMH Is Very Low—Does That Mean My Ovaries Have Failed?"

One of the most emotionally difficult fertility consultations is when a young woman tells me:

"Doctor, my periods have become irregular and my AMH is very low. Am I reaching menopause?"

Another patient asks:

"My FSH is high. Can medicines bring it down and make my ovaries normal again?"

Another woman says:

"I am only 32 years old. How can my ovaries stop working?"

And one of the most common questions is:

"Can Unani medicine increase my ovarian reserve and help me become pregnant naturally?"

These questions deserve a very careful answer.

The condition commonly called **Primary Ovarian Insufficiency** in North America is now preferably termed:

Premature Ovarian Insufficiency – POI

in the latest international guideline.

POI means that normal ovarian activity becomes impaired:

before the age of 40 years.

The ovaries may:

- release eggs irregularly,
- produce less estrogen,
- produce fewer normally developing follicles,
- temporarily stop functioning and later show some activity again.

That last point is very important.

POI does not always mean complete and permanent ovarian shutdown.

The latest international POI guideline emphasizes that ovarian function can fluctuate in women with non-surgical POI. Some women continue to have occasional periods or ovulation, and spontaneous conception can sometimes occur.

This is why the older expression:

“Premature Ovarian Failure”

is increasingly avoided.

The word “failure” suggests that the ovary is completely and permanently inactive.

That is not accurate for every woman with POI.

What Is Primary or Premature Ovarian Insufficiency?

POI is defined as:

loss or significant impairment of normal ovarian activity before age 40.

The current international guideline recommends diagnosing POI when a woman has:

- spontaneous irregular menstrual cycles or amenorrhea for at least **4 months**, and
- an FSH concentration greater than **25 IU/L**.

If there is diagnostic uncertainty, FSH can be repeated after:

4–6 weeks.

The test does not have to be performed on a particular menstrual-cycle day when POI is suspected.

How Common Is POI?

POI was traditionally said to affect approximately:

1% of women.

However, newer international evidence suggests that the condition may be more common than previously believed.

The 2024 international guideline reports newer pooled data suggesting a prevalence of approximately:

3.5%.

The exact prevalence can vary according to:

- population,
- ethnicity,
- diagnostic criteria,
- availability of testing.

POI Is Not the Same as Menopause

This is one of the most important concepts for patients to understand.

Normal Menopause

During ordinary menopause:

- ovarian follicular activity essentially ceases permanently,
- ovulation stops,
- spontaneous pregnancy is no longer expected.

Natural menopause usually occurs around:

50–51 years of age, although there is individual variation.

POI

With POI:

- ovarian activity may be intermittent,
- FSH can fluctuate,
- periods may disappear and occasionally return,

- spontaneous ovulation can occasionally occur,
- pregnancy may remain possible in a small minority of women.

The international guideline specifically states that women with non-surgical POI should be informed that ovarian activity may occur and that this creates a possibility of natural conception.

POI Is Also Not the Same as Low AMH

This is another extremely common misunderstanding.

A woman comes to me with:

- AMH 0.5,
- AMH 0.2,
- or even lower,

and says:

“Doctor, I have ovarian failure.”

That conclusion may be incorrect.

Low AMH alone does not diagnose POI.

AMH mainly reflects the number of small recruitable follicles contributing to ovarian reserve.

A woman may have:

Diminished Ovarian Reserve – DOR

while still having:

- regular periods,
- ovulation,
- normal estrogen,
- FSH below the POI diagnostic range.

The international POI guideline specifically states:

AMH should not be used as the primary diagnostic test for POI.

It may be useful when:

- FSH results are inconclusive,
- diagnostic uncertainty remains.

Primary Ovarian Insufficiency vs Diminished Ovarian Reserve

Feature	Diminished Ovarian Reserve	Primary/Premature Ovarian Insufficiency
Menstrual cycles	Often still regular	Frequently irregular or absent
Age	Can occur at different reproductive ages	By definition before 40
AMH	Often reduced	Frequently very low, but not diagnostic alone
FSH	May be normal or moderately raised	Typically >25 IU/L with compatible menstrual history
Estrogen deficiency	Usually not marked initially	Often present
Hot flushes/vaginal dryness	Usually absent early	May occur
Natural ovulation	Usually continues	Intermittent or absent
Fertility	Reduced	Substantially reduced

This distinction matters enormously because:

low AMH is not automatically equivalent to POI.

How the Ovary Normally Works

A woman's ovaries have two principal reproductive functions.

They:

1. produce and release oocytes—eggs;
2. produce reproductive hormones such as estrogen and progesterone.

The ovaries contain follicles.

Each follicle contains an immature egg.

During a normal cycle:

1. FSH stimulates follicular growth;
2. one follicle usually becomes dominant;
3. estrogen rises;
4. an LH surge occurs;
5. the mature egg is released;
6. the remaining follicle becomes the corpus luteum;
7. progesterone is produced.

POI disrupts this process.

What Happens in POI?

Two broad biological problems can occur.

Follicle Depletion

There may simply be:

too few remaining functional follicles.

This can result from:

- genetic causes,
- chemotherapy,
- radiation,
- ovarian surgery,
- other factors.

Follicular Dysfunction

Some follicles may remain, but they:

- fail to mature normally,
- respond poorly to FSH,
- do not consistently ovulate.

This explains why ovarian function in some women with POI can:

come and go.

Why Is FSH High in POI?

FSH comes from the pituitary gland.

Normally, developing ovarian follicles produce hormones such as:

- estrogen,
- inhibin.

These hormones signal back to the brain and pituitary.

When ovarian responsiveness falls:

- estrogen/inhibin feedback decreases,
- the pituitary increases FSH production.

So the body is essentially:

trying harder to stimulate an ovary that is responding poorly.

That is why high FSH is a major clue.

Symptoms of Primary Ovarian Insufficiency

The presentation varies considerably.

Some women develop obvious estrogen-deficiency symptoms.

Others have almost no symptoms except:

difficulty getting pregnant.

Irregular Periods

One of the earliest signs may be:

- periods becoming farther apart,
- missed periods,
- several months without menstruation.

The latest guideline recommends considering POI in women younger than 40 who present with:

- amenorrhea,
- irregular menstrual cycles,

- symptoms of estrogen deficiency.

Amenorrhea

Amenorrhea means:

absence of menstruation.

POI should be considered when a woman under 40 develops persistent spontaneous amenorrhea.

But amenorrhea has many other causes, including:

- pregnancy,
- PMOS/PCOS,
- high prolactin,
- thyroid disease,
- hypothalamic amenorrhea,
- uterine adhesions.

Therefore:

amenorrhea does not automatically mean POI.

Hot Flushes

Low estrogen can cause:

- sudden warmth,
- facial flushing,
- sweating.

These symptoms may resemble ordinary menopause.

Night Sweats

Women may experience:

- sweating during sleep,

- repeated waking,
- poor sleep quality.

Vaginal Dryness

Reduced estrogen can make vaginal tissues:

- thinner,
- less lubricated,
- more sensitive.

This may cause:

- burning,
- irritation,
- pain during intercourse.

Low Sexual Desire

POI can affect sexual wellbeing through:

- estrogen deficiency,
- androgen changes,
- vaginal discomfort,
- infertility stress,
- psychological distress.

The international guideline specifically states that POI can significantly affect:

sexual wellbeing and function.

Pain During Intercourse

Vaginal dryness and tissue changes can result in:

dyspareunia

or painful sexual intercourse.

This should be treated rather than simply telling a patient:

“It is because your hormones are low; tolerate it.”

Sleep and Mood Changes

Women may experience:

- insomnia,
- irritability,
- anxiety,
- sadness,
- impaired concentration.

The psychological impact is often intensified because POI may occur:

many years before a woman expected any reproductive decline.

The international guideline recommends psychological-health assessment and access to individualized psychological support.

Infertility

For some women:

infertility is the first major symptom.

They may have been trying for pregnancy and discover:

- very high FSH,
- low AMH,
- few follicles.

Causes of Primary Ovarian Insufficiency

One of the difficult realities of POI is that:

the exact cause is not always found.

The latest guideline explicitly advises physicians to explain that current testing may not identify a cause in every woman.

The important known categories include the following.

1. Genetic and Chromosomal Causes

Genetic factors are among the most important identifiable causes.

These include:

- X-chromosome abnormalities,
- Turner syndrome,
- mosaic Turner syndrome,
- FMR1 premutation,
- other ovarian-development and follicle-function genes.

Turner Syndrome

Turner syndrome occurs when all or part of one X chromosome is absent or altered.

Examples include:

- 45,X,
- mosaic forms.

Ovarian development may be severely affected.

Girls or women may present with:

- primary amenorrhea,
- absent puberty,
- infertility,
- POI.

Pregnancy in Turner syndrome requires particularly careful:

cardiovascular evaluation

because some patients have major pregnancy-related heart risks.

FMR1 Premutation

FMR1 is the gene associated with:

Fragile X syndrome.

Women carrying an FMR1 premutation have an increased risk of:

Fragile-X-associated primary ovarian insufficiency.

The newest international guideline recommends:

FMR1 premutation testing for all women with non-iatrogenic POI.

Chromosome Testing Is Now Recommended Broadly

One significant guideline update is:

chromosomal analysis is recommended for all women with non-iatrogenic POI.

The recommendation is not restricted according to:

- age at diagnosis.

Additional modern genetic sequencing can also be considered where available after proper genetic counselling.

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2. Autoimmune POI

The immune system can sometimes damage ovarian endocrine tissue.

POI may occur alongside autoimmune diseases involving:

- adrenal glands,
- thyroid,
- other organs.

Adrenal Autoimmunity

The current POI guideline recommends testing:

21-hydroxylase antibodies – 21OH-Abs

when the cause of POI is unknown.

If these antibodies are positive:

endocrinology referral is recommended

because autoimmune adrenal insufficiency may be present or develop.

Should Anti-Ovarian Antibodies Be Tested?

No, not routinely.

The latest international guideline specifically recommends:

against using anti-ovarian antibodies to diagnose autoimmune POI.

Thyroid Testing

Thyroid disease may coexist with POI.

Current guidance recommends checking:

TSH at the time of POI diagnosis.

If normal, routine repeat TSH is generally suggested approximately every:

5 years

or earlier if symptoms develop.

Routine TPO-antibody screening specifically to determine the cause of POI is not recommended because positive TPO antibodies are common in the general population.

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3. Chemotherapy

Some chemotherapy medicines can damage ovarian follicles.

The effect depends on:

- medicine,
- dose,
- age,
- treatment duration,
- existing ovarian reserve.

Alkylating chemotherapy is especially gonadotoxic.

This is called:

iatrogenic POI

when ovarian insufficiency results from medical treatment.

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4. Pelvic Radiotherapy

Radiation involving:

- ovaries,
- pelvis,
- total body

can damage ovarian follicles.

Risk varies according to:

- radiation dose,
- age,
- field of treatment.

Fertility Preservation Before Cancer Treatment

This is a crucial point.

Whenever possible, girls or women facing gonadotoxic treatment should be counselled about:

fertility preservation before treatment begins.

Options may include:

- oocyte cryopreservation,
- embryo cryopreservation,
- ovarian-tissue cryopreservation in suitable circumstances.

The 2026 ASRM fertility-preservation guidance reinforces the importance of fertility-preservation services for patients exposed to treatments that may cause POI.

Once established POI occurs and the follicle pool has already been severely depleted:

the opportunity for fertility preservation may have been lost.

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5. Ovarian Surgery

Repeated or extensive ovarian surgery can sometimes reduce the follicle pool.

This is especially relevant in surgery for:

- endometriomas,
- large ovarian lesions,
- bilateral ovarian disease.

The risk depends on:

- type of surgery,
- amount of healthy ovarian tissue removed,
- previous ovarian reserve.

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6. Bilateral Oophorectomy

When both ovaries are surgically removed before age 40:

POI is immediate.

No additional diagnostic testing is required to prove ovarian insufficiency in this circumstance.

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7. Rare Metabolic or Genetic Disorders

Certain rare inherited conditions can affect:

- follicular development,
- ovarian function.

Modern gene testing is expanding the number of identifiable causes.

This is one reason genetic counselling is becoming increasingly important in POI.

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8. Environmental and Lifestyle Factors

Smoking has been associated with:

- earlier reproductive aging,
- ovarian toxicity.

A healthy lifestyle cannot guarantee prevention of genetically determined POI, but smoking avoidance is important for:

- fertility,
- cardiovascular health,
- bone health.

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9. Idiopathic POI

In many women:

no definite explanation is found.

This is called:

idiopathic POI.

It does not mean that the problem is psychological.

It means that:

current medical tests cannot yet identify the biological cause.

How Is Primary Ovarian Insufficiency Diagnosed?

The modern diagnosis is far more specific than simply checking:

AMH.

Step 1: Age

POI is a diagnosis involving ovarian insufficiency:

before age 40.

Women with ovarian decline after 40 are considered within:

- early menopause,
- normal reproductive aging

depending on age and context.

Step 2: Menstrual Pattern

The current guideline requires:

- amenorrhea,

- or irregular menstrual cycles

lasting at least:

4 months.

Step 3: Pregnancy Test

Pregnancy must be excluded when a reproductive-age woman:

- misses her period,
- develops amenorrhea.

This should happen before assuming POI.

Step 4: FSH

An FSH concentration greater than:

25 IU/L

with the appropriate menstrual history supports the diagnosis.

Does FSH Need to Be Repeated?

If the diagnosis is:

clear

one diagnostic result may be adequate within the newer guideline framework.

If there is uncertainty:

repeat FSH after 4–6 weeks.

This is a change from older criteria that routinely required two abnormal tests.

Step 5: Estradiol

Low estradiol may provide additional evidence of:

estrogen deficiency.

But estradiol alone should not be used to diagnose POI.

The guideline explicitly states that:

estradiol is supportive rather than the primary diagnostic test.

Step 6: AMH

AMH may be:

- very low,
- sometimes undetectable.

But again:

AMH does not diagnose POI by itself.

The international guideline advises using AMH mainly when:

- FSH is inconclusive,
- diagnostic uncertainty remains.

Step 7: TSH and Other Amenorrhea Tests

TSH should be checked.

Depending on the clinical presentation, other tests may include:

- prolactin,
- additional endocrine investigations.

This helps distinguish POI from other causes of amenorrhea.

Step 8: Genetic Testing

For non-iatrogenic POI:

chromosomal analysis

and:

FMR1 premutation testing

are recommended.

Additional genetic testing may be considered where available.

Step 9: Autoimmune Testing

When the cause is unknown:

21-hydroxylase antibody testing

is recommended.

Positive patients require assessment for:

- adrenal dysfunction.

Step 10: Pelvic Ultrasound

Ultrasound may assess:

- ovaries,
- antral follicles,
- uterus,
- other pelvic pathology.

But ultrasound cannot replace:

FSH-based diagnostic criteria.

A woman may have very few visible follicles, but that finding alone is not enough to diagnose POI.

Why POI Is More Than an Infertility Diagnosis

This is perhaps the most important message of the entire article.

POI is not simply:

“low egg count.”

Loss of ovarian estrogen years before the usual menopause can affect:

- bones,
- heart,
- brain,

- sexual health,
- vaginal health,
- psychological wellbeing.

The international guideline states that POI affects:

fertility, bone health, cardiovascular health, neurological function, sexuality and quality of life.

Bone Health and POI

Estrogen plays an important role in maintaining:

bone mineral density.

Women with POI have increased risk of:

- low bone density,
- osteoporosis,
- later fracture.

DXA Bone Density Scan

The current guideline recommends:

DXA bone-density testing at diagnosis

for all women with POI where available.

If bone density is normal and the woman receives appropriate hormone replacement:

- repeat DXA within five years may add little.

If bone density is reduced:

- monitoring every one to three years may be appropriate depending on risk.

Cardiovascular Health

Early estrogen deficiency is associated with increased long-term cardiovascular risk.

Women with POI should be informed about the increased risk of:

- coronary disease,
- heart failure,
- stroke.

Current guidance recommends:

- blood pressure,
- weight,
- smoking status

at least annually.

A:

- lipid profile,
- diabetes screening

should be obtained at diagnosis.

Psychological Health

Receiving a POI diagnosis at age:

- 22,
- 28,
- 34

can be emotionally devastating.

Women may grieve:

- fertility,
- menstrual normality,
- expectations about family building,
- their sense of femininity.

The international guideline specifically recommends:

psychological-health assessment and access to support.

This should not be considered optional or unimportant.

Sexual Health

Sexual difficulties may involve:

- low desire,
- vaginal dryness,
- painful intercourse,
- reduced arousal,
- fertility-related anxiety.

The guideline encourages doctors to discuss:

sexual wellbeing sensitively rather than waiting for the patient to raise the subject.

This is particularly relevant to my focused practice in:

Sexual Disorders & Infertility.

Modern Treatment of Primary Ovarian Insufficiency

There are two separate treatment goals.

Goal 1

Protect the woman's:

- hormonal,
- bone,
- cardiovascular,
- sexual,
- neurological health.

Goal 2

Address:

fertility and family-building goals.

These should not be confused.

Hormone Therapy – One of the Most Important Treatments

The latest international guideline strongly recommends:

hormone therapy until the usual age of natural menopause

for women with POI unless there is a contraindication.

Importantly:

hormone therapy is recommended even if a woman does not have hot flushes.

The goal is not only symptom relief.

It is also to reduce long-term morbidity associated with early estrogen deficiency.

Hormone Replacement Is Different in a 28-Year-Old With POI Than in a 55-Year-Old After Menopause

This distinction is important when patients are frightened by discussions about “HRT risk.”

For a young woman with POI, hormone treatment is often:

replacement of hormones that would normally still be present at her age.

The clinical situation is different from initiating postmenopausal hormone therapy decades later.

The international guideline reports no evidence that appropriately used hormone therapy in POI increases breast-cancer risk above that of women of the same age without POI.

Estrogen Therapy

Estrogen treatment may help:

- hot flushes,
- sleep,
- vaginal symptoms,
- bone protection,
- cardiovascular health.

It can be given in different forms including:

- transdermal patches,
- oral therapy.

The exact regimen should be individualized.

Women With a Uterus Also Need Progestogen

If a woman has an intact uterus and receives systemic estrogen:

a progestogen must generally be added

to protect the endometrium from:

- hyperplasia,
- cancer.

Women should never self-prescribe estrogen without understanding this principle.

Hormone Therapy Does Not Prevent Pregnancy

This is a particularly important difference from:

the contraceptive pill.

The POI guideline emphasizes that:

HRT is not reliable contraception.

If a woman with POI does not wish to become pregnant:

- contraception may still be required.

Can HRT Stop Natural Ovulation?

Appropriate HRT does not need to be stopped simply because a woman wishes to conceive naturally.

The latest guideline specifically states that in women with intermittent ovarian activity:

HRT does not reduce the chance of natural conception.

A sequential regimen may be used when natural pregnancy is desired.

Vaginal Estrogen

For persistent:

- vaginal dryness,
- painful intercourse,
- genitourinary symptoms,

vaginal estrogen may be used.

The guideline also supports:

- lubricants,
- moisturizers

for vaginal discomfort and dyspareunia.

Testosterone for Low Sexual Desire

In selected women with significant:

hypoactive sexual desire disorder

transdermal testosterone at physiological female dosing may be considered where available.

It is not:

- a fertility treatment,
- an ovarian-rejuvenation medicine,
- routine for every POI patient.

Bone Protection

Women with POI should focus on:

- adequate estrogen replacement,
- weight-bearing exercise,
- resistance exercise,
- adequate protein,

- sufficient calcium,
- sufficient vitamin D,
- smoking avoidance.

Calcium or vitamin D supplements are particularly appropriate when:

- dietary intake is inadequate,
- vitamin D is low,
- bone density is reduced.

Can POI Be Cured?

This question requires a careful answer.

At present:

there is no treatment proven to reliably restore normal ovarian activity in established POI.

The international guideline states clearly:

no intervention has been reliably shown to increase ovarian activity and natural conception rates.

This applies to claims involving:

- hormones,
- supplements,
- herbs,
- PRP,
- stem cells,
- “ovarian rejuvenation.”

Does That Mean Natural Pregnancy Is Impossible?

No.

This is the important difference between POI and permanent menopause.

Women with non-surgical POI can sometimes experience:

- follicular growth,
- ovulation,
- spontaneous pregnancy.

A clinical review has estimated spontaneous pregnancy after POI diagnosis in approximately:

5% of women

although individual probability varies and no woman should be given a guaranteed number.

Why Can Pregnancy Occasionally Occur?

Because POI may involve:

intermittent rather than completely absent ovarian function.

A follicle may occasionally respond:

- months after amenorrhea,
- even after repeatedly high FSH.

This unpredictability is precisely why:

- HRT is not contraception.

Can Medicines Lower FSH and Restore Fertility?

This is another common misunderstanding.

A treatment may temporarily lower:

FSH

without actually increasing the number of remaining follicles.

Lowering the laboratory number is not the same as:

creating eggs.

The meaningful fertility outcome is:

- ovulation,
- viable oocyte,
- pregnancy,

- ultimately live birth.

IVF With a Woman's Own Eggs

IVF cannot create follicles that are not present.

If a woman with POI still has intermittent:

- follicular activity,
- measurable follicles,

attempts with her own eggs may occasionally be possible.

But ovarian stimulation frequently produces:

few or no eggs.

Repeated high-dose stimulation should not be advertised as a guaranteed way to overcome established POI.

Donor-Egg IVF

The latest international guideline identifies:

oocyte donation

as an established fertility option for women with POI.

In donor-oocyte IVF:

1. an egg comes from a donor;
2. the egg is fertilized with sperm;
3. the embryo is transferred into the patient's uterus.

The woman can therefore:

- carry the pregnancy,
- give birth,

even when her own ovaries do not provide usable eggs.

Donor-Egg Pregnancy Requires Proper Medical Assessment

Some causes of POI also affect:

- cardiovascular health,
- pregnancy risk.

This is especially important in:

- Turner syndrome,
- women exposed to cardiac radiation,
- some cancer survivors.

The guideline recommends proper:

- cardiac,
- thyroid,
- metabolic

assessment before pregnancy.

Experimental "Ovarian Rejuvenation"

Women with low AMH or POI are frequently offered procedures marketed as:

ovarian rejuvenation.

These may include:

- platelet-rich plasma – PRP,
- stem-cell injections,
- in-vitro activation – IVA.

The latest international POI guideline reviewed these approaches.

Most available studies:

- lack adequate controls,
- involve small numbers,
- mix POI with diminished ovarian reserve,
- do not provide sufficiently reliable evidence.

Therefore:

PRP, stem-cell ovarian injections and IVA should still be regarded as experimental rather than established POI treatment.

The Unani Understanding of Amenorrhea and Ovarian Dysfunction

Classical Unani medicine predates:

- FSH testing,
- AMH,
- ovarian ultrasound,
- modern genetic diagnosis.

Therefore, there is no exact classical laboratory equivalent of:

FSH >25 IU/L POI.

However, Unani literature contains detailed descriptions of:

- amenorrhea,
- menstrual suppression,
- infertility,
- reproductive weakness.

The main traditional term for amenorrhea is:

Ihtibas al-Tamth

or:

Ihtibas-e-Tams.

A 2024 Unani review specifically recognizes POI among the modern ovarian causes that may present with amenorrhea.

Ihtibas al-Tamth

Traditional Unani literature describes Ihtibas al-Tamth as:

- absence of menstrual bleeding,
- or marked reduction in menstrual flow.

The 2024 review discusses classical mechanisms involving:

- Quwwat Dafia,

- Madda,
- Johar Khun-i-Hayd,
- uterine/reproductive pathways,
- Su-e-Mizaj.

These are:

traditional physiological concepts.

They should not be presented as scientifically identical to:

- low AMH,
- elevated FSH,
- ovarian follicular depletion.

Mizaj

Mizaj means:

temperament or constitutional balance

in the Unani system.

Traditional qualities include:

- Hararat – heat,
- Barudat – cold,
- Rutubat – moisture,
- Yubusat – dryness.

A Unani physician may assess how these patterns relate to:

- menstrual health,
- digestion,
- energy,
- sleep,
- general health.

Akhlat

Classical Unani medicine describes four humors:

- Dam,
- Balgham,
- Safra,
- Sauda.

These belong to:

the traditional theoretical system.

They should not be equated directly with:

- FSH,
- LH,
- estrogen,
- AMH.

POI Is Not Simply "Cold Uterus"

This is an important scientific correction.

A woman with:

- Turner syndrome,
- FMR1-associated POI,
- chemotherapy-induced follicular depletion

does not have POI merely because her uterus is:

"cold."

The primary modern pathology is:

ovarian insufficiency.

Traditional Mizaj assessment may still be used as a complementary framework, but it must not replace:

- genetic evaluation,
- FSH testing,

- endocrine assessment.

Asbab-e-Sitta Zarooriyah – Six Essential Factors

A 2026 Unani-biomedical review on anovulatory infertility discusses:

Asbab-e-Sitta Zarooriyah

or the six essential determinants of health, including:

- air/environment,
- food and drink,
- physical movement and rest,
- sleep and wakefulness,
- retention and evacuation,
- psychological activity and repose.

The review includes POI among modern causes of hypergonadotropic hypoestrogenic anovulation and argues that traditional lifestyle principles can offer a useful preventive/supportive framework.

This is one of the areas where Unani medicine can be genuinely useful:

whole-person health support.

Main Unani Treatment Approaches

The Unani system broadly includes:

Ilaj-bil-Ghiza

Dietotherapy.

Ilaj-bit-Tadbir

Regimenal therapy.

Ilaj-bid-Dawa

Pharmacotherapy.

Ilaj-bil-Yad

Surgical/manual therapy when appropriate.

In POI, the first three may support:

- symptoms,
- nutrition,
- metabolic wellbeing,
- sexual health,
- general health.

But they should not be presented as proven methods to:

regenerate depleted follicles.

Ilaj-bil-Ghiza – Dietotherapy

Diet should support:

- bone health,
- cardiovascular health,
- muscle health,
- general reproductive health.

A practical diet can emphasize:

- adequate protein,
- vegetables,
- fruit,
- pulses,
- nuts,
- seeds,
- suitable whole grains,
- healthy fats,
- calcium-rich foods.

Can Any Food Increase AMH?

There is no food proven to:

create a new ovarian reserve.

A nutrient-rich diet is important for:

- overall health,
- pregnancy preparation,
- bone protection.

But food should not be advertised as:

“egg-regenerating treatment.”

Calcium and Vitamin D

Women with POI are at increased risk of:

- low bone density.

Adequate:

- calcium,
- vitamin D

are important.

Supplements should be considered when:

- dietary calcium is inadequate,
- vitamin D deficiency is documented,
- bone density is reduced.

Ilaj-bit-Tadbir – Regimenal Therapy

A supportive regimen may include:

- regular physical activity,
- weight-bearing exercise,
- resistance exercise,
- appropriate sleep,
- stress management,
- smoking cessation.

These interventions have genuine relevance because POI affects:

- cardiovascular,
- skeletal,
- psychological health.

Is Hijama Proven to Restore Ovarian Function in POI?

No.

Hijama has a traditional place within Unani regimenal therapy.

But:

high-quality evidence does not show that Hijama regenerates ovarian follicles, normalizes ovarian reserve, or reliably restores fertility in established POI.

The 2024 Unani amenorrhea review lists Hijama among traditional regimenal approaches to amenorrhea generally, but this is not equivalent to a controlled POI fertility trial.

Therefore Hijama should not replace:

- hormone therapy,
- genetic testing,
- fertility counselling.

Fasd and Other Traditional Regimens

The same Unani review discusses traditional procedures such as:

- Fasd,
- Hammam,
- Hijama

for amenorrhea.

These treatments belong to the broader historical management of:

amenorrhea

rather than proven POI-specific ovarian-recovery therapy.

Unani Pharmacotherapy

The 2024 amenorrhea review lists traditional medicines such as:

- Habb-i-Mudir,
- Safoof-i-Baboona,
- Kushta Faulad,
- Safoof Muhazzil

for selected amenorrhea presentations.

However:

amenorrhea is a symptom—not a single disease.

A medicine used traditionally to stimulate menstruation in one condition should not automatically be given to a woman whose amenorrhea results from:

severe follicular depletion.

Bringing Bleeding Back Is Not the Same as Restoring Ovarian Reserve

This distinction is particularly important in POI.

A woman may experience bleeding after:

- estrogen,
- progesterone,
- traditional emmenagogue treatment.

That does not prove that:

- AMH increased meaningfully,
- ovarian reserve returned,
- ovulation occurred.

A withdrawal bleed simply proves that:

the endometrium responded to hormonal stimulation.

Kushta and Mineral Formulations

Herbomineral formulations require:

- careful sourcing,
- manufacturing quality,

- correct dosage,
- professional supervision.

I strongly discourage women with POI from buying unidentified:

- Kushta,
- powders,
- fertility mixtures

online and taking them for months simply to:

“increase AMH.”

The risks of:

- contamination,
- excessive metals,
- interactions

must be considered.

What Does Modern Research Say About Complementary Therapies in POI?

The latest international POI guideline specifically reviews complementary approaches.

It concludes that:

complementary therapies should not replace hormone therapy

because evidence is insufficient to show that they prevent the important long-term consequences of estrogen deficiency.

This does not mean traditional medicine has:

no role.

It means its role should be described accurately.

Where Unani Medicine May Be Most Useful in POI

In my view, responsible Unani care may contribute to:

- individualized nutrition,
- general constitutional wellbeing,

- sleep,
- stress,
- physical activity,
- sexual-health support,
- vaginal/sexual symptom counselling,
- metabolic risk management,
- patient education.

These are meaningful aspects of care.

But:

they should be integrated with rather than substituted for hormone replacement and modern POI evaluation.

Is There Direct Clinical Evidence That Unani Medicine Restores POI Fertility?

At present:

high-quality POI-specific Unani fertility trials are lacking.

There are published Unani studies on:

- amenorrhea,
- menstrual disorders,
- anovulation,
- constitutional/Mizaj assessment.

For example, a 2021 NIUM-associated study evaluated:

- general body temperament,
- uterine temperament

in women with amenorrhea.

A 2024 review discusses Unani treatment of:

Ihtibas al-Tamth

and recognizes primary ovarian insufficiency as one possible modern cause.

But these publications do not prove that an Unani formulation:

- restores the follicle pool,
- increases natural conception,
- increases live birth

in women meeting modern POI criteria.

Latest Complementary-Medicine Research: An Important Perspective

Complementary medicine research in POI is continuing internationally.

A new systematic review published in 2026 of Chinese herbal medicine found:

- uncertain effects on menstrual return,
- possible changes in FSH and AMH,

but very high study heterogeneity and substantial uncertainty.

Importantly, the authors emphasized that:

- hormone changes are surrogate markers,
- safety reporting was incomplete,
- superiority could not be established confidently.

This was:

Chinese medicine, not Unani medicine,

so its results cannot simply be transferred to Unani treatment.

It does, however, demonstrate an important scientific principle:

changing FSH or AMH is not enough—fertility treatment ultimately needs pregnancy and live-birth evidence.

Dr. Nizamuddin Qasmi's Special Approach to POI at Saira Health Care

When a woman comes to me saying:

“Doctor, my AMH is low. Please increase my eggs,”

I do not begin by giving a fertility powder.

My first task is:

determine whether she actually has POI.

Step 1: Confirm Age and Menstrual History

I ask:

- How old are you?
- Were periods previously regular?
- When did they become irregular?
- How many months have you been without menstruation?

Step 2: Do Not Diagnose POI From AMH Alone

I review:

- FSH,
- menstrual history,
- clinical symptoms.

AMH is interpreted as:

supporting information

rather than the sole diagnosis.

Step 3: Exclude Other Causes of Amenorrhea

I consider:

- pregnancy,
- PMOS,
- thyroid disease,
- hyperprolactinemia,
- hypothalamic amenorrhea,
- uterine problems.

Step 4: Confirm FSH Properly

If cycles have been disturbed for at least four months and FSH is:

>25 IU/L

POI becomes strongly supported.

If the picture is uncertain:

- repeat FSH in 4–6 weeks.

Step 5: Investigate the Cause

For unexplained non-iatrogenic POI, I encourage appropriate specialist assessment for:

- chromosomal analysis,
- FMR1 testing,
- 21-hydroxylase antibodies,
- thyroid function.

This is consistent with current international guidelines.

Step 6: Assess Bone Health

POI is not simply a fertility disorder.

I consider:

- DXA scan,
- calcium,
- vitamin D,
- exercise,
- fracture risk.

Step 7: Assess Cardiometabolic Health

I review:

- blood pressure,
- body weight,
- smoking,
- lipid profile,

- diabetes risk.

Current guidance recommends lipid and diabetes screening at diagnosis and annual review of key cardiovascular risk factors.

Step 8: Discuss Hormone Therapy

A woman with established POI should not be told:

"You are young; you do not need estrogen until you get hot flushes."

Current guidance recommends:

hormone replacement until the usual age of menopause

when medically appropriate, even if symptoms are mild.

Step 9: Assess Fertility Goals Immediately

I ask:

"Do you want pregnancy now, later, or not at all?"

That answer changes treatment priorities.

Step 10: Protect Reproductive Time

I do not advise a woman with genuine POI to spend:

- one year,
- two years

taking different medicines simply waiting for:

AMH to become normal.

There is no reliable evidence that such a strategy restores ovarian reserve.

Step 11: Look for Intermittent Ovarian Activity

Some patients with non-surgical POI may occasionally:

- develop follicles,
- ovulate.

If natural pregnancy is desired:

- reproductive monitoring may be discussed.

But I explain clearly that ovarian activity is:

unpredictable.

Step 12: Discuss Assisted Reproductive Options Honestly

Depending on:

- residual follicles,
- age,
- previous fertility preservation,

options can be discussed with a reproductive-medicine specialist.

For established POI:

donor-oocyte IVF is an evidence-based established option.

Step 13: Use Unani Assessment as an Additional Framework

I may assess:

- Mizaj,
- nutrition,
- digestion,
- sleep,
- physical activity,
- sexual wellbeing,
- general constitution.

This does not replace:

- FSH,
- genetics,
- endocrine evaluation.

Step 14: Ilaj-bil-Ghiza

My aim is to support:

- bone health,
- cardiovascular health,
- adequate nutrition,
- overall fertility preparedness.

I do not promise that diet will:

create new follicles.

Step 15: Ilaj-bit-Tadbir

I focus on:

- sustainable exercise,
- weight-bearing movement,
- sleep,
- smoking cessation,
- stress management.

Selected traditional regimenal care may be considered when safe.

Step 16: Ilaj-bid-Dawa

Traditional Unani pharmacotherapy may be individualized for:

- constitutional symptoms,
- associated menstrual concerns,
- general health.

But any claim of:

restoring ovarian reserve

should be objectively demonstrated before being made.

Step 17: Measure Meaningful Outcomes

I do not judge treatment success merely by:

- a lower FSH value,
- one episode of bleeding.

More meaningful outcomes include:

- symptom control,
- bone protection,
- improved quality of life,
- documented follicular activity when present,
- ovulation,
- pregnancy,
- live birth.

Step 18: Discuss Sexual Health

A woman with POI may have:

- vaginal dryness,
- pain,
- low libido,
- fear about intimacy.

These are real medical concerns.

My focused clinical work in:

Sexual Disorders & Infertility

is relevant because reproductive care should include:

the patient's sexual quality of life—not only her AMH report.

Step 19: Include the Male Partner in Fertility Planning

If pregnancy is desired, semen analysis remains important.

A woman with intermittent ovarian activity may have only limited opportunities for conception.

If her husband simultaneously has:

- severe low sperm count,
- poor motility,
- azoospermia,

those opportunities may be lost unless the male problem is identified early.

Step 20: Offer Psychological Support

Patients often hear:

“Your eggs are finished.”

This language can be devastating and may also be medically inaccurate.

I prefer explaining:

“Your ovarian activity is significantly reduced, but POI can fluctuate. We need to protect your long-term health while making a realistic fertility plan.”

This is both:

- more compassionate,
- more scientifically accurate.

Saira Health Care's Contribution to Female Infertility Care

Saira Health Care publicly lists female reproductive-health problems including:

- low AMH,
- irregular menstruation,
- PMOS/PCOS,
- unexplained infertility,
- thyroid-related infertility

within its fertility services.

The Saira Health Care physician profile also describes work involving:

- decreased AMH,
- hormonal imbalance,

- irregular menses,
- male and female infertility.

The clinic describes its broader model as:

- patient-centered,
- individualized,
- combining traditional knowledge,
- lifestyle guidance,
- contemporary medical understanding.

For POI, I believe this model is especially valuable when it is applied responsibly:

traditional supportive care plus modern diagnosis—not traditional treatment instead of diagnosis.

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**

Saira Health Care's public physician profile identifies Dr. Nizamuddin Qasmi's focused work in sexual disorders and infertility and lists BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK.

Saira Health Care's current published professional byline additionally includes:

- Masters in Male Infertility – MasterHealthPro,

- Integrated Sexual and Reproductive Health – ISRH, UNFPA.

Why Male Infertility Training Matters in POI

It may initially sound strange to mention:

male infertility

in an article about ovarian insufficiency.

But fertility belongs to:

the couple.

A woman with POI may ovulate:

- rarely.

When an ovulation does occur:

that opportunity is valuable.

If severe male infertility has not been diagnosed, the couple may lose that opportunity.

Therefore I believe in:

parallel male and female fertility assessment.

POI and Pregnancy: What Should Patients Know?

A woman diagnosed with POI should not be told:

“pregnancy is impossible.”

Natural conception may occur in non-surgical POI because ovarian activity can sometimes return temporarily.

But the chances are:

substantially lower than normal.

Therefore both:

- hope,
- realism

are necessary.

If Natural Pregnancy Occurs After POI, Is It Automatically High Risk?

For idiopathic POI and many chemotherapy-related forms, the international guideline states that spontaneous pregnancies do not appear to have worse obstetric or neonatal outcomes simply because the woman has POI.

However:

- the underlying cause

may itself affect pregnancy risk.

For example:

- Turner syndrome,
- uterine radiation,
- cardiotoxic cancer treatment

require specialized pregnancy planning.

POI and Contraception

Some women think:

“I have POI, so pregnancy cannot happen.”

That is not always true.

If pregnancy is not desired:

contraception may still be necessary

in non-surgical POI.

And again:

ordinary HRT is not contraception.

Common Myths About Primary Ovarian Insufficiency

Myth 1: POI means the ovaries are permanently dead.

Fact: Ovarian activity can fluctuate in non-surgical POI.

Myth 2: POI is exactly the same as menopause.

Fact: POI may involve intermittent ovarian activity and occasional natural conception.

Myth 3: Low AMH alone diagnoses POI.

Fact: AMH is not recommended as the primary diagnostic test.

Myth 4: Anyone with AMH below 1 has ovarian failure.

Fact: Diminished ovarian reserve and POI are different conditions.

Myth 5: FSH must be tested on cycle day 2 or 3 to diagnose POI.

Fact: Current POI guidance does not require FSH to be timed to a specific cycle day.

Myth 6: Two abnormal FSH tests are mandatory for every patient.

Fact: Repeat testing after 4–6 weeks is advised mainly when diagnostic uncertainty remains.

Myth 7: If periods return after treatment, ovarian reserve has been restored.

Fact: Bleeding can occur without normal ovarian reserve or ovulation.

Myth 8: Lowering FSH means new eggs were created.

Fact: FSH is a hormone signal. A change in FSH does not prove new follicles were generated.

Myth 9: HRT is only for hot flushes.

Fact: Hormone therapy is also recommended for long-term health protection in POI.

Myth 10: Young women do not need HRT.

Fact: Estrogen deficiency at a young age can affect bone and cardiovascular health.

Myth 11: HRT prevents natural pregnancy.

Fact: Appropriate HRT does not eliminate the chance of intermittent natural conception.

Myth 12: HRT works as contraception.

Fact: It does not.

Myth 13: POI only affects fertility.

Fact: It also affects bone, cardiovascular, psychological, sexual and neurological health.

Myth 14: Every POI patient needs only AMH and ultrasound.

Fact: Modern evaluation may include genetic and autoimmune investigations.

Myth 15: FMR1 testing is only needed when there is a family history.

Fact: Current guidance recommends FMR1 premutation testing for all women with non-iatrogenic POI.

Myth 16: PRP ovarian rejuvenation is proven.

Fact: Current studies remain inadequate to establish it as standard POI treatment.

Myth 17: Stem cells can already regenerate ovaries in routine clinical practice.

Fact: Stem-cell ovarian treatment remains experimental.

Myth 18: Unani medicine has no role in POI.

Fact: Unani care can offer meaningful supportive management through diet, lifestyle, constitutional assessment, sexual-health and general wellbeing.

Myth 19: Unani medicine has been proven to create new ovarian follicles.

Fact: No high-quality evidence currently demonstrates this.

Myth 20: An Unani medicine that brings back bleeding has cured POI.

Fact: Menstrual bleeding alone does not prove restored ovarian function or fertility.

SAIRA HEALTH CARE
An ISO Certified Clinic
SEXUAL DISORDERS & INFERTILITY CENTER

Frequently Asked Questions

What is primary ovarian insufficiency?

POI means impaired ovarian function:

before age 40.

Is premature ovarian insufficiency the same thing?

Yes.

Current international guidance prefers the name:

Premature Ovarian Insufficiency

while “Primary Ovarian Insufficiency” remains commonly used, especially in North America.

Why is “ovarian failure” no longer preferred?

Because ovarian activity can:

- fluctuate,
- occasionally return.

“Failure” implies permanent complete inactivity.

What are the current diagnostic criteria?

Generally:

- irregular or absent spontaneous periods for at least 4 months,
- FSH greater than 25 IU/L.

Does FSH need repeating?

Only when:

diagnostic uncertainty remains.

Then repeat after approximately:

4–6 weeks.

Can AMH diagnose POI?

No.

AMH is supportive but:

not the primary diagnostic test.

My AMH is 0.3. Do I definitely have POI?

No.

You need:

- age,
- menstrual history,
- FSH,
- clinical context

to determine whether POI is present.

Can POI occur with regular periods?

Early or fluctuating ovarian insufficiency can occasionally present less clearly, but established POI typically involves:

- irregular,
- absent cycles.

Can I naturally become pregnant with POI?

Yes, occasionally.

Ovarian activity can occur in non-surgical POI.

Is there a medicine that guarantees ovulation in POI?

No.

The international guideline states that no treatment has been reliably shown to increase ovarian activity or natural-conception rates.

Can IVF work with my own eggs?

Sometimes if:

- follicles remain,
- oocytes can be obtained.

But response can be very poor.

IVF cannot:

manufacture new eggs.

What is the established fertility option when my own eggs are unavailable?

Donor-oocyte IVF

is an established option.

Can PRP increase AMH?

Some uncontrolled studies report changes in:

- AMH,
- AFC,
- ovarian response.

But PRP remains:

experimental

and has not been established as a reliable fertility treatment for POI.

Can stem cells cure POI?

Not currently.

Stem-cell ovarian treatment remains investigational.

Why do I need genetic testing?

Some POI is related to:

- chromosome abnormalities,

- FMR1,
- other genetic causes.

Finding a cause may affect:

- family counselling,
- fertility planning,
- other health risks.

What genetic tests are recommended?

For non-iatrogenic POI:

- chromosomal analysis,
- FMR1 premutation testing

are recommended.

What autoimmune test is important?

When the cause is unknown:

21-hydroxylase antibodies

should be assessed.

Do I need thyroid tests?

Yes, TSH should be assessed at POI diagnosis.

Why do I need a bone-density test?

Early estrogen deficiency increases risk of:

- low bone density,
- osteoporosis.

DXA at diagnosis is recommended where available.

Do I need hormone therapy even if I have no hot flushes?

Usually yes, if there is no contraindication.

Hormone therapy is recommended until the usual menopause age for:

- long-term health protection.

What if I still want natural pregnancy?

HRT can generally still be used.

It does not eliminate the possibility of spontaneous ovarian activity.

Can Unani medicine increase my AMH?

There is insufficient high-quality evidence that Unani treatment can reliably:

- restore depleted ovarian reserve,
- normalize AMH,
- create new follicles.

Then what role can Unani medicine have?

It may support:

- nutrition,
- sleep,
- physical activity,
- stress,
- sexual wellbeing,
- general reproductive health,
- traditional constitutional care.

What is Ihtibas al-Tamth?

It is a traditional Unani term referring broadly to:

amenorrhea or suppression of menstruation.

Is Ihtibas al-Tamth the same as POI?

No.

POI is only:

one possible cause of amenorrhea.

Other causes include:

- pregnancy,
- PMOS,
- hypothalamic dysfunction,
- prolactin,
- thyroid disease,
- uterine disease.

Can Hijama restore ovarian reserve?

There is no good evidence showing that Hijama regenerates ovarian follicles in established POI.

Can traditional menstrual medicines bring back my fertility?

They may sometimes alter:

- bleeding patterns,

but:

bleeding is not the same as ovulation or restored ovarian reserve.

Latest Scientific Perspective: 2024–2026

The most important current development is the:

International Evidence-Based Guideline on Premature Ovarian Insufficiency

developed through collaboration involving:

- ESHRE,
- ASRM,

- CRE-WHiRL,
- International Menopause Society.

It contains:

145 recommendations

covering diagnosis, fertility, genetics, bone health, cardiovascular health, sexuality, neurological health, psychological wellbeing and treatment.

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1. Diagnosis Is Simpler Than Older Guidelines

The current criteria are:

- disrupted cycles ≥4 months,
- FSH >25 IU/L.

Repeat FSH is mainly required when uncertainty remains.

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2. AMH Has Been De-Emphasized for Diagnosis

AMH should:

not

be the main POI diagnostic test.

It may help in uncertain cases.

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3. Genetic Investigation Has Expanded

Current guidance recommends:

- chromosome analysis,
- FMR1 testing

for all non-iatrogenic POI patients.

Additional gene-panel testing can be considered after counselling.

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4. Adrenal Autoimmunity Matters

Women with unexplained POI should be screened for:

21-hydroxylase antibodies.

---

5. Hormone Therapy Is About Long-Term Health

HT should generally continue until the normal menopause age:

even when menopausal symptoms are absent.

---

6. Fertility Claims Have Become More Cautious

The guideline makes perhaps the clearest fertility statement available:

No intervention has been reliably shown to increase ovarian activity and natural conception rates in POI.

This means that claims involving:

- supplements,
- herbs,
- PRP,
- stem cells,
- special diets

should be interpreted very carefully.

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7. Donor Oocytes Remain an Established Fertility Treatment

Where pregnancy is medically safe:

oocyte donation

is an established option.

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8. PRP and Stem Cells Remain Experimental

Research is ongoing, but currently available studies are not strong enough to establish routine use.

---

9. Fertility Preservation Is Moving Earlier

The newest 2026 ASRM fertility-preservation guidance emphasizes counseling and preservation:

before gonadotoxic medical treatment whenever possible.

Prevention is sometimes much more effective than attempting to restore ovarian function afterward.

My Final Message to Women Diagnosed With POI

If a doctor tells you:

“Your ovarian reserve is finished,”

do not panic before understanding exactly what the tests show.

Ask:

Am I truly diagnosed with POI or do I only have low AMH?

Have my cycles been irregular for at least four months?

What is my FSH?

Does FSH need repeating?

What is my estradiol?

Was pregnancy excluded?

Was thyroid disease excluded?

Should I have chromosome testing?

Should I be tested for an FMR1 premutation?

Do I need 21-hydroxylase antibody testing?

Should I have a DXA scan?

Do I need hormone replacement even if I do not have hot flushes?

What is my natural pregnancy possibility?

Do I have any remaining follicles?

Would IVF with my own eggs be realistic—or would donor oocytes offer a better chance?

Am I being offered an experimental PRP or stem-cell procedure as if it were proven?

Can Unani diet, lifestyle and supportive treatment improve my overall health without delaying necessary fertility treatment?

These questions turn:

fear into informed decision-making.

Conclusion

Primary or Premature Ovarian Insufficiency is an important reproductive and endocrine condition in which ovarian function becomes impaired:

before the age of 40.

The current international diagnostic criteria are:

- irregular or absent spontaneous menstruation for at least 4 months,
- FSH greater than 25 IU/L.

Repeat FSH after 4–6 weeks is recommended when the diagnosis remains uncertain.

POI should not be confused with:

low AMH or diminished ovarian reserve.

AMH is not recommended as the primary diagnostic test.

Important causes include:

- genetic/chromosomal abnormalities,
- FMR1 premutation,
- autoimmune disease,
- chemotherapy,
- radiotherapy,
- ovarian surgery,
- bilateral oophorectomy.

In many women, however:

the exact cause remains unknown.

Current guidelines recommend extensive cause-directed evaluation including:

- chromosomal analysis,
- FMR1 testing,
- 21-hydroxylase antibodies in unexplained cases,

- thyroid assessment.

POI is not simply:

an infertility problem.

It also affects:

- bone health,
- cardiovascular health,
- psychological wellbeing,
- sexual function,
- neurological health.

Hormone therapy is therefore generally recommended until the usual age of menopause:

even if hot flushes are absent.

If the uterus remains intact:

a progestogen should accompany systemic estrogen therapy.

Women should also understand that:

HRT is not contraception

and spontaneous ovarian activity can occasionally occur.

For fertility, current international guidance is particularly clear:

there is no treatment reliably proven to increase ovarian activity or natural conception rates in established POI.

Natural pregnancy can still occasionally occur because ovarian function may fluctuate.

Where the patient's own oocytes are unavailable:

donor-oocyte IVF is an established fertility option.

Experimental techniques such as:

- ovarian PRP,
- stem-cell injections,
- in-vitro activation

should not presently be presented as established cures.

The **Unani system of medicine** offers a valuable whole-person framework through concepts such as:

- Mizaj,
- Akhlat,
- Ihtibas al-Tamth,
- Asbab-e-Sitta Zarooriyah,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa.

Contemporary Unani literature recognizes POI as one of the modern causes that may present with amenorrhea and continues to study how traditional lifestyle and constitutional approaches may support reproductive health.

However:

current evidence does not establish that Unani medicine regenerates a depleted follicular pool or reliably restores fertility in established POI.

At **Saira Health Care**, my approach as **Dr. Nizamuddin Qasmi** is therefore to:

confirm that the woman truly has POI rather than low AMH alone;

review menstrual history and FSH properly;

exclude other causes of amenorrhea;

encourage modern genetic and autoimmune evaluation when indicated;

assess bone and cardiovascular health;

protect the patient from the long-term effects of estrogen deficiency;

use hormone therapy appropriately rather than withholding it simply because she is young;

evaluate fertility goals immediately;

identify intermittent ovarian activity when present;

evaluate the male partner at the same time;

discuss assisted reproductive options honestly;

use individualized Unani nutrition, lifestyle, sexual-health and supportive pharmacological care where appropriate;

avoid claiming that bleeding equals ovarian recovery;

avoid promising that herbs, Hijama or supplements create new eggs;

avoid allowing experimental ovarian-rejuvenation procedures to be presented as established cures;

and protect the woman's reproductive time rather than repeatedly chasing AMH or FSH numbers.

When a woman asks me:

“Doctor, I have POI. Is there still hope for me?”

my answer is:

Yes—there are important reasons for hope, but hope must be based on correct information. POI does not always mean complete permanent ovarian shutdown, and occasional natural ovarian activity can occur. At the same time, no medicine has yet been proven to restore a depleted ovarian follicle pool reliably. Our responsibility is therefore to protect your bone, heart, sexual and hormonal health, investigate the cause properly, preserve every realistic fertility opportunity, use modern reproductive treatment when appropriate, and integrate Unani supportive care responsibly without giving false promises.

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About the Author

Dr. Nizamuddin Qasmi

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Professional Education & 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**

Saira Health Care publicly identifies Dr. Nizamuddin Qasmi's focused clinical work in sexual disorders and infertility and includes hormonal imbalance, irregular menstruation and decreased AMH among the reproductive-health problems addressed by the clinic.

Medical Disclaimer

This article is intended for:

- patient education,
- fertility awareness,
- reproductive and hormonal health information.

It is not a substitute for:

- gynecological consultation,
- reproductive-endocrinology consultation,
- genetic counselling,
- endocrinology evaluation,
- fertility-specialist assessment.

Do not diagnose POI from:

- AMH alone,
- ultrasound alone,
- one missed period.

Do not independently start or stop:

- estrogen,
- progesterone,
- contraceptive hormones,
- fertility injections,
- DHEA,
- testosterone,
- Unani medicines,
- herbal emmenagogues,
- Kushta formulations,
- supplements

because your AMH is low or your FSH is elevated.

Do not stop prescribed hormone replacement simply because you:

- have no hot flushes,
- wish to become pregnant.

Do not delay evidence-based fertility counselling while spending months or years attempting to:

- normalize AMH,
- lower FSH,
- “rejuvenate” the ovary

with unproven treatments.

Procedures such as:

- ovarian PRP,
- stem-cell therapy,
- in-vitro activation

remain experimental for POI and should not be represented as guaranteed ovarian-regeneration treatments.

No modern, Unani, herbal, hormonal or assisted-reproductive treatment can ethically guarantee:

- restoration of ovarian reserve,
- natural ovulation,
- conception,
- pregnancy,
- live birth.

Saira Health Care
www.sairahealthcare.com