

Endometrial Polyps and Fertility

Understanding Uterine Polyps, Implantation Problems, Infertility, Abnormal Bleeding, Hysteroscopic Polypectomy and an Integrative Unani Approach

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When a woman comes to me for infertility and her ultrasound report says:

“Endometrial polyp suspected,”

she often becomes worried immediately.

She may ask:

“Doctor, is this a tumour?”

“Can a small polyp stop pregnancy?”

“Do I definitely need surgery?”

“Will it affect IVF?”

“Can it become cancer?”

“Can medicine dissolve it?”

These are important questions because an **endometrial polyp** is common, usually benign, and often treatable—but not every polyp has exactly the same significance for fertility.

An endometrial polyp is a localized overgrowth of the inner lining of the uterus. It projects into the uterine cavity and contains endometrial glands and supporting stromal tissue arranged around a vascular core. The new **2026 British Fertility Society guideline** describes polyps as common intrauterine lesions in reproductive-aged women that may be associated with infertility and reduced effectiveness of assisted conception treatment.

My first message to patients is:

An endometrial polyp does not automatically mean infertility, and it certainly does not automatically mean cancer.

But the uterine cavity is where an embryo must implant.

Therefore, when a polyp is present in a woman who is having difficulty becoming pregnant, experiencing repeated implantation failure or recurrent miscarriage, we should not ignore it either.



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The correct question is not simply:

“Is there a polyp?”

The better questions are:

How large is it? Where is it located? Is there one or several? Is it causing bleeding? Is the woman trying naturally, undergoing IUI or preparing for IVF? Has she had previous implantation failure or miscarriage? Are there features requiring histological examination?

At **Saira Health Care**, I approach such cases as part of a complete fertility evaluation rather than treating the ultrasound image alone.

What Is the Endometrium?

The **endometrium** is the specialized tissue lining the inside of the uterus.

During each menstrual cycle it changes under the influence of hormones, particularly:

- estrogen,
- progesterone.

It prepares itself to receive a fertilized embryo.

If pregnancy does not occur, much of the functional endometrial lining is shed during menstruation.

If pregnancy occurs, the embryo interacts with this highly specialized tissue and begins implantation.

Therefore, healthy endometrial function is essential for:

- embryo attachment,
- implantation,
- early placental development,
- continuation of pregnancy.

This explains why a lesion arising from the endometrium can sometimes influence fertility even when the ovaries and fallopian tubes are otherwise normal.

What Is an Endometrial Polyp?



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An endometrial polyp is a **focal growth of endometrial tissue projecting into the uterine cavity**.

It may be:

- only a few millimetres in diameter,
- more than one or two centimetres,
- broad-based,
- attached through a narrow stalk,
- single,
- multiple.

Most are benign.

The 2024 Society of Obstetricians and Gynaecologists of Canada guideline defines endometrial polyps as localized intrauterine lesions composed of glands, stroma and blood vessels covered by endometrial epithelium.

Is an Endometrial Polyp the Same as a Fibroid?

No.

This distinction is important.

Endometrial polyp

Develops mainly from the **endometrial lining**.

It is usually soft tissue containing:

- endometrial glands,
- stroma,
- blood vessels.

Fibroid

A fibroid, or leiomyoma, develops primarily from **uterine smooth muscle**.

A fibroid may grow:

- outside the uterus,
- within the uterine wall,
- toward the uterine cavity.



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A **submucosal fibroid** can also interfere with fertility because it distorts the uterine cavity, but it is biologically different from an endometrial polyp.

Treatment therefore differs.

How Common Are Endometrial Polyps?

Endometrial polyps are common.

Their reported prevalence varies greatly depending on:

- age,
- symptoms,
- imaging method,
- whether the woman is being evaluated for infertility.

Recent literature reports polyps in a substantial proportion of reproductive-aged and subfertile women, with prevalence increasing with age and selected hormonal/metabolic risk factors. A 2026 fertility review reported approximate prevalence ranges of **15–25% in some European subfertility populations and 12–20% in several Asian studies**, although estimates vary considerably.

The important point is:

Polyps are common enough that finding one does not automatically explain infertility.

We need to decide whether that particular polyp is clinically relevant.

Why Do Endometrial Polyps Develop?

The exact cause is not completely understood.

Their development appears to involve several factors, including:

- hormonal stimulation,
- local estrogen activity,
- altered endometrial cell growth,
- abnormal regulation of cell death,
- angiogenesis or new blood-vessel development,
- local inflammatory and molecular changes.



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The 2024 SOGC guideline notes evidence that polyp growth is influenced by estrogen and that polyp tissue expresses estrogen and progesterone receptors.

Hormonal Influence

Endometrial polyps are considered partly hormone-responsive.

Estrogen stimulates growth of the endometrium.

Conditions that increase prolonged estrogen exposure relative to progesterone may therefore be associated with greater endometrial proliferation.

This may help explain associations with:

- obesity,
- some ovulatory disorders,
- later reproductive age,
- selected hormonal treatments.

However, having high estrogen does not mean a woman will definitely develop a polyp.

The condition is multifactorial.

Obesity

Obesity is associated with increased peripheral conversion of hormones into estrogen-like compounds.

Recent reviews identify obesity as a risk factor for endometrial polyps and also as a factor associated with greater concern for abnormal endometrial pathology in certain populations.

This does not mean:

“Every overweight woman has polyps.”

It means metabolic and hormonal health are part of the wider uterine environment.

PCOS and Ovulatory Disorders

Women with polycystic ovarian syndrome may experience prolonged periods without ovulation.

When ovulation does not occur regularly, progesterone exposure can be reduced while estrogen continues stimulating the endometrium.

This can contribute to various forms of endometrial overgrowth.

Endometrial polyps may therefore coexist with PCOS, although one condition does not prove the other.

For fertility treatment, both problems may need attention.

Tamoxifen

Tamoxifen is an important medicine used particularly in some women treated for breast cancer.

Although it blocks estrogen effects in breast tissue, it can have estrogen-like effects on the endometrium.

Endometrial polyps are considerably more common among some women receiving long-term tamoxifen treatment.

A woman taking tamoxifen should not stop it because of a uterine polyp without discussion with her oncology team.

Cancer treatment remains the priority.

Endometrial Polyps Can Occur Without Any Known Risk Factor

Many young healthy women with:

- normal weight,
- regular cycles,
- no tamoxifen exposure

still develop polyps.

Therefore, identifying a polyp should not automatically lead the patient to search for something she did “wrong.”

In many cases there is no single preventable cause.

Symptoms of Endometrial Polyps

Some women have no symptoms.



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The polyp may be discovered during:

- infertility ultrasound,
- saline sonography,
- hysteroscopy,
- investigation for another problem.

Others develop abnormal bleeding.

Intermenstrual Bleeding

One classic symptom is:

spotting or bleeding between periods.

For example, a woman may have her usual menstrual period but then notice:

- light bleeding,
- brown discharge,
- fresh spotting

at unexpected times during the cycle.

This can occur because the polyp contains fragile blood vessels.

Heavy Menstrual Bleeding

Some polyps are associated with:

- heavier periods,
- prolonged bleeding.

However, heavy bleeding has many other possible causes, including:

- fibroids,
- adenomyosis,
- hormonal dysfunction,
- bleeding disorders.

Therefore, bleeding does not prove that a polyp is responsible.



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Irregular Bleeding

A woman may also experience unpredictable bleeding.

This becomes especially important when combined with:

- increasing age,
- obesity,
- postmenopausal status,
- other risk factors for endometrial abnormality.

Such women require appropriate gynecological evaluation.

Postmenopausal Bleeding

Any bleeding after menopause deserves medical investigation.

A polyp may be benign, but postmenopausal bleeding carries greater concern for:

- endometrial hyperplasia,
- atypical hyperplasia,
- cancer.

The **2024 SOGC guideline identifies older age, menopause and postmenopausal bleeding among the major factors increasing concern for premalignant or malignant pathology within a polyp.**

Can Endometrial Polyps Cause Infertility?

Yes, they can contribute to infertility.

But the relationship is not absolute.

Some women with polyps become pregnant easily.

Others appear to experience significant difficulty until the lesion is removed.

Current evidence suggests several possible mechanisms.

A 2026 fertility review identifies:

- mechanical interference,
- chronic inflammation,
- altered endometrial receptivity,



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- disturbed implantation signalling,
- abnormal decidualization

as plausible pathways linking polyps with reduced fertility.

Mechanical Interference With Implantation

Think of the uterine cavity as the environment in which the embryo must establish contact with the endometrium.

A polyp physically projects into that space.

Depending on its:

- size,
- location,
- mobility,

it may disrupt the ideal surface for embryo implantation.

This mechanism is particularly plausible when the lesion occupies a significant part of the cavity.

Interference With Sperm Transport

For natural conception, sperm must travel:

vagina → cervix → uterine cavity → fallopian tube.

A polyp located close to the:

- cervix,
- uterotubal junction,
- tubal opening

could theoretically interfere with sperm movement.

This may help explain why polyp location sometimes appears relevant to fertility.

Polyps Near the Fallopian-Tube Opening

The upper corners of the uterus contain the openings where the fallopian tubes enter the uterine cavity.



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These areas are called the:

uterotubal junctions or cornual regions.

A polyp in this location may potentially interfere with:

- sperm passage into the tube,
- local implantation environment.

Older observational research suggested that polyp location may influence reproductive outcomes, although high-quality evidence remains limited.

Endometrial Receptivity

The endometrium is not receptive to an embryo throughout the whole menstrual cycle.

There is a limited period called the:

Window of Implantation

during which molecular and cellular conditions become favourable for implantation.

Modern infertility science increasingly recognizes that endometrial polyps may affect this biological receptivity—not merely occupy physical space.

HOXA10 and HOXA11

Two important genes involved in endometrial receptivity are:

HOXA10 and HOXA11.

These genes help regulate:

- endometrial differentiation,
- embryo implantation,
- decidualization,
- placental invasion.

Recent molecular reviews describe altered HOXA10/HOXA11 signalling in benign endometrial disorders including endometrial polyps.

A 2026 review specifically describes reduced receptivity signalling around polyps, including altered:

- HOX pathways,



- inflammatory cytokines,
- implantation proteins,
- progesterone-related endometrial responses.

This may partly explain why even a relatively small lesion can sometimes have reproductive importance disproportionate to its size.

Chronic Inflammation

Polyps may create a localized inflammatory environment within the uterine cavity.

Altered cytokines and immune-cell signalling could interfere with:

- implantation,
- embryo-endometrium communication,
- decidualization.

Current research is also studying overlap between:

- endometrial polyps,
- chronic endometritis.

However, finding a polyp does not mean chronic endometritis is automatically present, and antibiotics should not be prescribed simply because a polyp exists.

Abnormal Implantation Signalling

Researchers have also reported altered expression of molecules involved in implantation, including:

- glycodelin,
- osteopontin,
- integrins,
- progesterone receptors.

These findings support the concept that a polyp may affect the endometrium beyond the small area occupied by the visible lesion.

This remains an evolving research field.



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Can an Endometrial Polyp Cause Miscarriage?

It may contribute in selected women.

A polyp may interfere with:

- optimal implantation,
- development of the early gestational environment.

This is one reason polypectomy is often considered in women with:

- recurrent pregnancy loss,
- repeated implantation failure.

ACOG lists infertility and recurrent pregnancy loss among recognized indications for considering polyp removal.

However, miscarriage has many causes.

These include:

- embryo chromosome abnormalities,
- maternal age,
- uterine anomalies,
- antiphospholipid syndrome,
- endocrine disorders,
- other factors.

Therefore, finding a small polyp should not automatically be described as the proven cause of every miscarriage.

Endometrial Polyps and Natural Conception

For a woman trying to conceive naturally, a documented polyp raises the question:

Should it be removed before continuing to try?

The newest **2026 British Fertility Society guideline** states that hysteroscopic polypectomy **can be considered** in subfertile women wishing to continue natural conception because pregnancy outcomes may improve, although randomized controlled trial evidence specifically for natural conception remains lacking.

Therefore, management should be individualized.



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Endometrial Polyps and IUI

Evidence supporting polypectomy is stronger before:

Intrauterine Insemination — IUI

The best-known randomized study enrolled 215 women with endometrial polyps undergoing IUI.

The new British Fertility Society guideline summarizes that clinical pregnancy occurred more often after polypectomy than after diagnostic hysteroscopy with biopsy alone—approximately **63% versus 28%** in that trial. However, the guideline also notes important methodological and data-quality concerns regarding this older study.

Therefore, current guidance is appropriately cautious:

polypectomy can be considered before ovulation induction/IUI and appears to improve clinical pregnancy rates.

Some Women Conceive Naturally After Polypectomy Before IUI Begins

An interesting finding from the same body of evidence is that some women conceived naturally during the months after polyp removal and before proceeding to IUI.

The British Fertility Society guideline notes that in the older randomized study approximately 29% of women in the polypectomy arm conceived naturally during this period compared with about 3% following diagnostic hysteroscopy/biopsy alone.

These numbers should not be promised to individual patients.

But they support the possibility that restoring the uterine cavity may itself improve fertility in selected women.

Endometrial Polyps and IVF

The IVF question is more complicated.

A patient may ask:

“If IVF bypasses natural fertilization, why does the polyp matter?”

IVF bypasses several steps.

The embryo does not need sperm to travel naturally through the uterus and fallopian tube.



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But the embryo must still implant into the endometrium.

Therefore, uterine-cavity abnormalities can still matter.

Should Every Polyp Be Removed Before IVF?

Not necessarily.

The evidence is less definitive than for IUI.

A 2021 review concluded that strong randomized evidence showing that polypectomy improves IVF pregnancy rates was lacking, particularly for very small polyps.

However, more recent observational evidence and the 2026 fertility-specific guideline support considering removal of documented polyps before IVF, especially when there are additional clinical reasons to do so.

The decision should therefore be individualized.

The New 2026 British Fertility Society Approach Before IVF

The 2026 guideline recommends that **polypectomy can be considered when an endometrial polyp is identified before an IVF cycle begins.**

That wording is important.

It says:

can be considered

rather than:

every IVF patient must have every polyp removed.

Factors influencing the decision include:

- polyp size,
- location,
- symptoms,
- reproductive history,
- previous IVF outcomes,
- number and quality of embryos,
- underlying cause of infertility.



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What If a Polyp Is Discovered During IVF Stimulation?

This is a difficult clinical situation.

The woman may already have:

- taken fertility injections,
- developed multiple follicles,
- invested substantial time and money.

The new British Fertility Society guideline provides useful practical guidance.

Polyp greater than 20 mm

If a polyp larger than approximately 20 mm is detected during ovarian stimulation, the guideline recommends considering:

egg retrieval → embryo cryopreservation → polypectomy → later frozen embryo transfer.

Polyp smaller than 20 mm

Management can be more individualized.

Options may include:

- proceeding with fresh embryo transfer when there are no concerning endometrial risk factors,
- freezing embryos and removing the polyp first when there is concerning pathology or poor previous reproductive outcome.

These are fertility-guideline recommendations, not rigid laws.

Is There a Universal Size at Which a Polyp Must Be Removed?

No.

There is no universally agreed cut-off.

This is important because patients frequently ask:

“My polyp is 8 mm. Does it have to be removed?”

Evidence is not strong enough to state that every 8-mm polyp should be removed or every 7-mm polyp ignored.

The 2026 British Fertility Society guideline confirms that no universal size threshold is supported by the literature.

Clinical context matters.

Small Polyps May Sometimes Regress

Very small asymptomatic polyps can occasionally disappear spontaneously.

The older AAGL guideline reported spontaneous regression in up to approximately one quarter of conservatively followed polyps, particularly lesions below 10 mm.

More recent fertility reviews continue to recognize possible spontaneous regression of some polyps below 10 mm.

Therefore, observation can sometimes be reasonable.

When Observation May Be Reasonable

Depending on the patient, expectant management may be considered when the polyp is:

- small,
- asymptomatic,
- discovered incidentally,
- without concerning endometrial features,
- in a young woman with favourable fertility circumstances.

However, observation becomes less attractive when there is:

- infertility,
 - abnormal bleeding,
 - repeated miscarriage,
 - repeated implantation failure,
 - suspicious imaging,
 - larger lesion,
 - increasing age.
-



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Recurrent Implantation Failure

When a woman has had repeated high-quality embryo transfers without implantation and a polyp is present, most fertility specialists have a lower threshold for hysteroscopic removal.

The 2026 British Fertility Society guideline specifically states that polypectomy is preferred in women with:

- recurrent implantation failure,
- recurrent miscarriages.

The reasoning is straightforward:

when valuable embryos are being transferred, it is reasonable to optimize the uterine cavity where a potentially correctable lesion is present.

How Are Endometrial Polyps Diagnosed?

Several methods are available.

They include:

- transvaginal ultrasound,
- Doppler ultrasound,
- saline infusion sonography,
- 3D ultrasound,
- hysteroscopy.

The appropriate sequence depends upon:

- symptoms,
- fertility status,
- previous imaging.

Transvaginal Ultrasound — First-Line Test

The **2024 SOGC guideline recommends transvaginal ultrasound as the initial investigation** when an endometrial polyp is suspected because it is:

- safe,



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- accessible,
- well tolerated.

An endometrial polyp may appear as:

- focal thickening,
- a relatively echogenic lesion,
- a lesion containing small cystic spaces.

Colour Doppler sometimes demonstrates a characteristic feeding vessel.

Best Time for Ultrasound

In women with regular menstrual cycles, imaging is often easier shortly after menstruation.

At this time:

- the endometrium is relatively thin,
- focal polyps may stand out more clearly.

The 2026 British Fertility Society guideline recommends performing 2D transvaginal ultrasound ideally during the **early proliferative phase** when practical.

Later in the cycle, thick secretory endometrium can make interpretation more difficult.

Can an Ordinary Ultrasound Miss a Polyp?

Yes.

A routine transvaginal ultrasound is useful, but it is not perfect.

A meta-analysis comparing techniques reported pooled sensitivity around **55% for ordinary 2D transvaginal ultrasound**, compared with approximately 92% for saline contrast sonohysterography in detecting endometrial polyps.

This is why an uncertain ultrasound does not always end the investigation.

Saline Infusion Sonography — SIS

During SIS, a small amount of sterile saline is introduced through the cervix while transvaginal ultrasound is performed.



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The fluid separates the uterine walls.

A polyp then becomes much easier to see because it projects into the fluid-filled cavity.

Systematic reviews show that SIS is considerably more sensitive than ordinary ultrasound for identifying endometrial polyps.

Is SIS the Same as HSG?

No.

SIS

Uses:

- saline,
- ultrasound.

It primarily evaluates the **uterine cavity**.

HSG

Uses:

- X-ray contrast,
- radiography.

It is often used during infertility evaluation to assess:

- fallopian-tube patency,
- general cavity shape.

The 2024 SOGC guideline does **not** recommend HSG as the preferred diagnostic test specifically for endometrial polyps.

HSG may suggest a filling defect, but it does not characterize the lesion as accurately as hysteroscopy.

Hysteroscopy — The Gold Standard

Hysteroscopy involves passing a thin telescope through the cervix into the uterus.

The doctor can directly inspect the cavity.

The **2024 SOGC guideline identifies hysteroscopy with guided biopsy as the diagnostic gold standard for endometrial polyps.**



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The 2026 British Fertility Society guideline reaches the same conclusion while noting that diagnostic hysteroscopy is not necessarily required as the first test in every low-risk patient.

Why Hysteroscopy Is So Useful

Hysteroscopy can show:

- exact polyp size,
- exact location,
- number of polyps,
- whether other pathology is present,
- condition of the surrounding endometrium.

Most importantly:

the polyp can often be removed at the same procedure.

This combination of diagnosis and treatment makes hysteroscopy particularly valuable.

Office Hysteroscopy

Many polyps can now be removed without traditional operating-room surgery.

ACOG recommends considering **office hysteroscopy for endometrial-polyp treatment whenever appropriate**, depending upon:

- lesion size,
- patient preference,
- comorbidities,
- clinician expertise,
- equipment availability.

Potential advantages include:

- faster recovery,
- avoiding general anesthesia,
- lower cost,
- convenience.



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Not every woman or every polyp is suitable for office removal.

Why Blind D&C Is Not the Preferred Treatment

A blind dilation and curettage does not allow the surgeon to see the polyp directly.

The curette can:

- miss the lesion,
- remove only part of it,
- damage surrounding healthy endometrium.

The 2024 SOGC guideline specifically recommends **against blind endometrial biopsy or D&C for diagnosing endometrial polyps**.

The 2026 British Fertility Society guideline likewise recommends hysteroscopic removal rather than blind D&C.

For fertility patients, preserving healthy endometrium is particularly important.

Hysteroscopic Polypectomy

The established surgical treatment is:

Hysteroscopic Polypectomy

The polyp is directly visualized and removed from its attachment.

Techniques may include:

- hysteroscopic scissors,
- mechanical tissue-removal systems,
- bipolar instruments.

The goal is to remove the lesion completely while minimizing damage to surrounding healthy endometrium.

Mechanical Removal in Fertility Patients

The latest 2026 British Fertility Society guidance favours **mechanical hysteroscopic tissue-removal systems over bipolar electrodes** when suitable and recommends considering approaches that minimize thermal injury to the endometrium.



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This is particularly relevant in infertility.

The objective is not only to remove the polyp.

It is also to preserve the best possible implantation surface.

Does Polypectomy Damage Fertility?

When performed appropriately, hysteroscopic polypectomy is generally considered a low-risk fertility-preserving procedure.

Modern evidence-based guidance describes hysteroscopic polypectomy as feasible and safe with a low risk of intrauterine adhesion formation.

No procedure is risk-free, however.

Possible complications include:

- bleeding,
- infection,
- uterine perforation,
- fluid-related complications,
- cervical injury,
- intrauterine adhesions.

The absolute risk is generally low in experienced hands.

Should the Polyp Be Sent for Histopathology?

Yes.

The latest fertility-specific British guidance recommends that **all excised endometrial polyps undergo histopathological examination.**

This allows the laboratory to determine whether the lesion is:

- benign,
- hyperplastic,
- atypical,
- rarely malignant.

An ultrasound image alone cannot provide this certainty.



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Are Most Endometrial Polyps Benign?

Yes.

Especially in younger reproductive-aged women, the great majority are benign.

The 2024 SOGC guideline states that malignancy risk is generally low but varies greatly according to:

- age,
- menopause,
- bleeding,
- other clinical characteristics.

This distinction is very important when counselling fertility patients.

Can an Endometrial Polyp Be Cancer?

Occasionally.

A polyp can contain:

- atypical endometrial hyperplasia,
- endometrial carcinoma.

But the risk is **not the same for every woman**.

Cancer Risk Is Much Higher in Older and Postmenopausal Women

A 2025 systematic review and meta-analysis involving **11,204 women, mainly peri- and postmenopausal women older than 45**, found malignant tissue in approximately 2.75% of polyps. Menopausal status substantially increased the odds of premalignant or malignant pathology.

That number should **not** be applied directly to a 28-year-old woman undergoing fertility treatment because the study population was older.

The risk among young reproductive-aged infertility patients is much lower.

Abnormal Bleeding Matters

Abnormal uterine bleeding increases concern that a polyp may contain atypical or malignant pathology.

The 2024 SOGC guideline identifies:

- older age,
- menopause,
- postmenopausal bleeding

as major risk features.

More recent reviews also identify abnormal uterine bleeding and higher BMI among relevant malignancy-risk indicators.

Therefore, a symptomatic polyp should not be dismissed simply because the lesion is small.

Does Polyp Size Predict Cancer?

Not reliably by itself.

Current guideline evidence indicates that size alone has not consistently predicted malignancy.

Clinical context remains more important.

What Happens if Atypical Hyperplasia or Cancer Is Found?

This is no longer ordinary benign-polyp management.

The woman should receive appropriate gynecologic oncology assessment.

The 2024 SOGC guideline recommends involvement of a gynecologic oncologist when premalignant or malignant pathology is identified, particularly if uterine preservation is being considered.

Fertility preservation may still be discussed in carefully selected circumstances, but cancer safety becomes the priority.

Can a Polyp Grow Back?

Yes.

New polyps or recurrent polyps can occur after removal.



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Recurrence rates vary substantially among studies according to:

- duration of follow-up,
- number of polyps,
- hormonal environment,
- definition of recurrence.

Therefore, a previous polypectomy does not mean the patient can never develop another polyp.

Multiple Polyps

When several polyps are present, I also consider whether there may be:

- greater endometrial proliferative tendency,
- hormonal/metabolic contributors,
- increased likelihood of recurrence.

Some recent observational studies have associated multiple polyps with a greater risk of abnormal pathology, although evidence is not uniform across all studies.

Does Removing a Polyp Improve Fertility?

In selected infertile women, evidence suggests it can.

However, strength of evidence varies according to the fertility pathway.

Natural conception

Likely benefit in selected patients, but randomized evidence is limited.

IUI

The best evidence of fertility benefit exists here.

IVF

Evidence is less definitive, but targeted removal of documented polyps is commonly considered, especially before treatment begins or after previous implantation failure.

The new 2026 British Fertility Society guideline reflects exactly this graduated evidence base.



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Pregnancy Rates After Polypectomy

A recent 2026 structured review of 83 studies reported generally favourable reproductive outcomes following hysteroscopic polypectomy, although populations and study methods varied substantially.

Reported clinical pregnancy rates after polypectomy in IVF/ICSI populations ranged broadly from approximately **53–72%**, with live-birth rates approximately **43–66%** in the included studies.

These numbers should **never be presented as an individual patient's expected pregnancy rate.**

The final outcome also depends strongly on:

- maternal age,
- ovarian reserve,
- egg quality,
- sperm quality,
- embryo genetics,
- fallopian tubes,
- other uterine conditions.

When Can Fertility Treatment Resume After Polypectomy?

Many women do not require a long waiting period.

The 2026 British Fertility Society guideline notes that available evidence does not show a clear benefit from delaying ovarian stimulation for many months following uncomplicated polypectomy.

For frozen embryo transfer, the guideline recommends performing the transfer within approximately **four months of hysteroscopic polypectomy.**

The exact timing should be individualized according to:

- recovery,
- pathology results,
- menstrual cycle,
- fertility plan.



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Does Polypectomy Improve Endometrial Receptivity?

There is biologic evidence suggesting that removal may improve the implantation environment.

Research has shown abnormalities involving:

- HOXA10,
- HOXA11,
- inflammatory mediators,
- implantation proteins

in polyp-associated endometrium.

Removing the lesion eliminates a focal source of:

- abnormal tissue,
- mechanical distortion,
- potentially adverse signalling.

However, molecular recovery after polypectomy remains an evolving research topic.

Should Every Woman Undergoing IVF Have a Routine Hysteroscopy?

No.

This is different from removing a **known polyp**.

Routine hysteroscopy in every IVF patient with:

- normal imaging,
- no suspicious symptoms,
- no prior implantation problems

is not the same question as targeted hysteroscopy for a documented intrauterine lesion.

The new British Fertility Society guideline specifically distinguishes routine screening hysteroscopy from management when a polyp has actually been identified.

Unnecessary procedures should be avoided.

Endometrial Polyps and Chronic Endometritis

There is growing research interest in an association between endometrial polyps and **chronic endometritis**, a persistent inflammatory disorder of the endometrium.

Some women appear to have both conditions.

However, it remains inappropriate to assume that every polyp is caused by infection.

Likewise, routine antibiotics should not be prescribed solely because a polyp exists.

Investigation for chronic endometritis should be based on the complete clinical picture.

Can Medicines Make a Polyp Disappear?

Hormonal treatment can sometimes modify:

- bleeding,
- endometrial growth.

But no medical treatment provides the same reliable combination of:

- complete lesion removal,
- direct cavity assessment,
- histopathology

as hysteroscopic polypectomy.

The 2024 SOGC guideline recognizes expectant, medical and surgical management depending upon symptoms, malignancy risk and patient preference, but identifies hysteroscopic polypectomy as the most effective option for diagnosis plus treatment.

Birth-Control Pills and Progestogens

Hormonal medicines may control associated abnormal bleeding in selected patients.

They may also suppress endometrial proliferation temporarily.

However, for a fertility patient actively trying to conceive, hormonal suppression prevents conception during treatment.

Furthermore, the lesion may remain.

Therefore, medical therapy has a more limited role when the specific goal is optimizing the uterine cavity for pregnancy.



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Can a Polyp Fall Off Naturally?

Small polyps can regress spontaneously.

This is more common among small lesions, particularly below approximately 10 mm.

But we cannot reliably predict exactly which lesion will disappear.

Therefore, observation should be intentional and based on the patient's broader reproductive situation—not simply indefinite waiting.

How I Evaluate a Woman With Endometrial Polyp and Infertility

When a woman comes to me at **Saira Health Care**, I do not begin with:

“Remove the polyp.”

I first want to understand the entire fertility situation.

I ask:

How old is the patient?

How long has she been trying for pregnancy?

Has she ever conceived previously?

Does she experience bleeding between periods?

How large is the polyp?

Is there one or several?

Where is it located?

Was it seen on routine ultrasound or confirmed by SIS/hysteroscopy?

Are periods regular?

Is PCOS present?

Are fallopian tubes open?

What is the ovarian reserve?

Has the male partner had semen analysis?

Has there been recurrent miscarriage or IVF failure?

Only then can the importance of the polyp be judged properly.

A Small Polyp May Be the Least Important Fertility Problem

Consider a 39-year-old woman with:

- AMH markedly reduced,
- one 5-mm asymptomatic polyp.

Her fertility management must consider ovarian reserve and age urgently.

The small polyp should not distract the team from the time-sensitive ovarian issue.

A Small Polyp May Sometimes Still Matter

Now consider a 29-year-old woman with:

- good ovarian reserve,
- normal semen analysis in the male partner,
- open tubes,
- unexplained infertility for three years,
- repeated spotting,
- a clearly documented intracavitary polyp.

Here the polyp may be much more clinically relevant.

The same millimetre measurement can have a different meaning depending upon the patient.

The Male Partner Should Still Be Evaluated

This is extremely important.

Finding a uterine polyp does not mean the cause of infertility has been completely identified.

A couple can have:

endometrial polyp + male-factor infertility.

If the man's sperm concentration is severely reduced, removing the polyp alone may not solve the couple's fertility problem.



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At Saira Health Care, infertility is therefore approached as a **couple's reproductive condition**, even when one clear abnormality has been discovered.

Fallopian-Tube Assessment

For natural conception or IUI, the fallopian tubes also matter.

If both tubes are severely blocked, removal of a small uterine polyp will not restore natural fertility.

Similarly, hydrosalpinx may have a major impact on implantation.

The complete fertility picture matters.

Ovarian Reserve

Especially after age 35, ovarian reserve and reproductive age influence treatment urgency.

Tests may include:

- AMH,
- antral follicle count

when clinically appropriate.

A polypectomy may optimize the cavity, but it cannot reverse ovarian ageing.

This is why unnecessary delays should be avoided.

Endometrial Polyps During Pregnancy

Polyps are usually evaluated before conception.

Once pregnancy has begun, management becomes more conservative because invasive uterine procedures may threaten pregnancy.

Bleeding during pregnancy should not simply be attributed to a previously known polyp.

Pregnancy-specific causes must be evaluated.

The Unani Perspective on Endometrial Polyps and Fertility



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As a physician trained in **Unani medicine** and focused clinically on **Sexual Disorders & Infertility**, I view female reproductive health within the broader state of the woman.

Traditional Unani medicine gives importance to:

- uterine health,
- menstrual pattern,
- **Mizaj** or constitutional temperament,
- digestive function,
- nutrition,
- body weight,
- sleep,
- physical activity,
- emotional wellbeing,
- reproductive and sexual health.

The Central Council for Research in Unani Medicine's standardized terminology includes the classical term **Bawāsir al-Raḥim** with “uterine polyps” listed as a possible English equivalent.

However, this equivalence needs to be interpreted carefully.

A modern histologically confirmed **endometrial polyp** is defined through:

- imaging,
- hysteroscopy,
- pathology.

Classical terminology should not replace that modern anatomical diagnosis.

How Unani Medicine Can Be Useful

In selected women, an individualized Unani approach may help support aspects of reproductive health such as:

- healthy nutrition,
- metabolic balance,
- digestive wellbeing,



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- menstrual-health support,
- sleep,
- physical wellbeing,
- stress management,
- associated sexual-health concerns.

This may be especially relevant when the woman also has:

- obesity,
- irregular cycles,
- PCOS-related metabolic issues,
- digestive complaints,
- general reproductive-health concerns.

These are meaningful aspects of fertility care.

But a Structural Polyp Is Still a Structural Lesion

This distinction is essential.

A polyp protruding into the uterine cavity is a physical lesion.

If it is clinically significant, hysteroscopy provides something oral treatment cannot:

- direct visualization,
- complete removal,
- pathology examination.

Therefore, I do not advise a fertility patient with a clearly significant endometrial polyp to spend many months repeatedly changing herbal medicines in the hope that a documented structural lesion will disappear.

That delay may be particularly harmful when:

- age is increasing,
 - ovarian reserve is declining,
 - IVF is planned.
-



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What Does the Evidence Say About Unani Medicine Specifically for Endometrial Polyps?

At present, **direct high-quality clinical evidence demonstrating that Unani medicines reliably eliminate hysteroscopically confirmed endometrial polyps or improve live-birth rates specifically in polyp-associated infertility is insufficient.**

This needs to be stated clearly.

There is clinical literature describing Unani treatment in other areas of reproductive health and female infertility, but those studies involve biologically different disorders.

For example, a published Unani case report described conception in a woman with unilateral tubal obstruction.

That observation cannot be used as proof that Unani treatment removes endometrial polyps.

The conditions are completely different.

Why I Still Use an Integrative Approach

Integrative medicine does not mean claiming that every condition can be treated by one system alone.

For endometrial polyps:

Modern hysteroscopy is particularly useful for structural diagnosis and removal.

Unani medicine can be useful for individualized whole-patient reproductive support.

These approaches can complement each other when used responsibly.

Herbal Medicines Before Hysteroscopy

Patients should tell the gynecologist about every:

- Unani medicine,
- herbal product,
- supplement

being used before surgery.

Some products may affect:



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- bleeding,
- anesthesia,
- drug metabolism.

Transparent coordination between clinicians is safer.

Special Treatment Planning by Dr. Nizamuddin Qasmi

At **Saira Health Care**, my approach to endometrial polyps and infertility is based on the patient's complete reproductive situation.

I first decide:

Is the polyp likely to matter?

Then:

Does it require removal now, observation, or further confirmation?

Where hysteroscopy is indicated, I encourage proper targeted treatment rather than blind procedures.

After structural treatment, I continue to evaluate:

- ovulation,
- ovarian reserve,
- fallopian tubes,
- male-factor fertility,
- metabolic health,
- sexual health,
- nutritional and lifestyle factors.

Where appropriate, individualized Unani supportive management can then be incorporated.

What “Special Treatment” Means in My Practice

Specialized care does not mean:

“One medicine for every uterine polyp.”

Consider these different patients.



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Patient One

Age 24, asymptomatic, 5-mm polyp detected incidentally, not trying for pregnancy.

Observation may be reasonable.

Patient Two

Age 29, unexplained infertility for three years and a clearly documented intracavitary polyp.

Hysteroscopic removal may be a meaningful fertility intervention.

Patient Three

Age 35, preparing for IUI with a polyp.

Current evidence supports considering polypectomy before IUI.

Patient Four

Age 38, preparing for IVF with repeated implantation failure.

Optimizing the uterine cavity before another embryo transfer becomes particularly important.

Patient Five

Age 63 with postmenopausal bleeding and a polyp.

This is no longer primarily a fertility problem.

Histological assessment for precancerous or malignant disease becomes a priority.

These five patients cannot responsibly receive the same treatment.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At **Saira Health Care**, our objective in infertility care is not simply to identify one abnormality and declare it “the cause.”

We aim to understand the reproductive system as a whole.

A woman with an endometrial polyp may also have:

- PCOS,
- tubal blockage,
- diminished ovarian reserve,
- endometriosis,



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- adenomyosis,
- thyroid disease,
- recurrent miscarriage,
- sexual-health difficulties.

Her male partner may simultaneously have:

- oligospermia,
- poor sperm motility,
- varicocele,
- azoospermia.

Identifying and coordinating these factors prevents the couple from spending months treating only one small part of the problem.

What Patients Should Avoid

I advise patients to avoid several common mistakes.

Do not assume every polyp causes infertility.

Do not assume a tiny polyp must always be operated upon urgently.

Do not assume IVF makes the uterine cavity irrelevant.

Do not undergo blind D&C for treatment of a polyp when hysteroscopic removal is available.

Do not ignore postmenopausal bleeding.

Do not rely for months on an unproven remedy for a clinically significant intracavitary lesion when age or ovarian reserve makes time important.

And do not accept guaranteed pregnancy claims after polypectomy.

Frequently Asked Questions

What is an endometrial polyp?

An endometrial polyp is a localized overgrowth of the uterine lining containing glands, stromal tissue and blood vessels that projects into the uterine cavity.



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Is an endometrial polyp a tumour?

It is a growth, but most endometrial polyps are **benign**.

Only a small proportion contain premalignant or malignant tissue, with risk increasing particularly in older and postmenopausal women.

Is it cancer?

Usually not.

Cancer risk is low in young reproductive-aged women and substantially higher in:

- postmenopausal women,
 - older women,
 - women with abnormal bleeding.
-

Can an endometrial polyp cause infertility?

Yes, it may contribute by:

- physically interfering with implantation,
- affecting sperm transport,
- altering inflammatory signalling,
- disrupting endometrial receptivity.

However, not every woman with a polyp is infertile.

Can a small polyp prevent pregnancy?

Possibly, but not always.

Small polyps can sometimes regress spontaneously, and the evidence does not establish one universal size threshold requiring removal.

Management should consider:

- size,
- location,
- symptoms,
- reproductive history,



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- treatment plan.

Can a woman with an endometrial polyp become pregnant naturally?

Yes.

Many women with small or asymptomatic polyps conceive naturally.

A polyp reduces fertility probability in some women; it does not function as absolute contraception.

Can polyps cause miscarriage?

They may contribute in selected women by disturbing the implantation environment.

For recurrent pregnancy loss, polypectomy is commonly considered when a polyp is present.

Can polyps cause IVF failure?

They may.

A polyp can interfere with the endometrial environment required for embryo implantation.

This is particularly relevant in women with previous implantation failure.

Should a polyp be removed before IUI?

Current fertility guidance states that polypectomy **can be considered before ovulation induction/IUI** because available evidence suggests improved clinical pregnancy rates.

Should a polyp be removed before IVF?

Often it is considered, especially when the lesion is clearly documented before the IVF cycle, symptomatic or associated with previous poor reproductive outcome.

However, evidence is not strong enough to say every very small asymptomatic polyp must always be removed before every IVF cycle.

What if a polyp is discovered after IVF injections have already started?



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The new 2026 British Fertility Society guideline recommends individualized treatment.

For a polyp larger than approximately 20 mm, embryo freezing followed by polypectomy and later transfer can be considered.

For lesions below 20 mm, either proceeding or removing the polyp after freezing embryos may be reasonable depending upon the patient's risk factors and reproductive history.

Is there a definite size at which every polyp must be removed?

No.

There is no universally established size threshold.

Can a 5-mm polyp disappear naturally?

Yes, some small polyps can regress spontaneously.

Regression is particularly reported with polyps below approximately 10 mm.

What is the best first test?

Transvaginal ultrasound is generally the first-line investigation.

Can ordinary ultrasound miss a polyp?

Yes.

Saline infusion sonography is more sensitive when the diagnosis remains uncertain.

What is SIS?

SIS means:

Saline Infusion Sonography or **Sonohysterography**.

Sterile saline is introduced into the uterine cavity during ultrasound so that polyps become easier to see.

What is the gold-standard test?



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Hysteroscopy with directed assessment/biopsy remains the diagnostic gold standard.

What is hysteroscopic polypectomy?

It is removal of an endometrial polyp under direct visualization using a hysteroscope.

Is D&C a good way to remove a polyp?

Blind D&C is not recommended when hysteroscopic removal is available because it may:

- miss the polyp,
 - incompletely remove it,
 - unnecessarily injure healthy endometrium.
-

Does polypectomy require general anesthesia?

Not always.

Many suitable polyps can be removed through office hysteroscopy without general anesthesia.

Is hysteroscopic polypectomy safe?

It is generally a low-risk procedure when appropriately performed.

Potential complications include:

- bleeding,
 - infection,
 - perforation,
 - fluid complications,
 - rare intrauterine adhesions.
-

Should removed polyps be sent to the laboratory?

Yes.



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The latest fertility guidance recommends histopathological examination of excised polyps.

Can a polyp grow back after removal?

Yes.

Recurrence is possible.

Future symptoms or fertility difficulties may justify repeat uterine assessment.

Can endometrial polyps cause heavy periods?

Yes.

They may cause:

- heavy bleeding,
 - prolonged bleeding,
 - intermenstrual spotting.
-

Can they cause pain?

Polyps generally cause bleeding more commonly than pain.

Pelvic pain should therefore prompt evaluation for other conditions such as:

- endometriosis,
 - adenomyosis,
 - fibroids,
 - infection.
-

Can PCOS cause polyps?

PCOS and polyps can coexist.

Chronic anovulation can create prolonged estrogen stimulation of the endometrium, which may contribute to endometrial overgrowth.

But PCOS does not automatically mean polyps are present.



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Does obesity increase polyp risk?

Evidence suggests obesity is associated with endometrial-polyp development and may also increase concern for abnormal endometrial pathology.

Does tamoxifen cause polyps?

Tamoxifen is strongly associated with endometrial changes, including increased polyp formation.

Patients should not stop tamoxifen without oncology advice.

Can medicine dissolve a polyp?

Hormonal treatment can sometimes influence bleeding and endometrial growth, and very small polyps may regress spontaneously.

However, medication cannot provide the same certainty as hysteroscopic removal and histopathological examination.

Can Unani medicine treat endometrial polyps?

Unani medicine may be useful as **supportive integrative care** for the woman's wider reproductive health, including:

- nutrition,
- menstrual health,
- metabolism,
- digestion,
- lifestyle,
- associated sexual-health concerns.

However, there is currently insufficient high-quality evidence that Unani medicine alone reliably removes hysteroscopically confirmed endometrial polyps.

Can Unani medicine replace hysteroscopy?

Not when a clinically significant structural polyp requires:

- direct evaluation,



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- removal,
- histopathology.

Hysteroscopy and Unani supportive treatment serve different purposes.

What is the Unani term for uterine polyps?

CCRUM's standard terminology lists **Bawāsir al-Raḥim** with “uterine polyps” as a possible English equivalent.

However, traditional terminology and the modern hysteroscopic/histopathological diagnosis should not be assumed to be exactly identical.

How quickly can we try for pregnancy after polypectomy?

Timing is individualized.

In uncomplicated cases, prolonged delay is generally unnecessary.

For fertility treatment, current evidence permits relatively prompt resumption once recovery and pathology are satisfactory.

The 2026 British Fertility Society guideline recommends frozen embryo transfer within approximately four months following polypectomy.

Does removing a polyp guarantee pregnancy?

No.

Polypectomy removes one potential fertility barrier.

Pregnancy still depends upon:

- female age,
- ovarian reserve,
- egg quality,
- fallopian tubes,
- sperm quality,
- embryo quality,
- other uterine factors.



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A Message From Dr. Nizamuddin Qasmi

When a patient comes to me with an ultrasound report saying:

“Endometrial polyp — 8 mm,”

I do not tell her immediately:

“This is why you are not pregnant.”

And I do not immediately say:

“This is too small to matter.”

I ask:

How long have you been trying?

Are you bleeding between periods?

Where exactly is the polyp located?

Is it definitely a polyp or only suspected on routine ultrasound?

Have there been miscarriages?

Has IVF failed previously?

How old are you?

How is your ovarian reserve?

Are your fallopian tubes open?

What does your husband's semen analysis show?

Only then does that 8-mm finding become meaningful.

What I Tell Patients Preparing for IUI

If a genuine intracavitary polyp is present before IUI, the evidence for removal is reasonably supportive.

Therefore, hysteroscopic polypectomy deserves serious consideration before proceeding.

But fertility treatment is still couple-based.

We should also know:

- is ovulation occurring?



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- is at least one fallopian tube open?
- is the male sperm count suitable for IUI?

Removing the polyp cannot correct unrelated fertility problems.

What I Tell Patients Preparing for IVF

The decision is more individualized.

A significant polyp identified before IVF is often removed.

A very small polyp discovered midway through ovarian stimulation creates a different decision.

We need to balance:

- lesion size,
- endometrial appearance,
- age,
- embryo number,
- history of implantation failure,
- cost and burden of cancelling a transfer.

The newest fertility guidance recognizes this complexity rather than applying one rule to everyone.

What I Tell Patients About Cancer Fear

Most reproductive-aged women with endometrial polyps do **not** have cancer.

I do not want a young fertility patient to become frightened simply because she reads online that polyps can sometimes contain malignant cells.

Risk rises particularly with:

- menopause,
- increasing age,
- abnormal bleeding,
- selected other risk factors.

When a polyp is removed, histopathology provides the definitive tissue diagnosis.



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My Integrative Clinical Philosophy

For me, the best approach is:

Detect accurately → decide whether the polyp is clinically important → remove it hysteroscopically when indicated → obtain histopathology → assess the complete fertility picture → support reproductive health → move toward natural conception, IUI or IVF according to the couple's needs.

Unani medicine can fit responsibly into this pathway.

It should not compete with structural diagnosis.

It should complement the woman's overall reproductive care.

Latest Medical Understanding — 2026 Update

Several recent developments are particularly important for patients and fertility professionals.

1. Fertility-specific guidance is now more detailed

The new **2026 British Fertility Society guideline** gives separate recommendations for:

- natural conception,
- IUI,
- IVF,
- polyps discovered during ovarian stimulation.

This represents an important improvement because not every fertility patient should be managed identically.

2. Polypectomy before IUI has the clearest fertility evidence

Available randomized evidence supports improved clinical pregnancy rates following polyp removal before IUI, although the underlying trial has important methodological limitations.

3. IVF decisions should be individualized

For IVF, evidence remains less certain.

Current guidance considers:

- size,
- location,
- previous reproductive outcomes,
- stage of ovarian stimulation,
- embryo availability.

4. Very small asymptomatic polyps do not always require immediate surgery

Some may regress spontaneously, particularly lesions below approximately 10 mm.

Careful observation can therefore be reasonable in selected young low-risk patients.

5. Hysteroscopy remains the definitive diagnostic and therapeutic approach

The 2024 SOGC guideline continues to identify:

hysteroscopy with guided biopsy as the diagnostic gold standard

and recommends against blind D&C for diagnosis.

6. Fertility-preserving removal is increasingly emphasized

The 2026 British Fertility Society guideline recommends techniques minimizing thermal damage to surrounding endometrium and favours mechanical hysteroscopic removal where appropriate.

7. Research increasingly supports a biological effect on endometrial receptivity

The newest research goes beyond the old explanation that polyps simply “occupy space.”

Current evidence implicates:

- HOXA10/HOXA11 dysregulation,
- inflammatory signalling,
- altered implantation proteins,
- impaired decidualization.



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This is helping explain how polyps can influence fertility even when they are relatively small.

Conclusion

Endometrial Polyps are common, usually benign localized growths of the uterine lining that project into the uterine cavity.

They may cause:

- no symptoms at all,
- spotting between periods,
- heavy or irregular bleeding,
- infertility,
- recurrent miscarriage,
- implantation problems.

The relationship between polyps and fertility is complex.

A polyp may interfere with reproduction through:

- mechanical distortion of the uterine cavity,
- interference with sperm transport,
- interference with embryo implantation,
- localized inflammation,
- altered endometrial receptivity,
- disturbance of HOXA10/HOXA11 and other implantation-related pathways.

Diagnosis usually begins with:

Transvaginal Ultrasound

When the diagnosis is uncertain, **saline infusion sonography** can provide greater diagnostic accuracy.

Hysteroscopy remains the gold-standard diagnostic method

because it provides direct visualization and allows targeted removal and tissue examination.

When treatment is required:

Hysteroscopic Polypectomy is the preferred approach.

Blind D&C should not be used as routine treatment when hysteroscopic removal is available.

For women trying naturally, polypectomy may improve pregnancy outcomes in selected cases, although randomized evidence remains limited.

For women undergoing **IUI**, evidence supporting polypectomy is stronger.

For women preparing for **IVF**, management should be individualized according to:

- polyp size,
- location,
- reproductive history,
- previous implantation failure,
- age,
- treatment stage.

The new **2026 British Fertility Society guideline** provides the most detailed current fertility-specific recommendations, including individualized approaches for polyps discovered during ovarian stimulation.

Most polyps in reproductive-aged women are benign.

Cancer risk becomes more important particularly with:

- increasing age,
- menopause,
- postmenopausal bleeding,
- abnormal uterine bleeding,
- other endometrial risk factors.

All surgically removed polyps should therefore undergo proper histopathological assessment.

From the **Unani perspective**, female fertility should be viewed through the woman's overall reproductive health, including:

- Mizaj,
- nutrition,
- digestion,



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- metabolic health,
- menstrual wellbeing,
- sleep,
- physical activity,
- psychological and sexual wellbeing.

These can be valuable areas for individualized supportive treatment.

However:

a documented endometrial polyp is a structural intrauterine lesion.

There is currently insufficient high-quality evidence that an Unani or herbal medicine can reliably eliminate such a lesion or replace hysteroscopic polypectomy when removal is clinically indicated.

At **Saira Health Care**, my approach is therefore integrative and diagnosis-led:

confirm whether a true polyp is present, assess whether it is relevant to fertility, evaluate the woman and her partner completely, use hysteroscopic treatment where appropriate, obtain histopathology, optimize ovulation and overall reproductive health, and integrate individualized Unani supportive care where it can complement—rather than delay—evidence-based fertility treatment.

The most important message I give patients is:

Do not judge the importance of an endometrial polyp from its size alone.

A 7-mm polyp may be insignificant in one woman and clinically relevant in another.

Age, symptoms, location, fertility history, previous miscarriage or IVF failure, ovarian reserve and male-factor fertility all need to be considered together.

That is the difference between simply treating an ultrasound report and treating the patient.

About the Author

Dr. Nizamuddin Qasmi

**Founder & Chief Physician, Saira Health Care
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Qualifications & Professional Training



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Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health (ISRH) — UNFPA

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** focuses on sexual disorders, male and female reproductive health, and infertility.

His approach to endometrial polyps emphasizes identifying whether the lesion is truly contributing to the couple's infertility rather than attributing every fertility problem to one ultrasound finding.

Depending upon the patient, assessment may include:

- menstrual and reproductive history,
- pelvic and transvaginal ultrasound,
- saline sonography or hysteroscopy where indicated,
- evaluation of ovulation and ovarian reserve,
- assessment of fallopian-tube status,
- evaluation of the male partner,
- coordination with hysteroscopic and reproductive-medicine specialists.

Where clinically appropriate, individualized principles of Unani medicine may be incorporated to support the patient's broader reproductive, menstrual, metabolic, nutritional and sexual wellbeing.

Medical Disclaimer

This article is intended for health education and public awareness and does not establish an individual diagnosis.

A suspected endometrial polyp should be evaluated according to the woman's:

- age,
- symptoms,
- reproductive goals,
- ultrasound findings,



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- malignancy risk.

Women with:

- postmenopausal bleeding,
- persistent abnormal uterine bleeding,
- suspicious endometrial imaging,
- recurrent miscarriage,
- recurrent implantation failure,
- persistent infertility

should receive appropriate gynecological or fertility assessment.

Hysteroscopy with targeted evaluation remains the definitive diagnostic approach for endometrial polyps, and hysteroscopic polypectomy is the preferred technique when removal is clinically indicated.

Blind D&C should not be used as routine treatment for a suspected polyp when hysteroscopic management is available.

No herbal, Unani, hormonal or nutritional treatment should be assumed to eliminate a structural endometrial polyp without objective follow-up.

Women should not delay indicated hysteroscopic assessment or fertility treatment while relying solely on unproven remedies.

Pregnancy, IVF and other fertility-treatment decisions should always consider the reproductive status of **both partners**, not the endometrial polyp alone.

