

Fertility After Cancer Treatment

Understanding Fertility After Chemotherapy, Radiotherapy, Cancer Surgery, Hormonal Therapy and Stem-Cell Transplantation — Natural Conception, IVF, Fertility Preservation and an Integrative Unani Approach

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

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

A Message I Give Cancer Survivors Who Want Children

When a cancer survivor comes to me and asks:

“Doctor, can I still become a parent after chemotherapy or radiotherapy?”

I never answer that question from the word:

cancer

alone.

And I never assume that cancer treatment automatically means permanent infertility.

Some people recover reproductive function almost completely.

Some have reduced fertility but can still conceive naturally.

Some may need:

- IUI,
- IVF,
- ICSI,
- previously frozen sperm,
- frozen eggs,
- frozen embryos,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- ovarian tissue,
- donor eggs or sperm.

Others may have treatment-related damage that makes carrying a pregnancy difficult even when eggs or embryos are available.

Therefore, the correct question is not:

“Does cancer treatment cause infertility?”

The better question is:

“What cancer treatment did you receive, how old were you when you received it, which reproductive organs were exposed, and how much reproductive function remains now?”

Modern cancer survival has improved enormously, and fertility has consequently become an increasingly important part of survivorship care.

The **2025 American Society of Clinical Oncology—ASCO—guideline update** states that reproductive risks should be discussed not only at cancer diagnosis but also during survivorship. Patients interested in fertility—or uncertain about their future family-building goals—should be offered access to reproductive specialists.

That is a major and welcome change in modern cancer care.

A patient's cancer may have been successfully treated.

But questions about:

- future children,
- sexual function,
- menstruation,
- sperm production,
- premature menopause

may remain for many years.

What Does “Fertility After Cancer Treatment” Mean?

Fertility after cancer treatment refers to a person's ability to achieve a biological pregnancy after:

- chemotherapy,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- radiotherapy,
- cancer surgery,
- hormonal or endocrine therapy,
- targeted treatments,
- immunotherapy,
- stem-cell or bone-marrow transplantation.

Treatment can affect fertility by damaging:

- ovaries,
- eggs,
- testes,
- sperm-producing cells,
- uterus,
- fallopian tubes,
- reproductive hormones,
- nerves controlling ejaculation,
- organs required for sexual function.

The effect can be:

temporary,

partially reversible,

or:

permanent.

The National Cancer Institute emphasizes that reproductive outcomes depend on several factors, including the type and dose of treatment, treatment duration, age at treatment, the cancer itself, baseline fertility and the amount of time that has passed since treatment.

Therefore, two people who both say:

“I had chemotherapy”

may have completely different fertility prospects.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Cancer Itself Can Sometimes Affect Fertility

Another important point is that fertility may already be reduced **before treatment begins**.

For example, some men with:

- testicular cancer,
- Hodgkin lymphoma,
- other germ-cell cancers

have reduced sperm counts at diagnosis.

The National Cancer Institute specifically notes that some men with testicular cancer, prostate cancer, germ-cell cancers and Hodgkin lymphoma may already show poor semen quality before cancer therapy starts.

Likewise, illness itself may temporarily affect:

- menstrual cycles,
- weight,
- nutrition,
- hormone function,
- sexual activity.

Therefore, post-cancer infertility should not always be attributed entirely to chemotherapy.

Female Fertility After Cancer Treatment

Female fertility depends upon several reproductive systems working together:

- ovaries must contain functioning follicles,
- eggs must mature and ovulate,
- fallopian tubes must function when natural conception is attempted,
- the uterus must be capable of supporting implantation and pregnancy,
- reproductive hormones must function appropriately.

Cancer treatment can affect one or several of these areas.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Chemotherapy and Female Fertility

Chemotherapy destroys rapidly growing cancer cells.

Unfortunately, some chemotherapy medicines can also damage healthy ovarian follicles.

This is called:

Gonadotoxicity.

Some agents are substantially more toxic to ovarian follicles than others.

The National Cancer Institute identifies **alkylating chemotherapy agents** as particularly harmful to ovarian follicles and notes that risk rises with greater cumulative exposure and combinations of multiple chemotherapy drugs.

Cancer treatment can therefore lead to:

- reduced ovarian reserve,
- irregular ovulation,
- temporary amenorrhea,
- premature ovarian insufficiency,
- early menopause,
- infertility.

Chemotherapy Does Not Affect Every Woman Equally

Suppose two women receive similar chemotherapy.

Woman A

Age 22 at treatment.

Woman B

Age 39 at treatment.

Their reproductive outcomes may be very different.

The younger woman begins treatment with a much larger ovarian follicle reserve.

The older woman begins with fewer remaining follicles.

Therefore, the same additional ovarian injury may have a much greater reproductive impact at an older age.

This is why fertility-risk counselling must always consider:

age at the time of treatment.

Alkylating Chemotherapy

Alkylating agents deserve particular attention because they can damage the ovarian follicle pool.

Examples within this broad class include drugs such as:

- cyclophosphamide,
- ifosfamide,
- busulfan,
- melphalan.

The exact risk depends upon:

- cumulative dose,
- combination regimen,
- patient age,
- ovarian reserve before therapy.

One patient's regimen should never be interpreted from the name of one medicine alone.

Does the Return of Periods Mean Fertility Is Normal?

No.

This is one of the most important messages I give female cancer survivors.

A woman may finish chemotherapy and her periods return.

She may naturally think:

“My fertility has completely recovered.”

That may not be true.

Periods tell us that ovarian activity has resumed.

They do not tell us exactly:

- how many follicles remain,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- how long ovarian function will continue,
- whether menopause may occur earlier than expected.

Cancer survivors may experience a **shortened reproductive window**, even when menstrual cycles initially return. ASCO's current survivorship guidance specifically recommends post-treatment reproductive assessment because some women remain at increased risk of later infertility or premature ovarian insufficiency.

Premature Ovarian Insufficiency After Cancer Treatment

Cancer therapy may cause:

Premature Ovarian Insufficiency — POI.

POI means loss or marked impairment of normal ovarian function before age 40.

Possible signs include:

- irregular periods,
- absent periods,
- hot flushes,
- night sweats,
- vaginal dryness,
- infertility.

But ovarian activity in POI can sometimes be intermittent.

Therefore, occasional menstruation does not necessarily mean fertility has completely returned.

How Do I Assess Ovarian Function After Cancer Treatment?

Depending upon the patient, evaluation may include:

- menstrual history,
- age,
- treatment history,
- AMH,
- antral follicle count,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- FSH,
- estradiol,
- pelvic ultrasound.

No single test answers every fertility question.

AMH After Cancer Treatment

AMH means:

Anti-Müllerian Hormone.

It reflects the population of small recruitable ovarian follicles and can help estimate ovarian reserve.

ASCO's 2025 update specifically recognizes AMH and antral follicle count as useful when assessing residual ovarian reserve in survivors who may be considering post-treatment egg or embryo freezing.

But AMH should still be interpreted carefully.

It does not directly measure:

- egg chromosome quality,
- guaranteed natural conception,
- guaranteed IVF success.

Female age remains extremely important.

Ovarian Recovery Can Continue After Chemotherapy

Ovarian function immediately after chemotherapy may not necessarily represent the final long-term condition.

The 2026 ASRM fertility-preservation guidance notes that, in women with residual ovarian function, AMH can recover for a period after chemotherapy before eventually reaching a plateau.

Therefore, timing of ovarian-reserve assessment matters.

However, this does **not** mean every woman's ovarian reserve will recover.

Some treatments cause permanent ovarian failure.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Radiotherapy and Female Fertility

Radiotherapy can affect fertility depending upon:

- radiation dose,
- area treated,
- age,
- radiation technique.

Radiation involving:

- ovaries,
- uterus,
- pelvis,
- central nervous system

can influence reproductive function.

The National Cancer Institute notes that pelvic radiation may damage ovarian follicles and can also affect the uterus through vascular injury or scarring. Radiation to the brain may impair hypothalamic or pituitary signals needed for ovulation.

Therefore, normal ovarian function does not always guarantee normal pregnancy potential after pelvic radiation.

The uterus also matters.

Uterine Damage After Pelvic Radiation

Radiation affecting the uterus may alter:

- uterine blood supply,
- tissue elasticity,
- endometrial function,
- uterine growth during pregnancy.

Depending upon:

- dose,
- age at exposure,
- radiation field,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

future pregnancy may carry increased risks.

A cancer survivor with substantial prior pelvic or uterine radiation may therefore require assessment by:

- reproductive medicine,
- maternal-fetal medicine,
- oncology

before pregnancy is attempted.

In some circumstances, a gestational carrier may eventually need to be discussed if carrying a pregnancy is considered medically unsafe.

Radiation to the Brain and Fertility

Fertility is controlled not only by reproductive organs but also by the:

hypothalamic-pituitary-gonadal axis.

Radiation to parts of the brain may damage:

- hypothalamus,
- pituitary gland.

This can disturb hormone signals controlling:

- ovulation,
- estrogen,
- progesterone.

Therefore, a woman may have functioning ovaries but inadequate hormonal stimulation from the brain.

This is a very different reproductive problem from direct ovarian failure.

Stem-Cell or Bone-Marrow Transplantation

Hematopoietic stem-cell transplantation often involves:

- high-dose chemotherapy,
- sometimes total-body or other radiation.

These conditioning treatments can be highly gonadotoxic.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

The National Cancer Institute notes that conditioning for stem-cell transplantation can cause:

- primary ovarian insufficiency,
- infertility

in women.

ASRM therefore considers patients preparing for highly gonadotoxic therapy especially important candidates for timely fertility-preservation counselling.

Cancer Surgery and Female Fertility

The effect of surgery depends completely upon:

- cancer location,
- operation performed.

For example:

Removal of one ovary

Fertility may remain possible through the other functioning ovary.

Removal of both ovaries

The woman can no longer produce her own eggs.

Hysterectomy

The uterus is removed, so the woman cannot personally carry a pregnancy.

Pelvic surgery

Scar tissue or changes to reproductive anatomy may interfere with:

- tubes,
- uterus,
- ovaries.

The National Cancer Institute notes that gynecologic and pelvic cancer operations can affect fertility through removal of reproductive organs or postoperative adhesions.

Fertility-Sparing Cancer Surgery

Some carefully selected patients with certain:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- cervical cancers,
- endometrial cancers,
- ovarian cancers

may qualify for fertility-sparing approaches.

However:

cancer control comes first.

ASCO's 2025 guideline supports fertility-sparing surgery in selected gynecological malignancies when oncologically appropriate, with decisions made through multidisciplinary care.

Fertility preservation must never compromise necessary cancer treatment.

Hormonal Therapy and Female Fertility

Some hormone-sensitive cancers—particularly certain breast cancers—require prolonged endocrine treatment.

These medicines may:

- suppress ovarian function,
- prevent pregnancy while being taken,
- delay attempts at conception for several years.

This can create a different problem:

the medicine may not permanently destroy the ovaries, but the passage of reproductive time while treatment continues can reduce fertility.

Pregnancy During Long-Term Breast Cancer Endocrine Therapy

The NCI notes that early results from the **POSITIVE trial** found that selected women with hormone-sensitive early breast cancer could temporarily interrupt endocrine treatment to attempt pregnancy without an apparent increase in short-term recurrence risk.

This should **never** be interpreted as:

“stop breast-cancer medication when you want pregnancy.”

Treatment interruption is appropriate only for carefully selected patients under:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- oncology supervision,
- reproductive-specialist care.

Longer-term follow-up remains important.

Targeted Therapy and Female Fertility

Modern oncology increasingly uses:

- tyrosine-kinase inhibitors,
- monoclonal antibodies,
- antibody-drug conjugates,
- other targeted treatments.

Unfortunately, reproductive information for many newer medicines remains incomplete.

The NCI notes that some targeted therapies may affect fertility or endocrine organs, while evidence remains limited for many drugs.

Therefore, survivors should not assume:

“It wasn't chemotherapy, so fertility cannot be affected.”

The exact medicine matters.

Immunotherapy and Female Fertility

Immune checkpoint inhibitors and other immunotherapies have transformed cancer treatment.

But long-term reproductive effects remain incompletely understood.

The NCI currently states that the effects of immunotherapy on fertility and pregnancy are still being studied.

This uncertainty is itself a reason for fertility counselling before treatment where possible.

Male Fertility After Cancer Treatment

Cancer treatment can also have major effects on male fertility.

Potential problems include:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- reduced sperm concentration,
- poor sperm motility,
- abnormal morphology,
- azoospermia,
- hormonal failure,
- erectile dysfunction,
- retrograde ejaculation,
- failure of ejaculation.

Some problems affect:

sperm production.

Others affect:

sperm delivery.

These are completely different conditions.

Chemotherapy and Male Fertility

Sperm arise from rapidly dividing germ cells inside the testes.

Chemotherapy can damage:

- developing sperm,
- spermatogonial stem cells,
- testicular support cells.

The NCI identifies alkylating agents as particularly damaging and notes greater infertility risk with higher doses and multidrug chemotherapy.

ASCO's updated guideline also identifies alkylating and platinum-based treatments among important threats to spermatogenesis.

Temporary Versus Permanent Azoospermia

After chemotherapy, sperm production may stop.

This is called:

Azoospermia



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

when no sperm are found in the semen.

In some men, spermatogonial stem cells survive and sperm production gradually recovers.

In others, damage is severe enough that azoospermia becomes long-lasting or permanent.

Therefore, a semen analysis obtained soon after chemotherapy may not tell us the man's ultimate long-term fertility.

How Long Can Sperm Recovery Take?

Recovery depends upon:

- chemotherapy type,
- dose,
- radiation exposure,
- surviving testicular stem cells.

AUA/ASRM male infertility guidance notes that sperm counts are often lowest during the first year after gonadotoxic therapy and, in many treatment groups where recovery occurs, improvement is most apparent over approximately the next two to three years.

This does not mean every man should wait three years before consulting a fertility specialist.

It means the reproductive system may continue recovering for a prolonged period.

When Should Semen Analysis Be Performed?

For formal assessment of recovery after highly gonadotoxic therapy, AUA/ASRM guidance states that semen analysis performed at least **12 months after treatment**, and preferably later in some cases, may provide more meaningful information about recovery.

However, earlier semen testing may still be performed when immediate reproductive decisions are necessary.

The timing should be individualized.

Radiation and Male Fertility



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

The testes are highly sensitive to radiation.

Radiation can damage:

- sperm-producing germ cells,
- testicular endocrine function.

Recovery depends strongly upon dose.

Radiation can also affect male fertility indirectly.

The NCI notes that pelvic radiotherapy can injure:

- nerves,
- blood vessels,
- reproductive structures,

contributing to erectile dysfunction or problems with ejaculation. Brain radiation can affect pituitary and hypothalamic hormones required for fertility.

Stem-Cell Transplant and Male Fertility

High-dose chemotherapy and radiation used before hematopoietic stem-cell transplantation can severely impair:

- sperm,
- sperm-producing cells.

The NCI identifies stem-cell-transplant conditioning as an important infertility risk in men as well as women.

This is why sperm banking before such treatment is particularly important whenever feasible.

Surgery and Male Fertility

Cancer surgery may affect fertility by removing organs or disrupting:

- ejaculation,
- erection,
- semen production.

Examples include:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- bilateral orchiectomy,
- radical prostatectomy,
- radical cystectomy,
- pelvic or retroperitoneal surgery.

The NCI notes that prostate, bladder, testicular, colorectal and other pelvic operations can affect semen production, ejaculation or erectile function.

Dry Orgasm Does Not Always Mean No Sperm Production

Some men after pelvic surgery can still:

- produce sperm

but cannot ejaculate semen normally.

Possible causes include:

- retrograde ejaculation,
- failure of emission.

Therefore, infertility may result from a **delivery problem**, not necessarily loss of testicular sperm production.

Depending upon the cause, sperm can sometimes be obtained from:

- post-ejaculatory urine,
- epididymis,
- testes

for assisted reproduction.

Hormonal Cancer Treatment and Male Fertility

Treatments that suppress:

- testosterone,
- androgen activity

can reduce sperm production.

The NCI notes that endocrine cancer therapy can reduce sperm count.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

If future fertility is important, men should not assume that fertility will remain unaffected simply because treatment is hormonal rather than cytotoxic chemotherapy.

Immunotherapy and Male Fertility

Evidence remains limited.

The NCI states that reproductive effects of immunotherapy are still being studied.

ASCO likewise acknowledges limited fertility information for several newer:

- immune,
- targeted,
- antibody-based treatments.

Fertility preservation should therefore be considered before treatment when future biological parenthood matters and reproductive risk is uncertain.

Fertility Preservation Before Cancer Treatment

Although this article focuses on fertility **after** cancer treatment, one of the most important messages is:

fertility preservation works best when discussed before gonadotoxic treatment begins.

The 2025 ASCO guideline strongly recommends discussing reproductive risks as early as possible and referring interested or uncertain patients to fertility specialists before therapy.

However, patients who were never counselled beforehand should not feel that every option has disappeared.

Modern ASCO guidance specifically includes:

post-treatment fertility preservation.

Sperm Freezing Before Cancer Treatment

For pubertal and adult males:

Sperm Cryopreservation

is the established first-line fertility-preservation method.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

ASCO recommends offering sperm banking before cancer-directed therapy. When ejaculation is not possible, testicular sperm extraction may be considered before treatment.

Even a limited frozen sperm sample can later be useful because ICSI requires only a small number of sperm.

Why Sperm Is Preferably Frozen Before Treatment

Chemotherapy and radiation can temporarily increase genetic damage within developing sperm.

ASCO therefore recommends collecting sperm **before treatment whenever possible**, rather than soon after treatment has already begun.

This does not mean that men who missed pretreatment banking have no future options.

It simply means pretreatment banking is preferable.

Egg Freezing

For appropriate female patients:

Mature Oocyte Cryopreservation

is an established fertility-preservation method.

The ovaries are stimulated.

Mature eggs are retrieved and frozen.

ASRM's 2026 guidance identifies mature oocyte cryopreservation as an established option for postpubertal females.

Future success depends particularly upon:

- age when eggs were frozen,
 - number of eggs obtained.
-

Embryo Freezing

Embryo cryopreservation is another established option.

Eggs are:

- retrieved,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- fertilized with partner or donor sperm,
- embryos are frozen.

ASCO and ASRM both recognize embryo cryopreservation as an established fertility-preservation method.

Whether a patient chooses:

- eggs,
- embryos,
- both

depends upon individual circumstances and preferences.

Random-Start Ovarian Stimulation

Cancer treatment often cannot wait for the next menstrual period.

Modern fertility-preservation protocols can frequently begin ovarian stimulation:

at different points in the menstrual cycle.

ASRM notes that immediate or “random-start” ovarian stimulation can often be performed with negligible treatment delay compared with conventional cycle timing.

Therefore, referral should happen urgently rather than assuming there is no time.

Ovarian Tissue Cryopreservation

This has become an important advance.

Ovarian Tissue Cryopreservation — OTC

involves surgically removing and freezing ovarian cortical tissue containing many follicles.

The tissue can potentially be transplanted back after cancer treatment.

Importantly:

OTC is no longer considered experimental for appropriately selected female patients.

Both the 2025 ASCO update and 2026 ASRM guidance recognize it as an established fertility-preservation method.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Who May Particularly Benefit From Ovarian Tissue Freezing?

It may be valuable when:

- treatment is highly gonadotoxic,
- there is insufficient time for ovarian stimulation,
- the patient is prepubertal.

It does not require mature eggs to be retrieved before freezing.

However, later transplantation requires careful cancer-specific assessment because some malignancies may theoretically contaminate ovarian tissue.

Prepubertal Girls

Egg freezing is generally not available before reproductive maturation.

Ovarian tissue cryopreservation is currently the principal established option for preserving ovarian follicles in prepubertal girls facing high-risk gonadotoxic therapy.

Prepubertal Boys

The situation is different for boys who have not yet begun producing mature sperm.

Testicular tissue cryopreservation remains:

experimental.

ASCO recommends that it be performed only within appropriate clinical trials or experimental protocols.

Parents should be counselled clearly about this distinction.

GnRH Agonists During Chemotherapy

Some women receive medications called:

GnRH agonists

during chemotherapy in an attempt to reduce ovarian damage.

Current evidence is nuanced.

ASCO and ASRM agree that GnRH agonists:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

should not replace established fertility-preservation methods such as egg or embryo freezing.

They may be considered as an **adjunct** in selected premenopausal women with breast cancer and can also help with menstrual suppression in particular clinical circumstances.

Therefore, an injection to “protect the ovaries” should never be presented as equivalent to freezing eggs or embryos.

Ovarian Transposition Before Radiation

When pelvic radiation is required, the ovaries can sometimes be surgically repositioned outside the highest-dose radiation field.

This is called:

Ovarian Transposition

or:

Oophoropexy.

ASRM recognizes ovarian transposition as an established fertility-preservation strategy in selected women undergoing pelvic radiation.

It can reduce ovarian exposure but cannot eliminate all radiation exposure.

Fertility Preservation After Cancer Treatment

One of the most important changes in the **2025 ASCO guideline** is formal recognition that fertility preservation may still be relevant:

after treatment.

Post-treatment egg or embryo freezing can be considered in selected women who:

- did not preserve fertility beforehand,
- remain at risk of future ovarian failure,
- froze an insufficient number of eggs or embryos,
- need to delay pregnancy further.

This can be particularly valuable when ovarian function has returned but may not remain normal for many years.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Do Not Rush Post-Treatment Egg Retrieval Without Specialist Advice

Timing matters.

ASRM advises that ovarian stimulation:

- during gonadotoxic therapy,
- immediately after it

is generally not recommended.

Reproductive potential of eggs obtained very close to chemotherapy exposure is uncertain, and recovery of the recruitable ovarian follicle pool may continue after treatment.

There is no one universal waiting interval appropriate for every chemotherapy regimen.

The oncologist and reproductive specialist should decide together.

Can Natural Fertility Return After Cancer Treatment?

Yes.

Some female survivors resume:

- ovulation,
- menstrual cycles.

Some male survivors gradually resume:

- sperm production.

Therefore, natural pregnancy is sometimes possible.

But recovery should not be assumed.

A survivor who wants biological children deserves an objective reproductive assessment rather than relying only upon:

- periods in women,
 - sexual performance in men.
-

Sexual Function Is Not the Same as Fertility

This distinction is particularly important in male cancer survivors.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

A man may have:

- normal erection,
- normal desire,
- normal orgasm

but produce no sperm.

Another may produce sperm normally but have:

- erectile dysfunction,
- retrograde ejaculation,
- dry orgasm.

Similarly, a woman may have:

- regular sexual desire,
- normal intercourse

but severe ovarian insufficiency.

Sexual function and fertility overlap but are not identical.

Female Fertility Assessment After Treatment

Depending upon the survivor, assessment may include:

- treatment records,
- menstrual history,
- AMH,
- AFC,
- FSH and estradiol,
- pelvic ultrasound,
- evaluation of uterus and tubes when indicated,
- oncology clearance regarding pregnancy.

The question should not simply be:

“Are your periods back?”

The question is:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

“What reproductive capacity remains, and how much time may be available?”

Male Fertility Assessment After Treatment

A post-treatment male fertility evaluation may include:

Semen Analysis.

If sperm production is markedly abnormal, additional testing may include:

- FSH,
- LH,
- testosterone,
- reproductive examination.

If no sperm are present, repeat assessment may be appropriate because recovery can occur over time after some treatments.

Persistent azoospermia after sufficient recovery time may lead to consideration of:

- previously banked sperm,
- surgical sperm retrieval,
- donor sperm

depending upon the case.

Micro-TESE After Chemotherapy

Some men remain azoospermic long after cancer therapy.

Sperm may occasionally still be present in small areas of the testes despite absence from the ejaculate.

In selected men:

Microdissection Testicular Sperm Extraction — micro-TESE

may be considered.

AUA/ASRM guidance reports that testicular sperm retrieval has been successful in a proportion of men with persistent post-chemotherapy azoospermia, although success depends heavily upon previous treatment.

Retrieved sperm can potentially be used with:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

ICSI.

This is a specialized reproductive-urology procedure, not a treatment appropriate for every survivor.

When Can a Woman Try for Pregnancy After Cancer Treatment?

There is:

no single waiting period that applies to every cancer survivor.

Timing depends upon:

- cancer type,
- stage,
- recurrence risk,
- treatment received,
- ongoing medication,
- female age,
- ovarian reserve.

Some oncology teams recommend waiting at least several months after chemotherapy to avoid conception with oocytes exposed during recent treatment.

For some cancers, a longer interval may be recommended because recurrence risk is highest during the early years following treatment.

The American Cancer Society notes that some clinicians advise at least six months after chemotherapy, while others recommend longer intervals depending on cancer type and recurrence risk.

Therefore:

pregnancy timing should be decided with the oncology team.

Never Stop Cancer Medication to Become Pregnant Without Oncology Approval

This is particularly important for patients receiving:

- endocrine therapy,
- targeted therapy,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- maintenance therapy.

Some anticancer medicines can seriously harm:

- an embryo,
- fetus.

Others may be needed to reduce recurrence risk.

The decision to interrupt treatment for conception requires specialist guidance.

When Can a Man Try to Father a Pregnancy?

Cancer-directed treatments may temporarily damage developing sperm.

Older AUA/ASRM male-infertility guidance advises avoiding conception for at least **12 months** after chemotherapy or radiation, reflecting concerns about treatment-related germ-cell damage.

However, individual oncology recommendations may differ based on:

- drug,
- radiation,
- treatment duration,
- recovery.

Men should obtain individualized advice rather than using a generic waiting period.

Is Pregnancy After Cancer Generally Safe?

For many cancer survivors:

yes.

Available evidence regarding pregnancies conceived sufficiently after cancer treatment is generally reassuring.

ASRM's current fertility-preservation guidance notes that studies of cancer survivors remote from therapy have not shown a significant overall increase in congenital abnormalities, genetic abnormalities or childhood cancer among resulting offspring.

However, pregnancy safety for the survivor depends upon:

- original cancer,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- prior radiotherapy,
- heart function,
- lung function,
- uterine treatment,
- ongoing recurrence risk.

Therefore, reproductive clearance should be individualized.

Does Pregnancy Cause Cancer to Return?

There is no evidence that pregnancy universally causes previous cancer to recur.

For many survivors, pregnancy is considered oncologically safe after appropriate treatment and recovery.

However, recurrence risk differs dramatically between cancers.

This is why:

the oncologist must be part of the pregnancy-planning team.

For hormone-sensitive breast cancer, decisions can be particularly complex because long-term endocrine treatment may need to be interrupted under specialist supervision.

Pregnancy After Pelvic Radiation Requires Additional Assessment

A woman's ovaries may recover while her uterus has sustained radiation injury.

Therefore, survivors exposed to substantial uterine radiation may require assessment of:

- uterine anatomy,
- obstetric risks,
- cardiovascular health.

A maternal-fetal-medicine consultation can be valuable before pregnancy.

Fertility After Childhood Cancer

Children who survive cancer may not think about fertility until:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- adolescence,
- adulthood.

By then, information about the original treatment may be difficult to remember.

This is why childhood-cancer survivors should ideally retain a treatment summary documenting:

- chemotherapy agents,
- cumulative doses,
- radiation fields,
- surgery.

ASCO's updated guideline explicitly includes fertility counselling for:

- children,
- adolescents,
- adult survivors.

When Natural Conception Is Reasonable

Natural conception may be reasonable when:

- oncology has cleared pregnancy,
- ovulation is occurring,
- ovarian reserve is acceptable for age,
- tubes are functional,
- semen parameters are adequate,
- no other major infertility factor exists.

Cancer survivorship itself does not automatically mean:

IVF is required.

When IUI May Be Considered

Intrauterine insemination may be appropriate in selected survivors when there is:

- mild male-factor infertility,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- ejaculatory difficulty with retrievable sperm,
- otherwise favourable female fertility.

But IUI still requires:

- ovulation,
- at least one functioning tube,
- sufficient motile sperm.

It is not appropriate for every cancer-related infertility problem.

IVF After Cancer Treatment

IVF can be important when there is:

- reduced ovarian reserve,
- tubal disease,
- need to use frozen eggs,
- need to use frozen sperm,
- other infertility factors.

IVF also permits use of:

- previously frozen embryos,
 - donor gametes,
 - PGT when medically indicated.
-

ICSI After Cancer Treatment

ICSI involves injecting a single sperm directly into an egg.

It is particularly valuable when:

- very few frozen sperm are available,
- sperm count is severely reduced,
- sperm are surgically retrieved.

ASCO notes that the availability of ICSI means even limited pretreatment sperm banking can preserve an important future route to biological parenthood.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Hereditary Cancer and PGT-M

Some cancers are associated with inherited gene variants, for example certain:

- BRCA-related cancers,
- hereditary colorectal cancer syndromes,
- other familial cancer syndromes.

When a known pathogenic gene variant is present, some couples may consider:

Preimplantation Genetic Testing for Monogenic Disease — PGT-M.

ASRM recognizes PGT-M as a possible option for people with known mutations predisposing to serious inherited conditions.

Genetic counselling is appropriate before making these decisions.

Donor Eggs

If chemotherapy or radiation has caused permanent ovarian failure and no frozen eggs or embryos are available:

donor-oocyte IVF

may provide another route to pregnancy when the uterus can safely carry a pregnancy.

The egg comes from a donor.

The embryo can then be transferred into the survivor's uterus.

Donor Sperm

When permanent azoospermia exists and:

- no pretreatment sperm was frozen,
- surgical retrieval is unsuccessful,

donor sperm may be discussed.

This is a deeply personal decision and should never be presented as the only possible family-building identity.

Counselling can help couples explore their options.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Gestational Carrier

A gestational carrier may be relevant when:

- the uterus was removed,
- uterine radiation makes pregnancy unsafe,
- another major medical condition makes carrying pregnancy dangerous.

Embryos created from:

- the patient's own previously preserved eggs,
- donor eggs,
- partner sperm,
- donor sperm

may potentially be used depending upon individual circumstances and local law.

Adoption and Other Family-Building Options

Biological parenthood is one important path.

It is not the only path.

Some cancer survivors may choose:

- adoption,
- donor conception,
- gestational carrier,
- living without children.

Modern fertility counselling should provide information without suggesting that any one family-building path defines a successful survivorship outcome.

Cancer-Related Fertility Problems Can Affect Sexual Health

Cancer treatment may also alter sexuality.

In women, treatment may produce:

- vaginal dryness,
- painful intercourse,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- vaginal narrowing after pelvic radiation,
- reduced desire,
- menopausal symptoms.

In men it may produce:

- erectile dysfunction,
- dry orgasm,
- retrograde ejaculation,
- hormonal deficiency,
- reduced libido.

Therefore, fertility care that ignores sexual function is incomplete.

At Saira Health Care, I consider these concerns an important part of post-cancer reproductive assessment.

Emotional Impact of Cancer-Related Infertility

Cancer survivors frequently say:

“I survived cancer, but nobody told me I might lose fertility.”

This can create:

- grief,
- anger,
- guilt,
- anxiety,
- relationship stress.

The 2025 ASCO guideline emphasizes that early fertility discussions can reduce:

- uncertainty,
- distress,
- later regret.

These conversations matter even when the patient ultimately decides not to preserve fertility.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

The Unani Perspective on Fertility After Cancer Treatment

As a physician trained in **Unani medicine** and focused on **Sexual Disorders & Infertility**, I believe a cancer survivor should not be reduced to:

- AMH,
- sperm count,
- one laboratory value.

Cancer treatment affects the whole person.

A patient may be dealing with:

- fatigue,
- digestive disturbance,
- loss of appetite,
- sleep problems,
- weakness,
- anxiety,
- altered sexual function,
- menstrual changes,
- fear of infertility.

Traditional Unani medicine places importance on:

- **Mizaj** or constitutional temperament,
- nutrition,
- digestion,
- sleep,
- physical recovery,
- reproductive health,
- sexual wellbeing,
- psychological balance.

These areas can make Unani medicine useful as part of a carefully coordinated **supportive integrative programme** after cancer treatment.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

How Unani Medicine May Be Useful After Cancer Treatment

Once the oncology team confirms that active cancer therapy and drug interactions have been appropriately considered, individualized Unani care may be used to support selected areas such as:

- nutritional rehabilitation,
- digestive wellbeing,
- healthy sleep,
- general physical recovery,
- menstrual wellbeing,
- sexual health,
- emotional stress associated with infertility.

In men, supportive reproductive care may also focus on:

- general health,
- metabolic wellbeing,
- sexual function.

These are valuable clinical goals.

But Unani Medicine Cannot Be Claimed to Reverse Severe Gonadal Damage

This distinction is essential.

At present there is insufficient high-quality clinical evidence demonstrating that Unani medicine can reliably:

- recreate ovarian follicles destroyed by chemotherapy,
- reverse permanent premature ovarian failure,
- regenerate a severely irradiated ovary,
- restore a removed uterus,
- reconstruct surgically absent reproductive organs,
- regenerate spermatogonial stem cells destroyed by high-dose therapy,
- reverse permanent post-treatment azoospermia.

I do not believe patients should be given such promises.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Supportive reproductive medicine and biological regeneration are not the same thing.

There Is No Established Unani Cure for Chemotherapy-Induced Infertility

Unani medicine has an important history of treating:

- reproductive wellbeing,
- sexual disorders,
- selected infertility complaints.

However, direct high-quality clinical trials specifically showing restoration of fertility after proven chemotherapy- or radiotherapy-induced gonadal failure are currently insufficient.

Therefore, evidence from ordinary infertility patients should not automatically be applied to:

cancer-treatment-induced infertility.

The biology is different.

Herbs During Cancer Treatment Require Special Caution

This is especially important.

A patient receiving chemotherapy, radiotherapy, endocrine treatment, targeted therapy or immunotherapy should not assume:

“Herbal means safe.”

The National Cancer Institute warns that herbs and dietary supplements can change:

- absorption,
- metabolism,
- elimination

of cancer medicines and may alter their effectiveness or toxicity.

Therefore:

every Unani medicine, herb and supplement should be disclosed to the oncology team.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Unani Medicine Must Never Replace Cancer Therapy

No diet, herbal medicine, supplement or Unani formulation should be promoted as a substitute for:

- chemotherapy,
- surgery,
- radiotherapy,
- immunotherapy,
- targeted therapy,
- endocrine therapy

when these are oncologically indicated.

The National Cancer Institute states that there is no evidence that dietary supplements or herbs can cure cancer or prevent its recurrence and warns that some products may interfere with cancer treatment.

At Saira Health Care, cancer treatment always takes priority.

Special Treatment Planning by Dr. Nizamuddin Qasmi

When a cancer survivor consults me regarding fertility, I first reconstruct the entire reproductive history.

I ask:

What cancer did you have?

How old were you when treatment began?

What chemotherapy medicines did you receive?

How many cycles?

Did you receive radiotherapy?

Which body area was irradiated?

Did you have cancer surgery involving reproductive organs?

Did you undergo a stem-cell transplant?

Did you freeze sperm, eggs, embryos or ovarian tissue before treatment?

Then I ask reproductive questions.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

For women:

Have periods returned?

Are they regular?

What is the AMH?

What is the antral follicle count?

Was the uterus exposed to radiation?

For men:

Has semen analysis been performed?

Is there sperm production?

Is ejaculation normal?

Is erectile function normal?

Finally:

Has the oncology team medically cleared pregnancy?

Only after these questions can responsible fertility planning begin.

What “Special Treatment” Means at Saira Health Care

Specialized fertility care does not mean one medicine for every cancer survivor.

Consider several examples.

Patient One — Young Woman After Moderate-Risk Chemotherapy

Age 27.

Periods returned after treatment.

AMH is reduced but follicles remain.

She wants children in several years.

Her best strategy may include:

- reproductive-endocrinology consultation,
- discussion of post-treatment egg or embryo freezing,
- ongoing oncology follow-up.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Individualized Unani supportive care may assist with general recovery, but delaying fertility planning for several years solely while trying to improve AMH would not be sensible.

Patient Two — Woman With Permanent Ovarian Failure

Age 34.

No periods.

Repeated tests indicate severe ovarian insufficiency after high-dose chemotherapy.

No eggs were frozen.

If her uterus is suitable, options may eventually include:

- donor-oocyte IVF.

I would not tell this patient that an herbal medicine can reliably regenerate a depleted ovarian follicle pool.

That could cost her valuable reproductive time.

Patient Three — Man With Azoospermia Six Months After Chemotherapy

A semen analysis shows no sperm.

This does not necessarily establish permanent infertility.

Spermatogenesis may continue recovering over time after some treatment regimens.

Repeat specialist assessment later may be appropriate.

If he banked sperm before treatment, those samples provide an additional option.

Patient Four — Persistent Azoospermia Years Later

If azoospermia remains after appropriate recovery time, reproductive-urology assessment may consider:

- micro-TESE,
- use of banked sperm,
- donor sperm

depending upon the individual case.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Patient Five — Woman After Pelvic Radiation

Her periods have returned.

But the uterus received substantial radiation.

Her problem cannot be assessed from AMH alone.

She may need:

- reproductive-medicine assessment,
- maternal-fetal-medicine evaluation

to determine whether carrying a pregnancy is safe.

Patient Six — Breast Cancer Survivor on Endocrine Therapy

She wants pregnancy.

She should **not stop endocrine therapy herself**.

Her oncology and fertility teams must decide:

- whether treatment interruption is oncologically appropriate,
 - when pregnancy can be attempted,
 - when treatment should resume.
-

Patient Seven — Survivor With Severe Sexual Dysfunction

A man's sperm count may be adequate, but pelvic cancer treatment has caused:

- erectile dysfunction,
- failure of ejaculation.

This is not primarily a sperm-production problem.

His infertility plan may require treatment of sexual dysfunction or assisted sperm retrieval.

This is particularly relevant to my focused practice in:

Sexual Disorders & Infertility.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Saira Health Care's Contribution to Cancer Survivorship and Fertility

At **Saira Health Care**, our role is not to treat the cancer itself unless under the appropriate oncology framework.

Our contribution lies in helping cancer survivors understand and manage:

- reproductive consequences,
- sexual-health consequences,
- infertility evaluation,
- fertility-treatment pathways,
- integrative supportive health.

My aim is to prevent two opposite mistakes.

The first is:

unnecessary hopelessness.

A cancer survivor is told:

“You had chemotherapy, so you can never have children.”

That may be completely wrong.

The second is:

false reassurance.

A patient is told:

“Your periods returned, so everything is normal.”

That can also be wrong.

Good reproductive medicine lies between those extremes.

The Importance of Multidisciplinary Care

Post-cancer fertility care may involve:

- oncologist,
- reproductive endocrinologist,
- fertility specialist,
- reproductive urologist,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- gynecologist,
- maternal-fetal-medicine specialist,
- genetic counsellor,
- sexual-health clinician,
- integrative physician.

ASRM specifically recommends multidisciplinary coordination for medically complex fertility-preservation patients.

This is particularly important because reproductive treatment should never interfere with cancer control.

Frequently Asked Questions

Can fertility return after chemotherapy?

Yes.

In both men and women, reproductive function can sometimes recover.

Recovery depends upon:

- treatment regimen,
- dose,
- age,
- baseline fertility,
- time since treatment.

In other patients, damage is permanent.

Which chemotherapy medicines are most harmful to fertility?

Alkylating agents are among the most consistently gonadotoxic treatments in both sexes.

Risk increases with cumulative dose and combination therapy.

Does chemotherapy always cause infertility?

No.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

My periods returned after chemotherapy. Am I fertile?

Possibly, but the return of periods does not prove that ovarian reserve is normal or that menopause will occur at the usual age.

Cancer survivors may have a shortened fertility window.

Can AMH be tested after cancer treatment?

Yes.

AMH and AFC can help estimate residual ovarian reserve, particularly when post-treatment fertility preservation is being considered.

Does low AMH mean pregnancy is impossible?

No.

AMH mainly reflects ovarian reserve and expected egg quantity.

Female age and the complete reproductive situation are also important.

Can ovarian function recover after chemotherapy?

Yes, in some women.

Recovery can continue after treatment, although it is not guaranteed.

Can cancer treatment cause early menopause?

Yes.

Chemotherapy and pelvic radiation can cause premature ovarian insufficiency or early menopause.

Can pelvic radiation affect pregnancy even if my ovaries work?

Yes.

Radiation may damage:

- uterus,

- uterine blood supply,
- surrounding reproductive structures.

Pregnancy-risk assessment may therefore be needed.

Can brain radiation cause infertility?

Yes.

Damage to the hypothalamus or pituitary can disturb reproductive hormones controlling ovulation or testicular function.

Does cancer treatment affect male fertility?

Yes.

Treatment can affect:

- sperm production,
 - hormones,
 - ejaculation,
 - erectile function.
-

Can sperm return after chemotherapy?

Yes.

Recovery may take months or years in some men.

It depends upon whether the sperm-producing stem cells survived treatment.

When should semen analysis be performed after chemotherapy?

Timing should be individualized.

AUA/ASRM guidance notes that assessment after at least about 12 months—and sometimes later—may provide more useful information about recovery after gonadotoxic treatment.

Can a man with post-chemotherapy azoospermia ever father a biological child?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Possibly.

Options can include:

- previously frozen sperm,
- recovery of natural spermatogenesis,
- surgical sperm retrieval in selected men,
- ICSI.

Is micro-TESE possible after chemotherapy?

Yes, in selected men with persistent azoospermia.

Sperm retrieval is not guaranteed, but sperm can be found in some post-chemotherapy patients.

Does stem-cell transplantation affect fertility?

It can have a major impact because conditioning often involves high-dose:

- chemotherapy,
- radiation.

These can cause ovarian or testicular failure.

Can immunotherapy affect fertility?

Possibly.

The long-term reproductive effects of many immunotherapies remain incompletely understood.

Can targeted cancer therapy affect fertility?

Some targeted therapies may affect reproductive or endocrine function, while information for many newer treatments remains limited.

Can fertility still be preserved after cancer treatment is finished?

Yes, in selected patients.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

The 2025 ASCO guideline specifically recommends considering post-treatment egg or embryo cryopreservation for suitable survivors with residual ovarian function and ongoing fertility risk.

What are the established fertility-preservation options for women?

Depending upon circumstances:

- mature egg freezing,
 - embryo freezing,
 - ovarian tissue cryopreservation,
 - ovarian transposition before radiation,
 - selected fertility-sparing cancer surgery.
-

Is ovarian tissue freezing experimental?

No.

It is now considered an established fertility-preservation option in appropriately selected females.

Can ovarian tissue be frozen in girls before puberty?

Yes.

It is the principal established fertility-preservation strategy currently available for prepubertal girls facing highly gonadotoxic therapy.

What is available for boys before puberty?

Testicular tissue cryopreservation remains experimental and should generally occur within appropriate research protocols.

Should men bank sperm before cancer treatment?

Yes, whenever treatment may threaten fertility and the patient may want biological children.

ASCO strongly recommends sperm cryopreservation before cancer-directed therapy.

Can very poor semen still be frozen?

Often yes.

Even limited sperm can potentially be useful later because ICSI requires very few sperm.

Does GnRH treatment completely protect female fertility during chemotherapy?

No.

GnRH agonists may reduce ovarian-failure risk in selected breast-cancer patients, but they should **not replace egg, embryo or ovarian-tissue preservation**.

When can pregnancy be attempted after chemotherapy?

There is no single interval appropriate for every patient.

Some clinicians recommend at least several months after chemotherapy, while longer waiting may be advised according to:

- cancer type,
- recurrence risk,
- ongoing treatment.

The oncology team should determine the timing.

Can pregnancy make cancer return?

For many survivors pregnancy does not appear to increase recurrence risk, but safety depends upon the specific cancer.

Cancer-specific oncology clearance is essential.

Can breast cancer survivors become pregnant?

Yes, some can.

For selected women receiving endocrine therapy for early hormone-sensitive breast cancer, temporary treatment interruption to attempt pregnancy has been investigated, with reassuring short-term results in the POSITIVE study.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

This must only occur under oncology supervision.

Are children conceived after cancer treatment more likely to have birth defects?

For pregnancies conceived sufficiently after treatment, available survivor data are generally reassuring and have not demonstrated a major overall increase in congenital or genetic abnormalities.

Individual treatment exposure and timing still matter.

Does hysterectomy mean pregnancy is impossible?

A woman without a uterus cannot personally carry a pregnancy.

If eggs or embryos are available, a gestational carrier may be discussed where medically and legally appropriate.

Can a woman become pregnant after both ovaries are removed?

She cannot produce her own eggs after both ovaries have been removed.

If her uterus remains suitable, pregnancy may potentially be achieved using:

- previously frozen eggs or embryos,
 - donor eggs.
-

Can a man father a child after one testicle is removed?

Yes, often.

One healthy remaining testicle can frequently produce adequate:

- testosterone,
- sperm.

The outcome depends upon the health of the remaining testis and other cancer treatments.

What if both testicles were removed?

Natural sperm production is no longer possible.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Previously frozen sperm may provide a biological-parenthood option if banking occurred before surgery.

Can fertility treatment be performed after cancer?

Yes, when oncology considers it medically appropriate.

Options may include:

- IUI,
 - IVF,
 - ICSI,
 - frozen gametes,
 - donor gametes.
-

Can Unani medicine restore fertility after chemotherapy?

There is currently insufficient high-quality clinical evidence that Unani medicine can reliably regenerate ovarian follicles or sperm-producing stem cells destroyed by gonadotoxic cancer therapy.

Is Unani medicine useful for cancer survivors?

It may have a useful **supportive integrative role** for appropriately selected survivors in areas such as:

- nutrition,
- digestion,
- sleep,
- menstrual wellbeing,
- physical recovery,
- sexual health,
- emotional wellbeing.

It should be coordinated with oncology care.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Can herbal medicines interact with cancer medicines?

Yes.

The National Cancer Institute warns that herbs and supplements can alter the metabolism or effectiveness of anticancer drugs and may increase adverse effects.

Should I tell my oncologist about Unani medicines?

Absolutely.

Every:

- Unani medicine,
- herb,
- supplement,
- traditional preparation

should be disclosed.

Can Unani medicine replace cancer treatment?

No.

Cancer treatment should never be delayed or replaced with unproven traditional or supplement-based therapy.

A Message From Dr. Nizamuddin Qasmi

When a cancer survivor asks me:

“Doctor, my fertility is finished—isn't it?”

I do not answer before understanding the treatment.

I ask:

What cancer was treated?

Which medicines were given?

Was radiation used?

Which body area received radiation?

Was surgery performed?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

How old were you at treatment?

Then I examine current fertility.

For women:

Are periods present?

What is the AMH?

What is the AFC?

Can the uterus safely carry pregnancy?

For men:

What does the semen analysis show?

Is sperm production recovering?

Is ejaculation normal?

Then I ask:

Did you freeze sperm, eggs or embryos before treatment?

Only after these questions do we know the real reproductive situation.

What I Tell Women Whose Periods Have Returned

I tell them:

“This is encouraging, but it is not the whole fertility assessment.”

Your ovaries may have recovered enough to menstruate while still having:

- reduced ovarian reserve,
- a shorter reproductive window.

If future pregnancy is important, do not assume that having periods means you can safely postpone fertility planning for many years.

What I Tell Men With No Sperm Soon After Chemotherapy

I explain:

“Azoospermia now does not always mean permanent azoospermia.”

Recovery can occur over time after some regimens.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

But we need:

- treatment records,
- appropriately timed repeat semen analysis,
- hormonal assessment where necessary.

We should avoid both:

- premature hopelessness,
- unrealistic guarantees.

What I Tell Patients About Fertility Supplements

I explain:

“Do not allow someone to sell you a promise that chemotherapy damage can be reversed simply by increasing antioxidants or taking a fertility tonic.”

Nutrition matters.

General health matters.

But destroyed ovarian follicles or severely damaged sperm stem cells cannot currently be reliably regenerated through supplements.

Treatment should focus on:

the reproductive function that actually remains.

What I Tell Patients About Time

Cancer survivors sometimes postpone fertility assessment because they have already been through many medical procedures.

I understand that.

But reproductive time still matters.

A 27-year-old cancer survivor and a 39-year-old cancer survivor with the same AMH do not have the same reproductive timeline.

If biological parenthood is an important goal:

fertility assessment should occur before another several years pass unnecessarily.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

My Clinical Philosophy at Saira Health Care

My approach can be summarized as:

Cancer safety first → identify reproductive damage → assess what function remains → evaluate both partners → use natural conception where reasonable → use fertility preservation or assisted reproduction when appropriate → support whole-person recovery through carefully coordinated integrative care.

I do not believe patients should be asked to choose between:

modern fertility medicine

and:

responsible Unani supportive care.

They can complement each other when their roles are clearly understood.

Latest Medical Understanding — 2026 Update

1. Fertility counselling is now a survivorship issue

The **2025 ASCO update** formally recommends discussing reproductive risks and options after cancer treatment as well as before it.

2. Post-treatment egg or embryo preservation is possible in selected survivors

Women with residual ovarian function may still have a window for:

- oocyte cryopreservation,
- embryo cryopreservation

after therapy.

3. Ovarian tissue cryopreservation is established treatment

Both ASCO and ASRM now recognize ovarian tissue cryopreservation as an established option in appropriately selected female patients.

4. Sperm banking before treatment remains the standard male strategy

ASCO strongly recommends sperm cryopreservation before cancer-directed treatment when fertility may be affected.

5. Very limited sperm can still be valuable

ICSI allows biological parenthood to remain possible even when only small quantities of cryopreserved sperm are available.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

6. Sperm recovery may continue for years

After gonadotoxic treatment, sperm production may gradually recover over approximately two to three years in some treatment groups, although severe damage can be permanent.

7. New cancer therapies have uncertain reproductive effects

For several modern:

- immunotherapies,
- targeted therapies,
- antibody-based treatments,

human fertility evidence remains incomplete.

8. Pregnancy after cancer is possible for many survivors

Available evidence regarding offspring conceived sufficiently after treatment is broadly reassuring, although pregnancy timing and maternal safety must be individualized.

9. Returning periods do not equal fully restored fertility

Female survivors can have menstrual recovery but still face:

- reduced ovarian reserve,
- premature menopause,
- shortened reproductive lifespan.

10. Complementary medicine requires oncology coordination

Modern cancer guidance warns that herbal and dietary supplements may interact with anticancer drugs.

Therefore, Unani care during or after cancer therapy should be coordinated with the oncology team rather than used independently.

Conclusion

Fertility After Cancer Treatment is one of the most important areas of modern cancer survivorship.

Chemotherapy, radiotherapy, surgery, stem-cell transplantation, endocrine therapy and newer systemic treatments can affect:

- ovarian follicles,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- sperm-producing cells,
- reproductive hormones,
- uterus,
- reproductive anatomy,
- ejaculation,
- sexual function.

The effect may be:

- temporary,
- partial,
- permanent.

The risk depends upon:

treatment type + dose + patient age + reproductive organs exposed + baseline fertility + time since treatment.

In women, high-risk cancer therapy can lead to:

- diminished ovarian reserve,
- premature ovarian insufficiency,
- early menopause.

Importantly:

menstrual recovery does not always mean complete fertility recovery.

A woman may resume normal-looking cycles but still have a shortened reproductive window.

In men, cancer treatment can cause:

- low sperm counts,
- poor sperm quality,
- temporary or permanent azoospermia,
- hormonal deficiency,
- ejaculatory dysfunction.

Sperm production can recover gradually after some treatments, sometimes over several years.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Modern fertility preservation provides important options.

The **2025 ASCO guideline** and **2026 ASRM guidance** recognize established strategies including:

For women

- egg freezing,
- embryo freezing,
- ovarian tissue cryopreservation,
- selected ovarian transposition,
- fertility-sparing surgery.

For men

- sperm cryopreservation,
- testicular sperm extraction when appropriate before therapy.

And importantly:

fertility care does not end when cancer treatment ends.

Post-treatment fertility preservation may still be appropriate in selected survivors who retain reproductive function.

Natural conception remains possible for many patients.

Others may eventually require:

- IUI,
- IVF,
- ICSI,
- frozen sperm,
- frozen eggs,
- frozen embryos,
- donor eggs,
- donor sperm,
- gestational-carrier treatment.

The appropriate pathway depends upon what reproductive function remains.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

From the **Unani perspective**, individualized care can have a valuable supportive role in cancer survivorship by addressing:

- Mizaj,
- nutrition,
- digestion,
- sleep,
- physical recovery,
- menstrual wellbeing,
- sexual wellbeing,
- emotional stress.

However:

Unani supportive treatment should never be represented as a proven method for regenerating ovarian follicles or sperm-forming stem cells permanently destroyed by cancer therapy.

And:

no herbal or Unani treatment should interfere with or replace necessary oncology treatment.

Herbs and dietary supplements can interact with anticancer medicines, so their use should always be disclosed to the oncology team.

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

cancer safety first, fertility assessment second, complete couple-based reproductive evaluation, evidence-based fertility treatment when needed, and individualized Unani supportive care where it can safely improve the patient's broader reproductive, sexual and general wellbeing.

My most important message to cancer survivors is:

Cancer treatment may change your fertility, but it does not automatically remove your possibility of parenthood.

Do not assume that chemotherapy means permanent infertility.

Do not assume that returning periods mean ovarian fertility is completely normal.

Do not assume that a normal erection means normal sperm production.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

And do not spend valuable reproductive years relying on unproven “fertility restoration” claims.

Instead:

find out exactly what reproductive function remains and build the fertility plan from that information.

That is the most precise and hopeful approach to fertility after cancer treatment.

About the Author

Dr. Nizamuddin Qasmi

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

Qualifications & Professional 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

Dr. Nizamuddin Qasmi is a well-qualified physician whose clinical practice at **Saira Health Care** has a focused emphasis on:

- sexual disorders,
- male infertility,
- female infertility,
- reproductive health.

His approach to fertility after cancer treatment focuses on determining the patient's **remaining reproductive potential** rather than assuming either complete recovery or permanent infertility.

Depending upon the patient, evaluation may include:

- detailed cancer-treatment history,
- review of chemotherapy and radiation exposure,
- menstrual and ovarian assessment,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- AMH and antral follicle count where appropriate,
- male semen analysis,
- reproductive hormone evaluation,
- pelvic and uterine assessment,
- sexual-function evaluation,
- assessment of previously preserved sperm, eggs, embryos or ovarian tissue,
- coordination with oncology,
- coordination with reproductive endocrinology, reproductive urology or maternal-fetal medicine where necessary.

Where medically appropriate and cleared in relation to cancer treatment, individualized Unani principles may be incorporated to support:

- nutrition,
- digestion,
- physical recovery,
- menstrual health,
- sexual wellbeing,
- emotional and general health

without delaying cancer therapy or time-sensitive reproductive treatment.

Medical Disclaimer

This article is intended for health education and public awareness and does not provide an individual diagnosis or treatment plan.

Anyone undergoing or having completed cancer treatment who is concerned about fertility should discuss reproductive risk with:

- their oncologist,
- an appropriately qualified fertility specialist,
- reproductive endocrinologist or reproductive urologist where indicated.

Cancer treatment should never be delayed, stopped or modified solely for fertility reasons without oncology approval.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

No patient should stop:

- chemotherapy,
- endocrine therapy,
- targeted therapy,
- immunotherapy

in order to attempt pregnancy without explicit advice from the treating oncology team.

The safe interval between cancer treatment and attempted conception varies according to:

- cancer type,
- treatment,
- recurrence risk,
- reproductive circumstances.

There is no single waiting period suitable for every cancer survivor.

Herbal, Unani and dietary supplements may interact with anticancer therapy. Patients receiving or recently completing oncology treatment should disclose every herbal medicine and supplement to their cancer-care team.

There is currently insufficient scientific evidence that Unani medicines can reliably regenerate ovarian follicles or spermatogonial stem cells permanently destroyed by chemotherapy or radiotherapy.

Cancer survivors should avoid treatments advertised as:

- “guaranteed ovarian regeneration,”
- “permanent sperm restoration after chemotherapy,”
- “cancer fertility cure,”

unless supported by appropriate clinical evidence.

Fertility after cancer treatment should be managed through individualized, multidisciplinary and evidence-based care.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com