

Age-Related Fertility Decline

Understanding Female and Male Reproductive Ageing, Egg Quantity and Quality, AMH, Miscarriage, IVF, Fertility Preservation and an Integrative Unani Approach

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When a couple comes to me and asks:

“Doctor, at what age does fertility really start decreasing?”

my answer is never simply:

“After 35.”

Human fertility does not suddenly disappear on one birthday.

Fertility changes gradually with age, and the effect is especially important in women because ageing affects both:

the number of eggs remaining in the ovaries

and

the biological quality of those eggs.

Men also experience reproductive ageing, although the decline is generally slower and less predictable.

Age-related fertility decline is therefore best understood as a **normal biological process that can gradually reduce the probability of conception and successful pregnancy.**

It is not a disease caused by infection, weakness or a lack of sexual ability.

The latest ACOG guidance published in 2025 emphasizes that ovarian-factor fertility declines naturally as ovarian follicles are progressively lost with age. Current ASRM guidance likewise identifies female age as the single most important predictor of female fecundity.

My purpose when discussing age with patients is not to frighten them.

My purpose is to help them understand:

what age changes, what it does not change, what tests can tell us, when treatment should begin, and when preserving fertility may deserve consideration.



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What Is Age-Related Fertility Decline?

Age-related fertility decline means that the biological ability to achieve pregnancy gradually decreases as the reproductive system ages.

In women, the major reasons are:

- progressive loss of ovarian follicles,
- reduced ovarian reserve,
- increasing chromosomal abnormalities in eggs,
- lower embryo implantation potential,
- increasing miscarriage risk.

In men, advancing age may gradually affect:

- semen volume,
- sperm motility,
- sperm morphology,
- sperm DNA integrity,
- the number of new genetic mutations carried by sperm.

The biological pattern is therefore different between women and men.

Female reproductive ageing is generally:

earlier, faster and more predictable.

Male reproductive ageing is:

more gradual and variable.

Fertility Decline Is Normal Biology

I often tell patients:

“Age-related fertility decline is not something you caused.”

A woman has not become infertile because she:

- worked too hard,
- studied too long,
- worried too much,



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- did not take enough fertility supplements.

The ovarian follicle pool naturally declines throughout life.

Lifestyle can influence overall reproductive health, but no lifestyle completely stops normal reproductive ageing.

This distinction is important because many patients develop unnecessary guilt.

Female Fertility Is Highest in the Twenties

Current ACOG patient guidance describes the late teenage years through the twenties as the period of highest female reproductive potential.

Fertility begins declining gradually around age 30 and the decline becomes faster during the mid-thirties. By approximately age 45, natural conception becomes unlikely for most women.

This does **not** mean that every woman should have children in her twenties.

Family building is a personal decision.

But people deserve accurate biological information when making those decisions.

Age 35 Is Not a Fertility Expiry Date

The age of 35 is frequently misunderstood.

A woman does not suddenly become infertile on her thirty-fifth birthday.

The decline is continuous.

Age 35 is clinically useful because after this point:

- natural conception probability is declining more noticeably,
- miscarriage risk is increasing,
- infertility evaluation should usually begin sooner.

Therefore:

35 is a clinical threshold, not a biological cliff.

What Happens Around Age 30?

Around age 30, fertility is still generally good for many women.



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However, ovarian ageing has already begun.

The follicle pool has declined from its younger level, and the proportion of eggs capable of producing chromosomally normal embryos gradually starts decreasing.

This process often occurs without symptoms.

A woman may still have:

- completely regular periods,
- normal ovulation,
- no pelvic symptoms.

That does not mean her reproductive biology has stopped ageing.

What Happens in the Mid-Thirties?

After approximately 35, reproductive decline tends to become more clinically significant.

On average:

- fewer follicles remain,
- ovarian reserve declines,
- chromosomally abnormal eggs become more common,
- conception takes longer,
- miscarriage becomes more frequent.

However, there is substantial individual variation.

One 37-year-old woman may conceive during her first month of trying.

Another may experience infertility.

Age changes probability—it does not determine every individual's outcome.

Fertility Around Age 40

Pregnancy at age 40 is absolutely possible.

But natural conception probability is lower.



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ACOG currently estimates that healthy couples in their twenties and early thirties may have around a **1 in 4 chance of conception in a menstrual cycle**, whereas by age 40 the chance is approximately **1 in 10 or less per cycle**.

These figures are population estimates.

They do not predict one particular woman.

What Happens After 40?

After 40, reproductive planning becomes increasingly time-sensitive.

This is because two important factors are changing at the same time:

egg quantity is declining

and

the percentage of chromosomally competent eggs is declining.

This is why current fertility guidance recommends prompt assessment rather than waiting a full year in women over 40.

Natural Conception Around Age 45

Natural conception can occur in the mid-forties, but it becomes uncommon.

ACOG states that by approximately age 45 the decline in fertility is substantial enough that natural pregnancy is unlikely for most women.

The word **unlikely** is important.

It does not mean biologically impossible.

But the probability is low enough that prolonged waiting is usually not sensible when pregnancy is actively desired.

Why Does Female Fertility Decline?

Two separate biological processes must be understood.

Egg Quantity

The number of eggs remaining decreases.

Egg Quality



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The probability that an egg can form a healthy chromosomally normal embryo also decreases.

Patients frequently confuse these two.

They are related—but not identical.

Egg Quantity: Understanding Ovarian Reserve

A woman begins life with a finite number of immature eggs.

These eggs are stored inside ovarian follicles.

Throughout childhood and adult life, follicles are continuously lost through a natural process called:

atresia.

Only a tiny percentage are ever ovulated.

Therefore:

ovarian reserve naturally decreases with age.

This process continues whether a woman:

- becomes pregnant,
- uses contraception,
- avoids pregnancy.

The ovaries do not “save” all their eggs simply because pregnancy is postponed.

Egg Quality: Why Age Matters Beyond AMH

Egg quality refers broadly to the biological capacity of the egg to:

- mature normally,
- fertilize,
- produce a viable embryo,
- implant,
- result in a healthy live birth.

Age is one of the strongest predictors of egg quality.

This is why:



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a 29-year-old woman with low AMH

and

a 41-year-old woman with the same AMH

do not have the same reproductive prognosis.

The younger woman may have fewer eggs, but each available egg generally has a better average chance of being chromosomally competent.

Why Do Chromosome Problems Increase With Age?

Human eggs can remain inside the ovaries for decades before being ovulated.

When an egg matures, its chromosomes must divide with great precision.

As reproductive age advances, chromosome-separation errors become more frequent.

The result may be:

Aneuploidy

meaning the embryo contains an abnormal number of chromosomes.

Aneuploid embryos may:

- fail to implant,
- result in early miscarriage,
- less commonly continue as a pregnancy affected by a chromosomal condition.

This age-related increase in aneuploidy is one of the main reasons fertility and live-birth rates decline even when ovulation remains regular.

Why Does Miscarriage Become More Common With Age?

A large proportion of early miscarriages result from embryo chromosome abnormalities.

Because aneuploid embryos become more common as eggs age, miscarriage risk also rises.

Therefore, age-related reproductive decline affects not only:

becoming pregnant

but also:

remaining pregnant successfully.



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Regular Periods Do Not Mean Fertility Is Unchanged

This is one of the most important misconceptions I explain to patients.

A woman aged 40 may say:

“My cycle is exactly 28 days. Why should fertility be lower?”

Regular periods tell us that ovarian and hormonal cycling is still occurring.

They do not tell us:

- how many follicles remain,
- the chromosome quality of the eggs,
- how many embryos would be euploid.

A woman can therefore have:

regular menstruation and age-related fertility decline at the same time.

What Is AMH?

AMH stands for:

Anti-Müllerian Hormone.

It is produced mainly by cells surrounding small ovarian follicles.

AMH is useful because it gives information about:

- ovarian reserve,
- likely response to ovarian stimulation,
- approximate egg yield during IVF.

But AMH is often misunderstood.

AMH Is Mainly a Quantity Test

AMH tells us mainly about:

the number of recruitable follicles.

It is not a direct measure of:

- egg chromosome quality,



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- embryo quality,
- natural conception potential,
- guaranteed live birth.

The 2025 ESHRE ovarian-stimulation guideline specifically recommends **AMH or antral follicle count to predict ovarian response**, but states that AMH and AFC should not be used as predictors of pregnancy or live birth. Female age is much more informative for those outcomes.

Normal AMH Does Not Make Eggs Younger

A 40-year-old woman with an AMH of:

3.0 ng/mL

may have an excellent ovarian response.

She may produce many eggs during IVF.

That is good.

But the eggs are still biologically 40-year-old eggs.

Therefore, excellent AMH does not cancel chronological reproductive age.

Low AMH in a Young Woman Does Not Mean Old Eggs

The opposite is also true.

A 28-year-old woman with AMH 0.7 may have:

- fewer remaining follicles,
- fewer eggs available during IVF.

But the eggs that remain are still from a 28-year-old ovary.

This is why low AMH and advanced reproductive age should not be treated as the same condition.

What Is Antral Follicle Count?

Antral Follicle Count—AFC—is measured by transvaginal ultrasound.

The clinician counts the small developing follicles visible inside both ovaries.



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AFC provides another estimate of ovarian reserve and likely stimulation response.

Current ESHRE guidance considers **AMH and AFC the recommended predictors of high or low ovarian response.**

Can AMH Predict Menopause?

Not accurately enough for an individual woman.

AMH generally falls as menopause approaches, but it cannot reliably tell one woman:

“You will become menopausal in exactly four years.”

The rate of decline varies considerably.

Therefore, AMH should not be used as a reproductive countdown clock.

Can AMH Tell Me Whether I Can Conceive Naturally?

Not reliably.

AMH is not a direct natural-fertility test.

A woman with low AMH may still:

- ovulate,
- conceive,
- carry a pregnancy.

A woman with high AMH may still be infertile because of:

- blocked tubes,
 - endometriosis,
 - severe male-factor infertility,
 - other reproductive problems.
-

Female Age Remains One of the Strongest Fertility Predictors

ASRM continues to describe female age as the single most important predictor of female fecundity.



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The updated 2025 ESHRE IVF guidance likewise identifies female age as a predictor of pregnancy and live birth, while AMH and AFC are mainly predictors of the number of eggs likely to respond.

Therefore:

AMH and age should be interpreted together—not against one another.

Fertility Decline Is Not Only an Ovarian Issue

With increasing age, other reproductive conditions also become more common.

These may include:

- uterine fibroids,
- endometriosis,
- adenomyosis,
- metabolic disorders.

Therefore, an older woman's fertility evaluation should not simply consist of:

“Check AMH.”

The entire reproductive system must be considered.

Male Fertility Also Declines With Age

A common misconception is:

“Only women have a biological clock.”

Men do not undergo menopause in the same way.

Sperm production can continue well into later life.

However, male reproductive ageing is real.

Current ASRM guidance describes advancing paternal age as being associated with:

- lower semen volume,
- reduced sperm motility,
- poorer morphology,
- greater sperm DNA fragmentation,
- accumulation of new germline mutations.



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Is There a Specific “Male Fertility Age”?

No universally accepted single age defines advanced paternal age.

ASRM describes paternal-age effects as a continuum becoming increasingly relevant through the fourth and fifth decades and beyond.

Therefore, male reproductive ageing should not be described as:

“normal until 40, abnormal after 40.”

The change is gradual.

Does Older Paternal Age Affect Pregnancy?

Some studies associate greater paternal age with:

- longer time to conception,
- miscarriage,
- preterm delivery,
- stillbirth,
- selected pregnancy complications.

Results vary between studies.

Therefore, paternal-age counselling should be balanced rather than alarmist.

Does Older Paternal Age Affect the Child?

Increasing paternal age is associated with increased accumulation of **de novo mutations** in sperm.

Current ASRM guidance notes associations between advanced paternal age and certain rare:

- genetic disorders,
- neurodevelopmental disorders.

However:

the absolute risk for any individual child remains relatively low.

This is a crucial point when counselling couples.



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Maternal Age Usually Has the Greater Effect on Fertility

Both partners should be considered.

However, when discussing:

- natural conception,
- embryo aneuploidy,
- miscarriage,
- live birth using the woman's own eggs,

female reproductive age is generally the stronger determinant.

This does not mean male age should be ignored.

It means the biological patterns are different.

How Often Should Couples Have Intercourse?

When natural conception is being attempted, the fertile window generally includes approximately:

the five days before ovulation and the day of ovulation.

Regular intercourse every one to two days during this period is effective.

But correct timing cannot reverse:

- ovarian ageing,
- chromosome abnormalities,
- blocked tubes,
- severe male-factor infertility.

Timed intercourse helps sperm meet the egg.

It does not make the egg younger.

When Should a Couple Seek Fertility Evaluation?

This is one of the most practical consequences of reproductive age.

Current ASRM guidance recommends that infertility evaluation generally begin:



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before age 35: after about 12 months of regular unprotected intercourse without pregnancy;

age 35 or older: after about 6 months;

over age 40: more immediate evaluation may be appropriate.

ACOG similarly recommends earlier investigation as age advances.

Do Not Wait if Another Fertility Problem Is Already Known

A couple should not necessarily wait six or twelve months if there is already a recognized fertility problem.

Earlier evaluation is appropriate when there is:

- absent or irregular ovulation,
- known endometriosis,
- tubal disease,
- previous chemotherapy or radiotherapy,
- significant diminished ovarian reserve,
- known male-factor infertility,
- sexual dysfunction preventing effective intercourse.

Current ASRM guidance specifically recommends immediate evaluation when a condition known to impair fertility is already present.

What Should Fertility Evaluation Include?

A good fertility assessment is couple-based.

It may include evaluation of:

- menstrual cycles and ovulation,
- ovarian reserve when appropriate,
- uterus,
- fallopian tubes,
- male semen parameters,
- sexual function.



ASRM recommends evaluating ovulatory status, reproductive-tract anatomy and male semen parameters in parallel where appropriate.

Should Every Woman Measure AMH?

No.

AMH can be extremely useful in:

- infertility treatment,
- IVF planning,
- fertility preservation,
- anticipated ovarian surgery,
- selected reproductive-risk situations.

But it should not be used as a general “fertility score” for every healthy woman.

A normal AMH may produce false reassurance.

A low AMH may produce unnecessary panic.

Does IVF Overcome Age-Related Fertility Decline?

IVF can help enormously.

But:

IVF does not make eggs younger.

During IVF, the ovaries are stimulated and eggs are retrieved.

Those eggs still carry the biological age of the woman who produced them.

Therefore, as age advances:

- fewer chromosomally competent embryos may develop,
- miscarriage remains more common,
- live-birth probability using one's own eggs declines.

The 2025 ESHRE guideline confirms the importance of female age for pregnancy and live-birth outcomes after IVF.

IVF Is Not Guaranteed Insurance Against Delayed Childbearing



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This is a message I particularly want younger patients to understand.

IVF has transformed reproductive medicine.

But it does not mean:

“I can postpone pregnancy indefinitely because IVF will work later.”

At older reproductive ages:

- more cycles may be required,
- fewer transferable embryos may be produced,
- success using one's own eggs may become very low.

Reproductive technology expands options.

It does not abolish reproductive ageing.

What Is Egg Freezing?

Egg freezing, or:

Oocyte Cryopreservation

allows mature eggs to be retrieved and stored for possible future use.

This can be considered for:

- medical fertility preservation,
- planned fertility preservation.

The eggs remain approximately the biological age they were when frozen.

Therefore:

an egg frozen at age 30 does not become a 40-year-old egg simply because it is used ten years later.

Does Egg Freezing Work Better When Done Younger?

Generally, yes.

ASRM's evidence review concludes that pregnancy and live-birth outcomes are better when oocyte cryopreservation occurs at younger ages compared with older ages, although evidence is insufficient to identify one perfect age at which every woman should freeze eggs.



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The important message is:

egg freezing becomes less efficient when delayed until ovarian ageing is already advanced.

Egg Freezing Does Not Guarantee a Baby

This point should always be explained.

Not every frozen egg will:

- survive warming,
- fertilize,
- form an embryo,
- reach blastocyst stage,
- implant,
- result in live birth.

ASRM therefore recommends individualized counselling based particularly on:

- age at egg freezing,
 - number of eggs stored.
-

Medical Fertility Preservation

Some women face fertility threats unrelated to normal ageing.

Examples include treatment with:

- chemotherapy,
- pelvic radiotherapy,
- gonadotoxic surgery.

The 2026 ASRM fertility-preservation guidance recognizes mature oocyte cryopreservation and embryo cryopreservation as established options for appropriate postpubertal patients, while ovarian tissue cryopreservation is also an established technique in selected medical circumstances.

Embryo Freezing



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Eggs can also be fertilized before freezing.

This is called:

Embryo Cryopreservation.

Embryo freezing provides some additional biological information because clinicians know:

- whether fertilization occurred,
- whether the embryo developed.

The decision between:

- egg freezing,
- embryo freezing

depends on the patient's personal and reproductive circumstances.

Does Freezing Eggs Stop All Age-Related Risk?

No.

Freezing eggs can preserve younger egg biology.

But it does not freeze the woman's:

- cardiovascular system,
- metabolic health,
- pregnancy physiology.

Therefore, a woman using eggs frozen at age 30 when she is 43 may benefit from younger eggs, but pregnancy at age 43 still carries age-related maternal risks.

Pregnancy Risks Also Increase With Maternal Age

Once pregnancy occurs, advancing maternal age is associated with increasing risk of conditions such as:

- hypertensive disorders,
- gestational diabetes,
- preterm delivery,
- cesarean delivery,



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- stillbirth.

Current ASRM guidance emphasizes that gestational health risks increase progressively at advanced reproductive ages.

These risks vary considerably according to:

- age,
- underlying health,
- pregnancy type,
- singleton versus multiple pregnancy.

Donor Eggs

For some women whose age-related egg quality has become the main fertility barrier, donor eggs may provide another reproductive pathway.

With donor-oocyte IVF:

- the egg comes from a donor,
- the intended mother can carry the pregnancy if medically appropriate.

The donor's age largely determines the biological age of the egg.

ASRM notes that oocyte donation can largely overcome the age-related decline in implantation and birth rates associated with using older autologous eggs.

Donor Eggs Do Not Reverse Maternal Age

Although donor eggs can overcome much of the age-related egg-quality problem, they do not make the gestating woman younger.

Pregnancy-related medical risks associated with advanced maternal age still require careful assessment.

What About PGT-A?

Preimplantation Genetic Testing for Aneuploidy—PGT-A—can be used during IVF to test embryos for chromosome-number abnormalities.

Because aneuploidy becomes more common with maternal age, older patients frequently ask about it.



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It is important to understand:

PGT-A does not improve the chromosome quality of an embryo.

It can only help identify which tested embryos appear chromosomally suitable for transfer.

It does not:

- create more eggs,
 - make old eggs younger,
 - guarantee pregnancy.
-

Can Exercise Prevent Fertility Ageing?

Healthy physical activity supports:

- metabolic health,
- cardiovascular health,
- healthy pregnancy preparation.

It cannot stop normal ovarian ageing.

The goal of exercise is therefore:

general reproductive health—not reversal of chronological age.

Can Diet Reverse Egg Ageing?

No diet has been shown to turn an older egg into a younger egg.

Balanced nutrition remains extremely important for:

- weight,
- metabolic function,
- micronutrient status,
- preconception health.

But patients should be cautious about “fertility diets” promoted as methods of reversing reproductive age.

Smoking and Fertility



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Smoking is an avoidable reproductive risk.

It is associated with poorer fertility and accelerated ovarian ageing.

Therefore, smoking cessation is one of the most sensible measures for someone who wishes to protect reproductive health.

However:

stopping smoking cannot regenerate follicles that have already been lost.

Obesity and Reproductive Health

Obesity can negatively affect:

- ovulation,
- metabolic health,
- pregnancy risks,
- fertility-treatment outcomes.

Weight optimization may therefore be beneficial.

But I am cautious about asking an older woman with significant infertility to delay fertility treatment for a very long period solely for weight loss.

Age continues advancing during that delay.

The better approach is often coordinated management.

Folic Acid and Preconception Health

Women planning pregnancy should receive appropriate preconception counselling, including folic-acid supplementation according to their individual medical needs.

Folic acid helps reduce neural-tube-defect risk.

It does not reverse egg ageing.

This is another example of the difference between:

improving pregnancy health

and:

reversing reproductive ageing.



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Can Supplements Improve “Egg Quality”?

Many products are marketed using this phrase.

Examples commonly include:

- antioxidants,
- CoQ10,
- DHEA,
- various herbal products.

Research continues into oxidative stress and mitochondrial function.

But no supplement has been proven to reliably reverse age-related embryo aneuploidy.

Patients should therefore be cautious about guaranteed claims.

DHEA

DHEA is an androgenic hormone.

It is sometimes marketed for:

- diminished ovarian reserve,
- older IVF patients.

However, current IVF guidance does not support routine DHEA treatment for predicted low responders.

It should not be self-prescribed simply because age or AMH is concerning.

Ovarian PRP and “Ovarian Rejuvenation”

PRP injection into the ovaries is increasingly marketed using terms such as:

ovarian rejuvenation.

Research remains ongoing.

It has not been established as a treatment capable of:

- producing a new young ovarian reserve,
- reversing egg chromosome ageing,
- restoring fertility to a younger biological age.



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Therefore, it should not be promoted as a proven reversal of reproductive ageing.

Stem Cells and Ovarian Regeneration

Stem-cell and regenerative research is scientifically interesting.

However, there is currently no routine clinical therapy that can reliably:

- create a new population of young eggs,
- reverse decades of reproductive ageing,
- eliminate age-associated aneuploidy.

Patients should clearly distinguish:

experimental research

from:

established fertility treatment.

The Unani Perspective on Age-Related Fertility Decline

As a physician trained in **Unani medicine** and working in the field of **Sexual Disorders & Infertility**, I believe fertility should be approached as part of the health of the whole individual and couple.

Traditional Unani medicine places importance on:

- **Mizaj** or constitutional temperament,
- balanced nutrition,
- digestion,
- menstrual health,
- sleep,
- physical activity,
- psychological wellbeing,
- sexual health,
- general reproductive vitality.

These areas can be very useful in comprehensive fertility care.

But age-related fertility decline requires careful scientific interpretation.



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Unani Medicine Can Support Reproductive Health

Individualized Unani care may be useful for addressing associated problems such as:

- nutritional weakness,
- digestive complaints,
- unhealthy weight,
- menstrual disturbances,
- sleep problems,
- stress,
- associated sexual-health concerns.

These issues can affect:

- quality of life,
- intercourse,
- fertility-treatment tolerance,
- overall pregnancy preparation.

This is where an integrative approach can be valuable.

What Published Unani Evidence Shows

Published Unani literature includes some studies and case reports involving female infertility.

For example, a National Institute of Unani Medicine case report described conception in a woman with unilateral tubal obstruction following a Unani treatment regimen.

Such reports show that traditional infertility approaches deserve scientific investigation.

However:

a single case report does not establish a treatment for reproductive ageing.

It cannot prove that Unani medicine:

- reverses egg age,
- produces new follicles,
- reverses embryo aneuploidy.



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Unani Medicine Should Not Be Presented as an “Age Reversal” Treatment

This is extremely important.

I would not tell a 41-year-old patient:

“Take this medicine for one year and your ovaries will become 30 again.”

That would not be scientifically responsible.

Age-related egg changes cannot currently be reliably reversed by:

- Unani medicines,
- herbal preparations,
- vitamins,
- PRP,
- supplements.

A supportive treatment and biological age reversal are completely different claims.

Unani Medicine Can Be Used Alongside Modern Fertility Care

The best integrative approach does not require choosing between:

Unani

and:

modern fertility treatment.

For many patients, the appropriate strategy may be:

- modern fertility assessment,
- timely IUI or IVF where required,
- individualized Unani supportive care,
- nutritional optimization,
- sexual-health management,
- lifestyle improvement.

This is particularly important in older patients because unnecessary delay can itself reduce fertility.



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Time Is a Treatment Factor

This is one of the most important principles in age-related infertility.

A 41-year-old woman with infertility cannot regain a year after spending twelve months trying unproven treatments.

Therefore, time itself must be treated as part of fertility planning.

For younger patients:

a conservative approach may sometimes be reasonable.

For older patients:

the same delay may have major reproductive consequences.

Special Treatment by Dr. Nizamuddin Qasmi

When a couple consults me for age-related fertility concerns, I do not begin by prescribing one “fertility medicine.”

I first understand the complete reproductive picture.

I ask:

How old are both partners?

How long have they been trying?

Are menstrual cycles regular?

Is ovulation occurring?

What is the ovarian reserve?

What is the antral follicle count?

Are the fallopian tubes open?

Is there endometriosis, fibroid, adenomyosis or another pelvic condition?

What does the male partner's semen analysis show?

Is intercourse occurring regularly during the fertile period?

Is there erectile dysfunction, painful intercourse, vaginismus, ejaculation difficulty or another sexual-health problem?

Only after this assessment can I decide what role age is actually playing.



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Individualized Fertility Treatment

The same chronological age does not mean the same treatment.

Consider several examples.

A 29-Year-Old Woman

Regular cycles.

Trying for four months.

No infertility risk factors.

She generally does not need aggressive infertility treatment.

A 36-Year-Old Woman

Trying for eight months without pregnancy.

She deserves fertility evaluation now rather than another year of waiting.

A 39-Year-Old Woman

Normal AMH.

Three years of infertility.

The normal AMH is reassuring regarding ovarian quantity but does not cancel:

- her age,
- long duration of infertility.

Treatment needs to be timely.

A 32-Year-Old Woman With Low AMH

Her young age can still be an important advantage for egg quality.

The discussion may focus on:

- ovarian reserve,
- reproductive timing,
- fertility preservation where appropriate.



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A 38-Year-Old Woman Whose Partner Has Severe Male Infertility

This is not simply “age-related female infertility.”

Both:

- reproductive age,
- male-factor infertility

must be addressed.

This is why couple-based evaluation is essential.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At **Saira Health Care**, one of our important roles is helping patients understand reproductive age without either:

unnecessary fear

or:

false reassurance.

Two harmful messages are common.

The first says:

“After age 35 pregnancy is almost impossible.”

That is incorrect.

The second says:

“Age doesn't matter anymore because IVF can always solve the problem.”

That is also incorrect.

The medically accurate position lies between these extremes.

Our approach is to help patients understand:

- ovarian reserve,
- egg quality,
- sperm ageing,
- natural conception,



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- miscarriage,
 - fertility-treatment timing,
 - fertility preservation,
 - sexual health.
-

Age-Related Infertility Can Affect Sexual Relationships

When a couple begins feeling that:

“time is running out,”

sexual intercourse can become stressful.

Couples may develop:

- performance pressure,
- reduced spontaneity,
- decreased libido,
- erectile difficulty,
- painful intercourse,
- relationship tension.

Because my practice is focused on both sexual disorders and infertility, I consider these concerns separately.

Treating infertility should not mean ignoring intimacy.

Fertility Age Does Not Define Personal Worth

A woman with low fertility at 40 is not:

- less feminine,
- less healthy as a person,
- less valuable.

A man with age-related sperm abnormalities is not less masculine.

Fertility is one biological function.

It should not become a judgment on someone's identity.



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When Should Patients Seek Earlier Assessment?

Fertility evaluation should be accelerated when there is:

- age above 35 with six months of unsuccessful attempts,
- age over 40,
- irregular or absent menstruation,
- previous pelvic surgery,
- known endometriosis,
- previous cancer therapy,
- diminished ovarian reserve,
- recurrent miscarriage,
- known male infertility.

Prompt assessment gives patients more—not fewer—choices.

What Should Patients Avoid?

I advise patients to be cautious about claims such as:

“Reverse ovarian age naturally.”

“Increase egg quality to age 25.”

“Guaranteed AMH increase.”

“Guaranteed pregnancy after 40.”

“PRP makes new eggs.”

“Herbal medicines permanently reverse ovarian ageing.”

Current science does not justify these promises.

Realistic treatment can still offer meaningful possibilities without using guaranteed language.

Frequently Asked Questions

Is age-related fertility decline normal?



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Yes.

It is a normal biological feature of human reproduction, particularly in women.

At what age does female fertility start decreasing?

The decline becomes detectable around age 30 and becomes faster during the mid-thirties.

Does fertility suddenly fall at 35?

No.

The decline is gradual.

Age 35 is mainly an important threshold for earlier fertility assessment.

Can a woman conceive naturally at 35?

Yes.

Many women conceive naturally at age 35 and beyond.

Can a woman conceive naturally at 40?

Yes.

But the probability per cycle is much lower than during the twenties and early thirties. ACOG estimates approximately 10% or less per menstrual cycle around age 40.

Can natural pregnancy happen after 45?

It can occur but is uncommon.

ACOG states that by approximately 45, natural pregnancy becomes unlikely for most women.

Does regular menstruation mean my fertility is normal?

No.

Regular cycles suggest ongoing ovarian activity.



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They do not directly measure:

- egg quantity,
 - chromosome quality,
 - embryo potential.
-

Does low AMH mean poor egg quality?

No.

Low AMH mainly indicates reduced ovarian reserve and likely lower ovarian response.

Age is much more important for average egg quality.

Does high AMH mean I have young eggs?

No.

High AMH indicates good follicle quantity.

It does not change chronological egg age.

Is AMH useful?

Yes.

AMH is very useful for predicting ovarian response, especially in IVF.

Current ESHRE guidance recommends AMH or AFC for prediction of high or low ovarian response.

Can AMH predict pregnancy?

It should not be used alone for this purpose.

ESHRE specifically states that AMH and AFC are not recommended as predictors of pregnancy or live birth.

Does miscarriage risk increase with age?

Yes.

One major reason is the increasing frequency of chromosomally abnormal embryos.



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Does IVF reverse age-related fertility decline?

No.

IVF can improve reproductive efficiency but the biological age of the woman's own eggs still matters.

Is IVF useless at older ages?

No.

IVF may still provide meaningful reproductive opportunities.

But success generally becomes lower with increasing age when using the woman's own eggs.

Can egg freezing preserve fertility?

It can preserve eggs at the biological age at which they were frozen.

It expands future reproductive options but does not guarantee a baby.

Is younger egg freezing generally better?

Yes.

Available evidence suggests improved outcomes when planned egg freezing is performed at younger rather than older ages.

How many eggs should be frozen?

There is no single number that guarantees a future live birth.

The number needed depends heavily upon:

- age,
- individual laboratory outcomes.

ASRM specifically notes that available evidence is insufficient to define one exact oocyte number guaranteeing live birth for each age group.



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Does male age matter?

Yes.

Advancing paternal age is associated with gradual changes in sperm quality and increased de novo mutation burden.

Does a 40-year-old man automatically have poor fertility?

No.

Many men father children after 40.

Male age affects fertility much more variably than female age.

Are children of older fathers usually unhealthy?

No.

Although some statistical risks increase, ASRM emphasizes that the overall absolute risk for an individual child remains low.

When should women under 35 seek fertility evaluation?

Usually after approximately 12 months of regular unprotected intercourse without conception, unless another infertility risk is already known.

When should women 35 or older seek help?

Generally after about six months without conception.

What about women over 40?

More immediate evaluation is generally appropriate.

Can supplements stop egg ageing?

No supplement has been established as a treatment that reliably reverses chromosomal ageing of human oocytes.



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Can DHEA reverse reproductive age?

No established evidence supports such a claim.

Can PRP make ovaries younger?

Ovarian PRP remains investigational and should not be presented as proven reversal of reproductive ageing.

Can stem cells create new young eggs?

This remains an experimental research area.

There is currently no routine established treatment that reliably regenerates a younger human ovarian reserve.

Can Unani medicine reverse reproductive ageing?

There is currently insufficient high-quality evidence showing that Unani medicines can reverse:

- chronological ovarian ageing,
 - depleted follicle numbers,
 - age-related egg chromosome abnormalities.
-

How can Unani medicine help?

Its responsible role can be supportive and integrative.

Depending upon the patient, individualized Unani care may support:

- nutrition,
- digestion,
- menstrual wellbeing,
- metabolic health,
- sleep,
- general vitality,
- sexual wellbeing,



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- infertility-related stress.

Can Unani treatment be combined with IVF?

Potentially, yes, when clinically appropriate.

All medicines and herbal products should be disclosed to the fertility specialist so potential interactions can be avoided.

Supportive Unani management should not delay age-sensitive treatment.

A Message From Dr. Nizamuddin Qasmi

When a woman tells me:

“Doctor, I am 38 but my periods are regular and my AMH is normal, so why should age matter?”

I explain:

Your regular periods tell me your ovaries are functioning.

Your AMH tells me something about the number of follicles available.

Neither test changes the age of your eggs.

That is why I never interpret fertility from:

- age alone,
- AMH alone,
- one ultrasound alone.

I assess the complete reproductive picture.

What I Tell Younger Patients

If a woman is in her twenties or early thirties, I do not want her to become unnecessarily frightened about fertility.

But if biological parenthood is very important to her and she expects to delay pregnancy for many years, she deserves accurate counselling regarding:

- reproductive ageing,
- ovarian reserve,



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- planned egg freezing where appropriate.

Good counselling preserves autonomy.

It does not pressure someone to become pregnant.

What I Tell Patients in Their Late Thirties

For a woman in her late thirties who wants pregnancy, I become much more conscious of time.

I do not want her spending a year solely trying to improve:

- AMH,
- “egg strength,”
- fertility supplements

without first completing proper infertility evaluation.

Supportive treatment can continue while evidence-based fertility planning proceeds.

What I Tell Patients About IVF

I explain:

IVF is powerful technology, but it cannot manufacture younger eggs.

If treatment is required, beginning at an earlier reproductive age generally provides more options than waiting until egg quantity and quality are both substantially reduced.

That does not mean every patient requires IVF.

It means IVF should not be treated as guaranteed insurance against age.

My Clinical Approach

At **Saira Health Care**, I follow a simple principle:

Do not treat age alone—and do not ignore age.

My approach is to:

understand the couple's reproductive ages, determine how long they have been trying, assess ovulation and ovarian reserve where appropriate, investigate the uterus and



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fallopian tubes, evaluate the male partner, identify sexual-health barriers, and then choose the most efficient reproductive strategy.

Depending upon the couple, that strategy may involve:

- natural conception,
- IUI,
- IVF/ICSI,
- fertility preservation,
- donor-oocyte counselling in selected circumstances.

Individualized Unani care may be integrated to support broader reproductive and sexual wellbeing.

Current Medical Understanding — 2026 Update

Modern fertility guidance now emphasizes several important points.

Female age remains a major determinant of reproductive outcome

Current ASRM guidance identifies female age as the strongest predictor of female fecundity.

AMH and AFC measure ovarian response better than pregnancy potential

The 2025 ESHRE guideline recommends AMH or AFC for ovarian-response prediction but specifically advises against using them to predict pregnancy or live birth.

Fertility evaluation should become earlier with age

Women under 35 generally begin investigation after about 12 months, those 35 or older after about six months, and women over 40 often deserve prompt evaluation.

IVF cannot completely overcome egg ageing

Age continues to influence pregnancy and live-birth probability when a woman's own oocytes are used.

Fertility preservation is effective but not guaranteed

Current ASRM guidance recognizes mature-oocyte and embryo cryopreservation as established fertility-preservation techniques. Future success depends significantly on age at freezing and the number of oocytes or embryos available.

Paternal age also deserves counselling

The 2025 ASRM opinion specifically recommends discussing the potential reproductive and offspring effects of both advancing maternal and paternal age.

Fertility care should remain evidence-based and accessible

The WHO's first comprehensive infertility guideline, published in November 2025, emphasizes evidence-based prevention, diagnosis and treatment of infertility and improved access to appropriate fertility care.

Conclusion

Age-Related Fertility Decline is a normal biological process that affects both women and men, but its effect is particularly important in women.

In women, reproductive ageing involves two simultaneous changes:

fewer eggs remain,

and:

a greater proportion of remaining eggs develop chromosome abnormalities.

This explains why increasing maternal age is associated with:

- reduced natural conception probability,
- increased time to pregnancy,
- greater miscarriage risk,
- lower IVF success using the woman's own eggs.

Female fertility is generally highest during the twenties.

It begins declining gradually around age 30 and declines faster during the mid-thirties. By approximately age 40, natural pregnancy remains possible but becomes substantially less likely per menstrual cycle.

Importantly:

age 35 is not a fertility cliff.

It is a clinical point at which infertility evaluation should generally occur sooner.

Tests such as:

- AMH,
- antral follicle count

provide valuable information about **egg quantity and expected ovarian response.**

They do not directly measure egg quality.

Current 2025 ESHRE guidance explicitly recommends AMH or AFC for predicting ovarian response while identifying female age—not AMH—as a clinically relevant predictor of pregnancy and live birth.

IVF can provide important reproductive opportunities.

But:

IVF does not make eggs younger.

Egg freezing can preserve younger eggs for possible future use, particularly when undertaken earlier, but it cannot guarantee a future pregnancy or live birth.

Male reproductive age should also be considered.

Advancing paternal age is associated with:

- declining semen characteristics,
- increasing sperm DNA fragmentation,
- more de novo mutations.

Nevertheless, most offspring of older fathers remain healthy, and the absolute risk of serious age-related conditions remains low.

From the **Unani perspective**, reproductive care can usefully address the whole patient through attention to:

- Mizaj,
- nutrition,
- digestion,
- menstrual health,
- metabolic balance,
- sleep,
- physical wellbeing,
- psychological wellbeing,
- sexual health.

These can be meaningful components of integrative infertility care.

However:



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supportive reproductive care should not be confused with biological age reversal.

There is currently insufficient scientific evidence to claim that Unani medicine can recreate depleted ovarian follicles, reverse egg chromosome ageing or make older ovaries biologically young again.

At **Saira Health Care**, my approach is therefore integrative, evidence-based and time-conscious:

understand both partners' reproductive ages, assess the complete cause of infertility, interpret AMH correctly, evaluate ovarian reserve, tubes, uterus and semen, identify sexual-health barriers, avoid unnecessary delay, discuss fertility preservation where appropriate, use modern fertility treatment when indicated, and incorporate individualized Unani supportive care for overall reproductive and sexual wellbeing.

The message I want every patient to remember is:

Age should guide your fertility planning—not create fear.

Do not assume pregnancy is impossible after 35.

Do not assume regular periods mean fertility has not changed.

Do not assume normal AMH makes eggs younger.

And do not assume IVF can always replace the reproductive opportunities available at an earlier age.

The best fertility decisions are based on:

accurate information, complete evaluation, realistic expectations and timely planning.

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

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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** has a focused emphasis on sexual disorders, male and female reproductive health and infertility.

His approach to age-related fertility decline emphasizes that neither chronological age nor AMH should be interpreted alone.

Depending upon the couple, evaluation may include menstrual and reproductive history, ovarian-reserve assessment where appropriate, pelvic ultrasound, ovulation assessment, evaluation of fallopian-tube patency, uterine assessment, male semen analysis, evaluation of sexual-health problems and review of previous fertility treatments.

Where clinically appropriate, individualized Unani principles may be incorporated to support reproductive, nutritional, metabolic and sexual wellbeing without delaying age-sensitive evidence-based fertility treatment.

Medical Disclaimer

This article is intended for health education and public awareness. It does not provide an individual infertility diagnosis or replace consultation with an appropriately qualified gynecologist, reproductive endocrinologist, fertility specialist, andrologist or reproductive urologist.

Age-related fertility decline occurs gradually; age 35 is not an absolute fertility boundary.

AMH and antral follicle count mainly assess ovarian reserve and expected ovarian response. They should not be used alone to predict natural conception, egg quality, pregnancy or live birth.

Women aged 35 or older who are not conceiving should generally seek fertility evaluation earlier, while women over 40 should consider prompt assessment rather than prolonged waiting.

IVF, ICSI, egg freezing, embryo freezing and donor-oocyte treatment can expand reproductive options but cannot guarantee conception, pregnancy or live birth.

No Unani medicine, herbal medicine, supplement, PRP procedure or stem-cell intervention has been established as a reliable treatment capable of reversing the chronological ageing of human eggs.



Patients should avoid delaying time-sensitive fertility assessment while relying solely on treatments marketed as “ovarian rejuvenation,” “egg-age reversal,” “guaranteed AMH improvement” or guaranteed pregnancy at advanced reproductive age.



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