

Thyroid Disorders and Female Infertility: Causes, Diagnosis, Treatment and the Role of Unani Medicine

Hypothyroidism, Hyperthyroidism, Hashimoto's Disease, Graves' Disease and Female Fertility

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Introduction: “Doctor, Can My Thyroid Be the Reason I Am Not Getting Pregnant?”

This is a question I hear frequently in fertility consultations.

A woman may come to me and say:

“Doctor, my periods have become irregular and my TSH is high. Is thyroid preventing pregnancy?”

Another asks:

“My TSH is 3.2. Someone told me it must be below 2.5 before I can conceive. Is that true?”

Another patient says:

“I have Hashimoto's disease but my thyroid hormones are normal. Do I need thyroid medicine only because I am trying to become pregnant?”

And women with hyperthyroidism often ask:

“Can I safely become pregnant while taking thyroid medicines?”

These questions deserve careful answers because the thyroid gland certainly influences reproductive physiology—but:



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every abnormal thyroid report does not cause infertility, and every infertile woman does not require thyroid medicine.

Current evidence distinguishes very clearly between:

- **overt thyroid disease**, which can meaningfully affect reproductive and pregnancy health;
- **mild subclinical abnormalities**, where the connection with infertility is far less certain.

A major 2026 review of thyroid disorders and female infertility confirms that overt thyroid dysfunction can impair reproductive physiology, while the fertility significance of subclinical hypothyroidism and thyroid autoimmunity remains controversial.

The American Society for Reproductive Medicine's 2024 guideline takes an especially important evidence-based position:

women with signs or symptoms of thyroid dysfunction—such as irregular menstrual cycles—should have TSH and T4 assessed, but routine thyroid screening of every asymptomatic infertile woman is not supported by current evidence.

So when I evaluate thyroid disease in infertility at Saira Health Care, my purpose is not simply:

“Make every woman's TSH less than 2.5.”

My purpose is to determine:

- Is genuine thyroid disease present?
- Is it severe enough to disturb ovulation or pregnancy?
- Is another fertility factor also present?
- Does treatment need to begin before conception?
- What needs to change once pregnancy occurs?
- Can individualized Unani care safely support metabolic and constitutional health without replacing necessary endocrine treatment?

What Is the Thyroid Gland?

The thyroid is a small butterfly-shaped gland located in the lower front part of the neck.

Although small, it influences almost every organ system.

It produces primarily:



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T4 – Thyroxine

and:

T3 – Triiodothyronine

These hormones help regulate:

- metabolism,
 - body temperature,
 - heart rate,
 - digestion,
 - muscle function,
 - energy,
 - brain activity,
 - menstrual physiology,
 - reproductive hormone interaction.
-

How Is the Thyroid Controlled?

The thyroid is controlled through the:

Hypothalamic-Pituitary-Thyroid Axis

or:

HPT axis.

The sequence is:

1. the hypothalamus produces TRH;
2. TRH stimulates the pituitary gland;
3. the pituitary produces TSH;
4. TSH stimulates the thyroid;
5. the thyroid releases thyroid hormones.

TSH means:

Thyroid-Stimulating Hormone.

TSH is therefore an extremely useful first test for thyroid function.



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How Can Thyroid Disease Affect Female Fertility?

Female reproduction depends on communication between:

- hypothalamus,
- pituitary,
- thyroid,
- ovaries,
- uterus.

Thyroid dysfunction can interact with:

- GnRH secretion,
- prolactin,
- FSH and LH signaling,
- ovarian steroid hormones,
- menstrual cyclicity,
- ovulation,
- endometrial physiology.

Overt thyroid disorders may therefore contribute to:

- irregular periods,
- absent periods,
- anovulation,
- reduced fertility,
- pregnancy complications.

Modern reviews continue to identify thyroid dysfunction as an important endocrine factor in female reproduction.

But Thyroid Disease Is Not the Cause of Every Infertility Case

This is equally important.

A woman may have a mildly abnormal thyroid test while her actual fertility problem is:



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- bilateral tubal blockage,
- severe PMOS-related anovulation,
- endometriosis,
- diminished ovarian reserve,
- male-factor infertility.

Therefore:

finding an abnormal TSH should not end the infertility investigation.

At Saira Health Care, I believe both partners should still be assessed according to the complete reproductive picture.

Main Thyroid Disorders Relevant to Female Fertility

The important categories are:

Hypothyroidism

The thyroid produces insufficient thyroid hormone.

Hyperthyroidism

The thyroid produces excessive thyroid hormone.

Subclinical Hypothyroidism

TSH is elevated while free T4 remains within the normal range.

Thyroid Autoimmunity

Antibodies are directed against thyroid tissue.

The main examples are:

- Hashimoto's thyroiditis,
- Graves' disease.

These conditions do not all affect fertility in the same way.

Hypothyroidism and Female Infertility

Hypothyroidism means:

underactive thyroid function.



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The body does not receive enough thyroid hormone.

The pituitary generally responds by producing:

more TSH.

Common Causes of Hypothyroidism

These may include:

- Hashimoto's thyroiditis,
- previous thyroid surgery,
- radioactive iodine treatment,
- iodine deficiency,
- certain medicines,
- pituitary disease in selected cases,
- congenital disorders.

Hashimoto's thyroiditis is a common autoimmune cause of hypothyroidism in women of reproductive age.

Symptoms of Hypothyroidism

Possible symptoms include:

- tiredness,
- low energy,
- feeling cold,
- weight gain,
- constipation,
- dry skin,
- hair changes,
- slowed heart rate,
- muscle aches,
- depression or low mood,



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- difficulty concentrating,
- menstrual changes.

Some women have:

very few obvious symptoms.

That is why laboratory confirmation matters.

Menstrual Changes in Hypothyroidism

Overt hypothyroidism can contribute to:

- irregular menstrual cycles,
- prolonged cycles,
- heavy bleeding,
- oligomenorrhea,
- occasionally amenorrhea.

Severe thyroid dysfunction may interfere with:

normal ovulation.

A woman with longstanding irregular menstruation therefore deserves thyroid evaluation as part of a targeted endocrine assessment.

ASRM specifically lists irregular menstrual cycles among symptoms that justify thyroid-function testing.

Why Can Hypothyroidism Affect Ovulation?

Several mechanisms may be involved.

One important pathway involves:

TRH and prolactin.

In primary hypothyroidism, increased hypothalamic TRH stimulation can sometimes increase prolactin.

High prolactin may interfere with:

- GnRH,
- FSH,



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- LH,
- ovulation.

Thus some women with significant hypothyroidism may develop:

- menstrual irregularity,
- anovulation.

Does Correcting Overt Hypothyroidism Improve Fertility?

When genuine overt hypothyroidism is present:

appropriate levothyroxine treatment is standard care.

Restoring normal thyroid hormone physiology can improve:

- menstrual regularity,
- ovulatory function

when thyroid disease was responsible for the disturbance.

However:

levothyroxine is not itself an infertility drug.

If ovulation becomes normal but pregnancy still does not occur, other causes should be investigated.

What Is Subclinical Hypothyroidism?

Subclinical hypothyroidism means:

- TSH is above the laboratory reference range,
- free T4 remains normal.

ASRM's 2024 guideline recommends using the:

laboratory-specific normal TSH range

for nonpregnant women.

When an appropriate reference range is unavailable in an iodine-sufficient population, ASRM discusses approximately:

4.12 mIU/L

as a reasonable upper normal limit in nonpregnant patients.



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This is important because many women have been told:

“Anything above TSH 2.5 means hypothyroidism.”

That is not correct for every nonpregnant woman.

Is TSH 2.5–4.0 a Cause of Infertility?

Current evidence says:

not necessarily.

ASRM's 2024 guideline found insufficient evidence that subclinical hypothyroidism is itself associated with infertility and specifically found that TSH values:

between 2.5 and 4.0 mIU/L

are not associated with increased miscarriage risk.

A major 2026 endocrine review likewise notes that using a universal 2.5 mIU/L threshold for infertility treatment is increasingly being questioned because improved fertility outcomes have not been consistently demonstrated.

Should Every Woman Trying to Conceive Take Levothyroxine if TSH Is Above 2.5?

No.

This is one of the most important current corrections.

ASRM 2024 does not recommend levothyroxine solely for the purpose of improving:

- pregnancy,
- miscarriage,
- live birth

in women diagnosed with subclinical hypothyroidism on the basis of mild TSH elevation.

Treatment decisions should consider:

- actual TSH level,
- free T4,
- symptoms,
- existing thyroid diagnosis,
- pregnancy status,



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- thyroid antibodies in selected situations,
- endocrinological assessment.

Important Distinction: A Woman Already Treated for Hypothyroidism Is Different

A patient who already has:

known established hypothyroidism

and takes levothyroxine should have her treatment optimized before pregnancy.

ATA guidance recommends that women already receiving thyroid replacement and planning pregnancy have TSH controlled toward:

the lower end of the normal range and no higher than approximately 2.5 mIU/L before conception.

This is different from starting thyroid medicine in every untreated woman whose TSH happens to be:

- 2.8,
- 3.1,
- 3.7.

Hyperthyroidism and Female Fertility

Hyperthyroidism means:

excessive thyroid hormone activity.

Common causes include:

- Graves' disease,
- toxic thyroid nodules,
- toxic multinodular goiter,
- thyroiditis in some cases.

Symptoms of Hyperthyroidism

These may include:

- unexplained weight loss,



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- heat intolerance,
- sweating,
- rapid heartbeat,
- palpitations,
- anxiety,
- tremor,
- frequent bowel movements,
- muscle weakness,
- menstrual irregularity.

Some women experience:

- oligomenorrhea,
- reduced menstrual flow.

Can Hyperthyroidism Affect Fertility?

Yes.

Significant uncontrolled hyperthyroidism may interfere with:

- menstrual cyclicity,
- ovulation,
- pregnancy health.

A woman with overt hyperthyroidism should ideally achieve good thyroid control before conception.

The American Thyroid Association advises women with Graves' disease to postpone pregnancy until thyroid function is stable. ATA describes stability as two normal thyroid tests at least one month apart without a change in medication dose.

Graves' Disease

Graves' disease is an autoimmune disorder in which antibodies stimulate the thyroid gland.

It can cause:

- hyperthyroidism,



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- goiter,
- eye symptoms in some patients.

Pregnancy planning in Graves' disease requires special care because:

- maternal hyperthyroidism itself can be harmful,
- antithyroid medicines can cross the placenta,
- Graves' antibodies can cross the placenta.

Preconception planning with an:

- endocrinologist,
- obstetrician

is therefore important.

Hashimoto's Thyroiditis

Hashimoto's thyroiditis is an autoimmune thyroid condition.

The immune system produces antibodies such as:

TPO antibodies

against thyroid tissue.

Over time, the thyroid may become:

- underactive.
-

Do Positive TPO Antibodies Automatically Cause Infertility?

No.

Thyroid autoimmunity has been associated in some observational studies with:

- infertility,
- miscarriage,
- reproductive outcomes.

But association does not automatically prove causation.

Current ASRM evidence is conflicting and does not support routine thyroid-antibody screening in:



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every asymptomatic infertile woman.

If TPO Antibodies Are Positive but TSH Is Normal, Should Levothyroxine Be Started?

Not automatically.

Large fertility studies have not shown consistent benefit from treating:

euthyroid thyroid-antibody-positive women

with levothyroxine solely to improve fertility outcomes.

Current reviews continue to describe this as an area of uncertainty rather than a proven fertility treatment.

Symptoms of Thyroid-Related Fertility Problems

There is no single symptom that proves thyroid infertility.

Possible clues include:

- irregular periods,
- absent periods,
- very light or heavy menstruation,
- difficulty conceiving,
- fatigue,
- unexplained weight change,
- heat/cold intolerance,
- palpitations,
- constipation,
- tremor,
- hair/skin changes.

But many of these symptoms are:

non-specific.

A thyroid blood test is required for diagnosis.



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How Are Thyroid Disorders Diagnosed in a Woman With Fertility Problems?

The work-up should be targeted and logical.

Step 1: TSH

TSH is generally the:

best first-line thyroid-function test.

An abnormal TSH then guides further testing.

ASRM recommends thyroid testing particularly when symptoms or signs of hypothyroidism are present, including:

- irregular cycles.
-

Does Every Infertile Woman Need a Thyroid Test?

Not necessarily.

The older approach was often to perform thyroid screening automatically in every infertility evaluation.

ASRM 2024 concluded that universal testing of asymptomatic infertile women is not supported strongly enough by current evidence.

Targeted testing is preferred when there are:

- symptoms,
 - menstrual irregularity,
 - known thyroid disease,
 - goiter,
 - other risk factors.
-

Step 2: Free T4

If TSH is abnormal, free T4 can help determine whether disease is:

Overt hypothyroidism

High TSH + low FT4.

Subclinical hypothyroidism



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High TSH + normal FT4.

Hyperthyroidism

Suppressed TSH with elevated FT4 and/or T3, depending on the disorder.

Does Everyone Need Free T3?

No.

Free T3 is:

not a universal infertility screening test.

It may be useful particularly when:

- hyperthyroidism is suspected,
 - T3-predominant thyrotoxicosis is possible.
-

Thyroid Antibodies

Testing may include:

- TPO antibodies,
- thyroglobulin antibodies,
- TSH-receptor antibodies in Graves' disease.

They should be requested for:

specific clinical reasons

rather than simply because a woman has not conceived.

Does Every Infertile Woman Need a Thyroid Ultrasound?

No.

This is another common misconception.

Ultrasound evaluates:

- thyroid structure,
- nodules,
- enlargement,



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- suspicious lesions.

It does not primarily determine whether thyroid hormone function is normal.

A thyroid ultrasound may be appropriate when there is:

- goiter,
- thyroid lump,
- nodule,
- structural concern.

It is not required merely because:

TSH is mildly abnormal.

Thyroid Disease and Other Fertility Tests

A woman whose thyroid disorder is identified should still undergo appropriate infertility evaluation if pregnancy does not occur.

Depending on the case, this may include:

- ovulation assessment,
- pelvic ultrasound,
- ovarian reserve assessment,
- HSG/HyCoSy,
- male semen analysis.

A normal thyroid does not prove fertility.

An abnormal thyroid does not prove it is the only infertility cause.

Modern Treatment of Hypothyroidism

The standard treatment for overt primary hypothyroidism is:

Levothyroxine – T4 replacement therapy.

The dose should be individualized.

How Should Levothyroxine Be Taken?



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Absorption can be affected by:

- iron,
- calcium,
- food,
- certain medicines.

During pregnancy, ATA specifically recommends separating:

levothyroxine from prenatal vitamins containing iron or calcium by at least four hours.

Patients should follow their endocrinologist's instructions regarding:

- timing,
- dose,
- monitoring.

Do Not Stop Levothyroxine After Becoming Pregnant

Pregnancy generally increases thyroid-hormone requirements.

A woman with established hypothyroidism who stops treatment when pregnancy begins can expose:

- herself,
- the developing baby

to significant risk.

What Happens to Levothyroxine Dose During Pregnancy?

ATA advises women with established hypothyroidism taking levothyroxine that as soon as pregnancy is confirmed:

the dose commonly needs to increase by approximately 20–30%.

One commonly used practical approach is taking:

- two additional usual daily tablets per week,

followed by prompt blood testing and individualized adjustment.

The exact plan should be discussed with the treating physician.



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How Often Is Thyroid Function Checked During Pregnancy?

ATA recommends thyroid-function testing approximately:

every four weeks during the first half of pregnancy

in women treated for hypothyroidism, with further monitoring later as clinically appropriate.

Why Is Maternal Thyroid Hormone Important in Pregnancy?

During the first part of pregnancy, the fetus depends heavily on:

maternal thyroid hormone.

Thyroid hormone is particularly important for:

- fetal brain development,
- nervous-system development.

This is why overt maternal hypothyroidism should be treated properly.

Treatment of Hyperthyroidism Before Pregnancy

The safest strategy is often:

stabilize thyroid function before conception.

Options may include:

- antithyroid medicine,
- surgery,
- radioactive iodine before pregnancy in selected patients.

The choice depends on:

- cause of hyperthyroidism,
 - disease severity,
 - fertility timeline,
 - Graves' antibody levels,
 - patient preference.
-

Antithyroid Medicines During Pregnancy



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When medication is necessary, ATA currently recommends:

PTU – propylthiouracil

as the preferred drug during the first trimester, generally until approximately:

week 16.

This is because birth defects associated with PTU appear less frequent and less severe than those associated with first-trimester methimazole exposure.

The lowest effective antithyroid-drug dose should be used to control maternal disease while reducing fetal risk.

Treatment decisions must be individualized by:

- endocrinology,
- obstetric specialists.

Radioactive Iodine and Pregnancy

Radioactive iodine should:

not be given during pregnancy.

Women who receive radioactive iodine therapy should delay conception.

ATA recommends waiting at least:

6 months

and some guidance uses a:

6–12 month

interval depending on clinical circumstances, while ensuring thyroid function has stabilized.

Does Radioactive Iodine Cause Permanent Female Infertility?

Not usually.

Research suggests it may temporarily affect:

- menstrual cycles,
- AMH

in some women, but long-term pregnancy rates have generally not shown a major permanent reduction.



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Pregnancy timing after treatment is nevertheless important.

Thyroid Surgery and Pregnancy Planning

Surgery may be considered before pregnancy in selected women with:

- Graves' disease,
- large goiter,
- toxic nodules,
- medication intolerance,
- thyroid cancer.

This decision is individualized.

Thyroid Disease During IVF and Other Fertility Treatment

Women undergoing:

- ovarian stimulation,
- IUI,
- IVF

may require thyroid review when they have:

- known thyroid disease,
- symptoms,
- abnormal previous tests.

The objective is:

stable euthyroid physiology

rather than chasing an arbitrary TSH number in every patient.

Current fertility-endocrine literature increasingly discourages automatic levothyroxine treatment at a TSH threshold of 2.5 mIU/L in otherwise euthyroid infertile women because improved fertility outcomes have not been demonstrated consistently.

Can Thyroid Treatment Alone Cure Infertility?

Sometimes thyroid treatment restores:



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- normal periods,
- normal ovulation,

and pregnancy then occurs.

But no physician should promise:

“Correct your thyroid and pregnancy is guaranteed.”

Pregnancy still depends on:

- age,
- egg quality,
- ovulation,
- fallopian tubes,
- uterus,
- sperm,
- embryo development.

Thyroid Disorders and Recurrent Miscarriage

Overt untreated thyroid disease can be associated with adverse pregnancy outcomes.

However, the older practice of blaming every miscarriage on:

borderline TSH

has changed.

ASRM's 2024 guideline found that:

TSH 2.5–4.0 mIU/L is not associated with increased miscarriage risk.

Therefore treatment decisions should be evidence based rather than driven by fear.

Thyroid Autoimmunity and Miscarriage

Thyroid antibodies have been associated with miscarriage in some observational studies.

But current data remain inconsistent.

A woman who is:

- TPO-positive,



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- but euthyroid

should not automatically be told:

“Your thyroid antibodies caused the miscarriage.”

Iodine, Thyroid Health and Pregnancy

Iodine is required for the production of thyroid hormones.

Pregnancy increases iodine requirements.

WHO recommends a total iodine intake of approximately:

250 micrograms per day during pregnancy.

ATA recommends a supplement containing:

150 micrograms of iodine daily

for women in North America who are planning pregnancy, pregnant or breastfeeding; outside North America, supplementation should consider regional diet and iodized-salt availability.

Does More Iodine Mean Better Fertility?

No.

Excess iodine can itself disturb thyroid function.

High-dose:

- kelp,
- seaweed concentrates,
- iodine drops

should not be taken simply to:

“boost the thyroid.”

ATA cautions against excessive iodine exposure.

In India, appropriately iodized dietary salt remains an important public-health source of iodine.

Women with established thyroid disease should discuss supplementation with:

- their endocrinologist,



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- obstetrician.

Lifestyle Measures That Support Thyroid and Reproductive Health

Patients can support general health through:

- balanced nutrition,
- regular appropriate exercise,
- healthy sleep,
- smoking cessation,
- appropriate body weight,
- diabetes control,
- stress management.

These are:

supportive measures.

They do not replace thyroid hormone in:

- overt hypothyroidism

or antithyroid therapy in:

- significant hyperthyroidism.

Can Stress Cause Thyroid Disease?

Stress can influence:

- wellbeing,
- sleep,
- immune physiology.

But patients should not be told:

“Your thyroid problem exists because you worry too much.”

Autoimmune thyroid disease has complex:

- genetic,
- immune,



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- environmental

mechanisms.

Thyroid Disorders in the Unani System of Medicine

The Unani system approaches health through a broader traditional framework involving:

- Mizaj,
- Akhlat,
- organ function,
- diet,
- lifestyle,
- general constitutional balance.

Modern thyroid diseases do not have a perfect one-to-one equivalent in every classical Unani text because modern laboratory endocrinology did not exist in that form.

Contemporary Unani researchers often discuss hypothyroid presentations through the traditional pattern:

Su-e-Mizaj Barid Balghami

or a cold-phlegmatic dyscrasia.

This terminology appears directly in current Unani clinical research on subclinical hypothyroidism.

What Does Su-e-Mizaj Barid Balghami Mean?

In traditional Unani theory:

Barid

means:

- cold.

Balghami

relates to:

- phlegmatic temperament.

Traditional symptoms may overlap phenomenologically with:



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- fatigue,
- cold intolerance,
- sluggishness,
- weight gain,
- constipation.

This helps explain why contemporary Unani researchers have applied the framework to:
hypothyroidism-like clinical presentations.

But Su-e-Mizaj Barid Balghami Is Not the Same as High TSH

This distinction is extremely important.

Mizaj is a traditional clinical concept.

TSH is:

a measurable pituitary hormone.

They should not be presented as scientifically identical.

A woman can receive a traditional Mizaj assessment while still requiring:

- TSH,
 - FT4,
 - endocrine evaluation.
-

The Four Traditional Akhlat

Classical Unani theory recognizes:

- Dam – blood,
- Balgham – phlegm,
- Safra – yellow bile,
- Sauda – black bile.

Alteration in these humors forms part of classical disease theory.

However:

Balgham should not be translated as thyroid hormone deficiency.



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The two systems should remain intellectually distinct.

Major Unani Therapeutic Approaches

Unani medicine includes:

Ilaj-bil-Ghiza

Dietotherapy.

Ilaj-bit-Tadbir

Regimenal therapy.

Ilaj-bid-Dawa

Pharmacotherapy.

Ilaj-bil-Yad

Surgical/manual intervention where relevant.

For a woman with thyroid disease and infertility, the first three may provide supportive value when used appropriately.

Ilaj-bil-Ghiza – Dietotherapy

Dietary care may focus on:

- balanced nutrition,
- adequate protein,
- micronutrient sufficiency,
- healthy metabolic status,
- appropriate energy intake.

If PMOS, obesity or insulin resistance coexist:

- carbohydrate quality,
- weight management where appropriate,
- physical activity

may be relevant.



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No Food Can Replace Levothyroxine

A patient with genuine hypothyroidism should not be told:

“Stop your thyroid tablet and eat this herb or food instead.”

There is no food proven to provide a physiologically reliable substitute for:

thyroxine replacement

when the thyroid gland cannot produce enough hormone.

Ilaj-bit-Tadbir – Regimenal Therapy

Unani regimenal medicine may emphasize:

- daily activity,
- sleep,
- stress management,
- constitutional care,
- appropriate physical regimen.

These can be useful adjuncts for:

- general health,
 - metabolic health.
-

Ilaj-bid-Dawa – Unani Pharmacotherapy

This is an area where new research is particularly interesting.

Rather than relying only on historical claims, we now have:

recent controlled human studies

evaluating specific Unani medicines for hypothyroidism.

Majoone Sarkhas: Important 2025 Unani Research

A randomized, single-blind clinical study published in 2025 involved:

100 patients with primary hypothyroidism.

Participants were divided into:



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- levothyroxine alone,
- levothyroxine plus Majoone Sarkhas.

The Unani formulation contained:

- Commiphora mukul,
- Operculina turpethum,
- Embelia tsjeriam-cottam,
- Dryopteris filix-mas.

Treatment lasted:

60 days.

The combination group showed a significantly greater reduction in TSH than levothyroxine alone, while monitored liver and kidney safety parameters remained within the study's accepted range.

What Does the Majoone Sarkhas Study Prove?

It provides:

promising evidence that the formulation may have an adjunctive role in primary hypothyroidism.

But it does **not** prove that Majoone Sarkhas:

- replaces levothyroxine,
- cures Hashimoto's disease,
- restores ovulation,
- increases pregnancy,
- prevents miscarriage,
- improves IVF live birth.

The study investigated:

thyroid laboratory outcomes

—not fertility outcomes.

That distinction is essential.



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Jadwar: Important 2026 Placebo-Controlled Research

An even newer randomized study was published in:

2026

from researchers associated with the National Institute of Unani Medicine.

The study evaluated:

Jadwar – Delphinium denudatum

in adults with subclinical hypothyroidism.

Thirty participants with TSH approximately:

4.5–15 mIU/L

were randomized to:

- Jadwar,
- placebo

for 56 days.

The Jadwar group showed:

- significant reduction in TSH,
- improvement in fatigue,
- improvement in constipation,

compared with placebo.

No adverse events were reported during the short study.

Why the Jadwar Study Is Important

This is stronger evidence than:

- an anecdote,
- a historical statement,
- a laboratory animal study.

It was:

- randomized,
- placebo controlled,



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- conducted in humans.

However, it involved only:

30 participants

at one centre.

It did not investigate:

- infertility,
- ovulation,
- conception,
- miscarriage,
- pregnancy safety,
- live birth.

Therefore:

Jadwar cannot currently be described as a scientifically proven treatment for thyroid-related infertility.

Should a Woman Stop Levothyroxine and Take Jadwar Instead?

No—not on the basis of current evidence.

The Jadwar study was conducted in:

- subclinical hypothyroidism.

It does not establish that Jadwar can safely replace hormone replacement in:

- overt hypothyroidism,
- pregnancy.

A woman with established thyroid-hormone deficiency should not discontinue levothyroxine without endocrinological supervision.

Are These Unani Medicines Proven Safe in Pregnancy?

Not sufficiently.

A medicine that appears safe in:

- nonpregnant adults for 56–60 days



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is not automatically proven safe for:

- embryos,
- fetuses,
- pregnancy.

Therefore once pregnancy is possible or confirmed:

all Unani and herbal medicines should be reviewed individually.

Unani Treatment and Hyperthyroidism

Evidence for Unani treatment of:

Graves' disease or overt hyperthyroidism

is much less established.

Because uncontrolled hyperthyroidism may lead to serious:

- cardiovascular,
- pregnancy

complications, antithyroid treatment should not be replaced by empirical herbal therapy.

Dr. Nizamuddin Qasmi's Approach at Saira Health Care

When a woman with infertility tells me:

"My thyroid is abnormal,"

I use a structured approach rather than assuming thyroid disease explains everything.

Step 1: Understand the Fertility Problem

I ask:

- How long have you been trying?
- Are cycles regular?
- Have you conceived before?
- Any miscarriages?
- What is your age?



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Step 2: Review Thyroid Symptoms and History

I ask about:

- fatigue,
 - cold/heat intolerance,
 - palpitations,
 - constipation,
 - weight changes,
 - neck swelling,
 - previous thyroid disease,
 - thyroid surgery,
 - radioactive iodine,
 - medicines.
-

Step 3: Review the Actual TSH Result

I do not accept only:

“My thyroid is high.”

I want to see:

- TSH value,
 - laboratory reference range,
 - FT4 when relevant,
 - previous results.
-

Step 4: Differentiate Overt and Subclinical Disease

This is one of the most important steps.

Overt disease

requires clear medical treatment.

Mild subclinical elevation



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may not require thyroid medicine simply because the woman is infertile.

Step 5: Avoid the Automatic “TSH Must Be Below 2.5” Rule

If a woman already has established hypothyroidism and takes levothyroxine:

- preconception optimization is appropriate.

If she has no known thyroid disease and a TSH of:

- 2.8,
- 3.2,
- 3.8

with normal FT4:

I do not automatically label her thyroid as the cause of infertility.

This approach is consistent with ASRM 2024 evidence.

Step 6: Evaluate Menstrual and Ovulatory Function

If periods are irregular, I assess possible:

- thyroid-related ovulatory dysfunction,
 - PMOS,
 - prolactin problems,
 - other endocrine causes.
-

Step 7: Evaluate the Male Partner

This is fundamental.

A woman may spend a year treating:

TSH 3.5

while her husband actually has:

- severe oligozoospermia,
- poor sperm motility,
- azoospermia.



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That is why infertility is treated as:
a couple's reproductive condition.

Step 8: Assess Tubal and Uterine Factors

Where appropriate:

- HSG/HyCoSy,
- pelvic ultrasound

may still be needed.

A normal thyroid does not open a blocked fallopian tube.

Step 9: Assess Traditional Mizaj

If Unani treatment is being considered, I assess:

- constitutional pattern,
- digestive health,
- sleep,
- lifestyle,
- traditional Mizaj.

This adds:

individualized traditional information

without replacing thyroid blood testing.

Step 10: Ilaj-bil-Ghiza

I individualize diet according to:

- metabolic health,
- thyroid condition,
- nutritional needs,
- fertility goals.

I do not promote extreme:



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- iodine restriction,
 - iodine loading,
 - “thyroid detox” diets.
-

Step 11: Ilaj-bit-Tadbir

I address:

- activity,
 - sleep,
 - stress,
 - smoking,
 - weight where appropriate.
-

Step 12: Consider Evidence-Informed Unani Pharmacotherapy

Recent research on:

- Majoone Sarkhas,
- Jadwar

is encouraging.

Where appropriate, such evidence can inform future integrative practice.

However:

treatment must remain individualized and should not replace standard endocrine care without sufficient evidence.

Step 13: Coordinate With an Endocrinologist

This is especially important in:

- overt hypothyroidism,
- Graves' disease,
- significant hyperthyroidism,
- pregnancy,



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- thyroid nodules,
- previous thyroid cancer.

An integrative doctor should know when:

specialist co-management improves safety.

Step 14: Plan Thyroid Management Before Pregnancy

If a woman is already taking levothyroxine:

- optimize thyroid control before conception.

If she has Graves' disease:

- stabilize disease before trying to conceive.
-

Step 15: Make a Pregnancy Plan in Advance

I advise the patient to know:

- whom to contact after a positive test,
 - whether levothyroxine dose should change,
 - when TSH will be checked,
 - which traditional medicines should stop or be reviewed.
-

Step 16: Do Not Allow Thyroid Treatment to Delay Necessary Fertility Treatment

ASRM specifically warns that overemphasis on obtaining a TSH below:

2.5 mIU/L

can unnecessarily delay:

- infertility treatment,
- IVF.

This is a particularly important message for women whose:

- age,
- ovarian reserve



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make reproductive time valuable.

Saira Health Care's Contribution to Sexual Disorders and Infertility

Saira Health Care's public physician profile identifies Dr. Nizamuddin Qasmi's focused clinical practice in:

Sexual Disorders & Infertility

and includes reproductive problems such as:

- hormonal imbalance,
- PMOS/PCOS,
- irregular menses,
- diminished AMH,
- male infertility disorders.

The clinic describes its broader model as:

- patient-centred,
- individualized,
- combining traditional knowledge,
- modern research,
- lifestyle guidance.

This model is particularly relevant to thyroid-related infertility because reproductive care should not focus on:

one laboratory number alone.

A woman may simultaneously have:

- thyroid disease,
- PMOS,
- a tubal problem,

while the husband may have:

- a semen abnormality.

The whole couple should therefore be evaluated.



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About Dr. Nizamuddin Qasmi

I am:

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

My professional education and additional training include:

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

Saira Health Care's public physician profile lists BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK, and describes my clinical focus in sexual disorders and infertility.

Saira Health Care's currently published professional articles also use:

- Masters in Male Infertility – MasterHealthPro,
- Integrated Sexual and Reproductive Health – ISRH, UNFPA

in the physician byline.

Why Male Infertility Training Matters in an Article About Thyroid and Female Fertility

Because pregnancy belongs to:

the couple.

Suppose the woman has:

- controlled hypothyroidism,
- regular ovulation.

Her husband may simultaneously have:

- low sperm count,



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- poor motility,
- varicocele.

Treating only the woman's thyroid could lose valuable fertility time.

This is why I prefer:

parallel male and female evaluation.

Common Myths About Thyroid and Female Infertility

Myth 1: Every infertile woman has to test TSH, T3, T4, antibodies and thyroid ultrasound.

Fact: Current ASRM guidance favors targeted testing. TSH is the key initial test when thyroid symptoms or menstrual irregularity are present.

Myth 2: TSH must always be below 2.5 to become pregnant.

Fact: TSH 2.5–4.0 mIU/L has not been shown to increase miscarriage risk, and routine treatment solely to reach <2.5 is not supported for every woman.

Myth 3: TSH 3.0 means I have hypothyroidism.

Fact: Diagnosis depends on the laboratory reference range, FT4 and clinical context.

Myth 4: Subclinical hypothyroidism always causes infertility.

Fact: Current evidence is insufficient to establish this consistently.

Myth 5: Levothyroxine improves IVF success in every woman with a mildly elevated TSH.

Fact: This has not been demonstrated reliably.

Myth 6: Positive TPO antibodies always cause infertility.

Fact: The association is complex, and antibody positivity alone does not prove causation.

Myth 7: Every TPO-positive woman needs levothyroxine.



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Fact: Treatment is not routinely recommended solely because antibodies are present when thyroid function is otherwise normal.

Myth 8: Hypothyroidism always means weight gain.

Fact: Some patients have little or no weight change.

Myth 9: Hyperthyroidism always causes weight loss.

Fact: Clinical presentation varies.

Myth 10: A thyroid ultrasound can tell whether thyroid hormones are normal.

Fact: Ultrasound primarily assesses structure; blood tests assess thyroid function.

Myth 11: Natural iodine supplements can cure thyroid disease.

Fact: Both deficiency and excess iodine can cause thyroid dysfunction.

Myth 12: Kelp is the best thyroid fertility supplement.

Fact: Kelp can contain unpredictable and excessive iodine.

Myth 13: If thyroid levels are corrected, pregnancy is guaranteed.

Fact: Fertility depends on many additional male and female factors.

Myth 14: Unani medicine has no scientific research in hypothyroidism.

Fact: Recent controlled human studies have evaluated Majoone Sarkhas and Jadwar.

Myth 15: The latest Unani studies prove thyroid infertility can be cured naturally.

Fact: Those trials studied thyroid laboratory outcomes—not pregnancy or live birth.

Myth 16: Jadwar can replace levothyroxine in pregnancy.



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Fact: This has not been established and would be unsafe to assume.

Myth 17: Herbal medicines are automatically safe in pregnancy.

Fact: Pregnancy safety must be established separately.

Myth 18: Thyroid medicine should be stopped once pregnancy begins.

Fact: Women with established hypothyroidism usually require continued—and often increased—levothyroxine.

Frequently Asked Questions

Can thyroid problems cause infertility?

Yes, especially:

- overt hypothyroidism,
- significant hyperthyroidism

when they disrupt menstrual or ovulatory physiology.

What thyroid test should I do first?

Usually:

TSH.

If abnormal, further testing such as:

- FT4

is often appropriate.

Do I need T3?

Not routinely for every fertility patient.

It is more useful in selected hyperthyroidism evaluations.

Do I need thyroid antibodies?



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Not automatically.

They are useful in selected autoimmune-thyroid situations.

Do I need thyroid ultrasound?

Only if structural thyroid disease is suspected, for example:

- goiter,
 - nodule.
-

My TSH is 3.5. Is this preventing pregnancy?

Not necessarily.

Current ASRM evidence does not show that TSH:

2.5–4.0

causes increased miscarriage or clearly causes infertility.

Should I take levothyroxine with a TSH of 3.5?

Not automatically.

The decision depends on:

- FT4,
 - symptoms,
 - existing thyroid disease,
 - pregnancy status,
 - other factors.
-

I already take levothyroxine. What should my TSH be before pregnancy?

ATA recommends optimizing known treated hypothyroidism before conception, generally toward:

the lower normal range and no higher than about 2.5 mIU/L.



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What should I do as soon as I become pregnant while taking levothyroxine?

Contact your physician promptly.

ATA guidance commonly recommends increasing the pre-pregnancy dose by:

20–30%

as soon as pregnancy is confirmed, followed by early blood testing.

How often is TSH checked during pregnancy?

For women with treated hypothyroidism:

approximately every four weeks during the first half of pregnancy

is commonly recommended.

Can prenatal vitamins interfere with thyroid medicine?

Yes.

Iron and calcium can reduce levothyroxine absorption.

ATA recommends separating them by:

at least four hours.

Can a woman with Graves' disease become pregnant?

Yes, but pregnancy should ideally be planned after thyroid function has stabilized.

Which hyperthyroidism medicine is preferred during early pregnancy?

When antithyroid therapy is necessary:

PTU

is generally preferred through approximately week 16.

Can I become pregnant immediately after radioactive iodine?

No.



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Pregnancy is generally postponed for:

at least six months

and often 6–12 months depending on the treatment context.

Does Hashimoto's disease always cause infertility?

No.

Many women with Hashimoto's conceive successfully, particularly when thyroid function is appropriately managed.

Can Unani medicine help hypothyroidism?

Recent research is promising.

A 2025 randomized study found that Majoone Sarkhas used as an **adjunct to levothyroxine** improved thyroid laboratory parameters more than levothyroxine alone.

A 2026 randomized placebo-controlled trial found that Jadwar reduced TSH and improved some symptoms in subclinical hypothyroidism.

Does that mean Unani medicine cures thyroid-related infertility?

No.

Neither trial measured:

- ovulation,
 - conception,
 - miscarriage,
 - live birth.
-

Can Unani medicine be used alongside modern thyroid treatment?

Potentially, yes, when:

- prescribed by a qualified practitioner,
- reviewed for interactions,
- coordinated with endocrine care.



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The 2025 Majoone Sarkhas study itself evaluated:

Unani medicine as an adjunct to levothyroxine.

Can I take Majoone Sarkhas or Jadwar during pregnancy?

Do not self-prescribe either during pregnancy.

The available trials do not establish fetal/pregnancy safety.

Latest Scientific Perspective: 2024–2026

Several developments are especially important.

1. Mild TSH elevation is being treated more cautiously

The ASRM 2024 guideline states that:

- TSH 2.5–4.0 is not associated with increased miscarriage,
 - SCH has not been clearly demonstrated to cause infertility,
 - routine levothyroxine solely to improve fertility/live birth is not recommended.
-

2. A 2026 Endocrine Review Reinforces This Change

A major 2026 review concludes that overt thyroid dysfunction clearly affects reproduction, while treatment thresholds around:

TSH 2.5 mIU/L

for subclinical disease are increasingly being reconsidered because improved reproductive outcomes have not been established consistently.

3. Known Hypothyroidism Still Requires Careful Pregnancy Management

Women already taking levothyroxine should:

- optimize control before conception,
 - increase the dose promptly when pregnancy occurs as directed,
 - monitor thyroid function frequently.
-

4. Graves' Disease Requires Planned Conception



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Women with Graves' disease should ideally enter pregnancy only after:
stable thyroid control.

5. Unani Thyroid Research Has Advanced

The 2025 Majoone Sarkhas randomized trial included:

100 participants

and demonstrated an adjunctive laboratory benefit with levothyroxine.

The 2026 Jadwar randomized placebo-controlled trial demonstrated significant improvement in:

- TSH,
- fatigue,
- constipation

in a small group of subclinical hypothyroid patients.

These represent important steps toward:

evidence-informed Unani medicine.

But fertility-specific trials are still needed.

My Final Message to Women With Thyroid Problems and Infertility

If you are trying to conceive and your thyroid test is abnormal, do not panic.

Ask:

Is this overt hypothyroidism or only a mild TSH elevation?

What is my free T4?

Do I actually have thyroid symptoms?

Do I have Hashimoto's or Graves' disease?

Are my periods irregular because I am not ovulating?

Could PMOS or prolactin be involved as well?

Are my tubes open?

What is my age and ovarian reserve?



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Has my husband's semen been evaluated?

Do I genuinely need levothyroxine—or am I being treated simply to push TSH below 2.5?

If I already take levothyroxine, is my dose optimized before pregnancy?

What should I do immediately after a positive pregnancy test?

Can evidence-informed Unani diet, lifestyle or supportive pharmacotherapy be integrated safely?

These questions are more useful than simply asking:

“What medicine will normalize my TSH?”

Conclusion

The thyroid gland is closely connected with female reproductive physiology.

Overt:

- hypothyroidism,
- hyperthyroidism

can disturb:

- menstruation,
- ovulation,
- pregnancy health.

When clinically significant thyroid dysfunction is responsible for reproductive disturbance:

appropriate thyroid treatment is important and may restore normal reproductive physiology.

However, modern evidence has also corrected a major area of over-treatment.

A mildly elevated TSH should not automatically be treated as:

the cause of infertility.

ASRM's current evidence concludes that:

- TSH 2.5–4.0 mIU/L does not increase miscarriage risk,
- subclinical hypothyroidism has not been clearly demonstrated to cause infertility,
- levothyroxine has not been shown to improve pregnancy or live birth when prescribed routinely for SCH solely for reproductive benefit.



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Women with established hypothyroidism are different.

They should enter pregnancy with:

- appropriately controlled thyroid function

and generally require a levothyroxine dose increase of approximately:

20–30%

once pregnancy is confirmed, with close monitoring.

Women with significant hyperthyroidism or Graves' disease should ideally stabilize thyroid function:

before conception.

If antithyroid medication is required in early pregnancy, PTU is generally preferred through approximately week 16.

The **Unani system of medicine** offers an important whole-person framework involving:

- Mizaj,
- Akhlat,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa.

Contemporary Unani medicine is also beginning to develop stronger clinical evidence.

A 2025 randomized trial found that:

Majoone Sarkhas plus levothyroxine

improved thyroid-function parameters more than levothyroxine alone in primary hypothyroidism.

A 2026 placebo-controlled trial found that:

Jadwar

reduced TSH and improved selected symptoms in subclinical hypothyroidism.

These studies are encouraging and demonstrate the potential for:

scientifically evaluated integrative Unani care.

But they do not yet prove that Unani medicines:

- induce ovulation,



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- increase natural conception,
- improve IVF live birth,
- prevent miscarriage,
- replace levothyroxine,
- are safe throughout pregnancy.

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

Confirm the thyroid diagnosis properly.

Differentiate overt disease from mild subclinical abnormalities.

Use TSH as the principal screening test where indicated.

Use FT4 and additional tests according to the clinical picture.

Do not order thyroid ultrasound unnecessarily.

Treat genuine hypothyroidism appropriately.

Stabilize hyperthyroidism before conception.

Do not automatically treat every TSH above 2.5.

Evaluate ovulation, the uterus and fallopian tubes when required.

Evaluate the male partner at the same time.

Use individualized Unani Mizaj, diet and lifestyle support where appropriate.

Use emerging Unani pharmacological evidence responsibly rather than turning preliminary results into cure claims.

Do not stop levothyroxine or antithyroid treatment without medical supervision.

Review every herbal and Unani medicine when pregnancy occurs.

And never allow treatment of one thyroid number to unnecessarily delay important fertility care.

When a patient asks me:

“Doctor, can my thyroid problem be treated and can I still become pregnant?”

my answer is:

In many cases, yes. Women with thyroid disorders commonly achieve healthy pregnancies when the thyroid condition is accurately diagnosed and properly controlled. The key is to distinguish significant thyroid disease from mild laboratory variation, treat the real



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endocrine problem, evaluate the rest of the reproductive system, and use Unani supportive care responsibly alongside modern thyroid and fertility treatment where appropriate.

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About the Author

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

Professional Education & Additional Training

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



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Saira Health Care's public professional profile identifies Dr. Nizamuddin Qasmi's clinical work as focused on **Sexual Disorders & Infertility**, including hormonal imbalance, irregular menstruation and male and female reproductive-health conditions.

Medical Disclaimer

This article is intended for:

- patient education,
- thyroid awareness,
- fertility education,
- reproductive-health information.

It does not replace:

- endocrinology consultation,
- gynecological consultation,
- obstetric care,
- individual thyroid testing,
- infertility assessment.

Do not independently start, stop or change:

- levothyroxine,
- methimazole,
- carbimazole,
- PTU,
- beta-blockers,
- iodine supplements,
- Majoone Sarkhas,
- Jadwar,
- other Unani or herbal medicines

because you are trying to conceive.

Seek appropriate medical care promptly if you have:

- severe palpitations,



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- chest pain,
- fainting,
- severe weakness,
- marked neck swelling,
- severe hyperthyroid symptoms,
- pregnancy with poorly controlled thyroid disease.

Women taking thyroid medicine who become pregnant should inform their treating physician promptly.

No modern, hormonal, Unani, herbal, IUI, IVF or other fertility treatment can ethically guarantee:

- ovulation,
- conception,
- pregnancy,
- live birth.

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