Recurrent Pregnancy Loss:

Causes, Diagnosis, Modern Treatment and the Role of Unani Medicine

Recurrent Miscarriage / Habitual Abortion / Kasrat-i Isqat

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Introduction: "Doctor, I Can Become Pregnant—Why Do I Keep Losing the Pregnancy?"

Few experiences in reproductive medicine are as emotionally difficult as becoming pregnant repeatedly and then losing the pregnancy.

Women often come to me and say:

"Doctor, I conceive easily, but the pregnancy does not continue."

Another patient asks:

"I have had two miscarriages. Should I wait for a third before getting investigated?"

Someone else says:

"All my reports are normal. Why does my pregnancy stop developing at six or eight weeks?"

And many women ask:

"Can my uterus be strengthened so that the next pregnancy stays?"

These questions require compassion, but they also require accurate diagnosis.

The condition is now preferably called:

Recurrent Pregnancy Loss – RPL

or:

Recurrent Miscarriage.

The older expressions:

- habitual abortion,
- recurrent abortion,
- *Isqat-e-Hamal*,
- *Kasrat-i Isqat*

are still encountered in older textbooks and Unani literature.

For a modern patient-facing medical article, however, I prefer:

Recurrent Pregnancy Loss

because the word “abortion” may be misunderstood as referring to an intentionally terminated pregnancy.

How Many Miscarriages Are Considered Recurrent Pregnancy Loss?

There is no single definition used by every international organization.

ASRM – Updated 2026

The American Society for Reproductive Medicine now defines recurrent pregnancy loss as:

two or more spontaneous pregnancy losses

and excludes confirmed:

- ectopic pregnancy,
- molar pregnancy.

ASRM 2026 also allows pregnancy losses documented by:

- urine hCG,
- blood hCG,

rather than requiring every loss to have been seen on ultrasound.

ACOG

The American College of Obstetricians and Gynecologists also defines recurrent pregnancy loss as:

two or more miscarriages

and recommends evaluation after two pregnancy losses.

ESHRE

The European Society of Human Reproduction and Embryology uses:

two or more pregnancy losses

as the basis for recurrent pregnancy loss.

RCOG

The Royal College of Obstetricians and Gynaecologists continues to formally define recurrent miscarriage as:

three or more first-trimester miscarriages.

However, its 2023 guideline specifically encourages clinicians to consider detailed investigation after:

two miscarriages

when the losses appear more likely to be pathological than simply sporadic.

My Practical Approach

If a woman has suffered:

two pregnancy losses

I do not believe she should automatically be told:

“Come back only after you lose another pregnancy.”

The decision to investigate should consider:

- maternal age,
- gestational age of the losses,
- whether fetal heart activity had been seen,
- chromosome results if available,
- family history,
- second-trimester loss,

- previous infertility,
- uterine abnormalities,
- medical diseases.

Recurrent Pregnancy Loss Is Different From Infertility

This is important.

Infertility

means difficulty:

becoming pregnant.

Recurrent Pregnancy Loss

means pregnancy occurs, but repeatedly:

does not continue successfully.

A couple can have:

- infertility alone,
- recurrent miscarriage alone,
- both infertility and recurrent miscarriage.

ASRM's 2026 guideline specifically describes RPL as a condition distinct from infertility requiring its own evaluation.

How Common Is Miscarriage?

A single early miscarriage is unfortunately common.

Approximately:

10–20% of recognized pregnancies

may end in miscarriage, depending on how pregnancy is defined and the population studied.

The risk increases strongly with:

maternal age.

RCOG notes that sporadic miscarriage risk increases substantially with advancing reproductive age.

Repeated miscarriage is much less common.

ACOG estimates that fewer than:

5 in 100 women

experience two consecutive miscarriages.

The Most Important Cause of Early Miscarriage: Chromosome Abnormality

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

Approximately:

50–60% of first-trimester miscarriages

are related to an abnormal number of chromosomes in the embryo.

This is called:

aneuploidy.

Examples include:

- trisomy,
- monosomy,
- polyploidy.

ASRM's updated 2026 guideline identifies embryonic aneuploidy as the most common explanation for first-trimester miscarriage.

Does Chromosome Abnormality Mean the Parents Have a Genetic Disease?

Usually:

No.

Most embryonic chromosome abnormalities occur:

- randomly,
- during egg or sperm cell division.

This is particularly common with increasing:

female age.

The egg may receive an incorrect chromosome number even though both parents have normal chromosomes.

Why Maternal Age Matters

Egg quality is closely related to:

chromosomal competence.

ASRM reports that chromosome abnormalities may be found in approximately:

- 50% of miscarriages among women younger than 35,
- around 75% among women over 40

in tested miscarriage tissue.

Therefore:

age cannot be ignored in recurrent miscarriage counselling.

Important Message to Patients

When an early embryo has a major random chromosome abnormality:

no diet, hormone, bed rest, injection or uterine tonic can reliably make that genetically abnormal embryo become chromosomally normal.

This is why miscarriage should never automatically be blamed on:

- uterine weakness,
- walking,
- intercourse,
- working,
- stress,
- eating one particular food.

Causes of Recurrent Pregnancy Loss

Recurrent miscarriage is not one disease.

Several different mechanisms may be responsible.

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1. Embryonic Chromosomal Abnormalities

This is especially important in:

- early miscarriage,
- older maternal age.

Most are random events.

But repeated genetic testing can sometimes identify patterns that require further evaluation.

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2. Parental Chromosome Rearrangements

A small number of couples have a:

balanced structural chromosomal rearrangement

such as a balanced translocation.

The parent may be completely healthy.

But some eggs or sperm may receive:

- too much,
- or too little

chromosomal material.

This can lead to:

- miscarriage,
- abnormal pregnancy.

Should Every Couple Automatically Have a Karyotype?

Current ASRM 2026 guidance has become more targeted.

ASRM now recommends first considering:

chromosome analysis of miscarriage tissue

when feasible.

Parental karyotyping should particularly be offered when:

- miscarriage testing identifies an unbalanced structural rearrangement,
- or miscarriage tissue was not available for testing.

Genetic counselling is important when an abnormality is identified.

3. Uterine Structural Abnormalities

The shape and internal cavity of the uterus can influence pregnancy.

Relevant conditions may include:

- septate uterus,
- bicornuate uterus,
- submucosal fibroids,
- endometrial polyps,
- intrauterine adhesions,
- retained pregnancy tissue.

ASRM recommends offering uterine-cavity evaluation to women with unexplained recurrent pregnancy loss.

Septate Uterus

A uterine septum is a wall of tissue dividing part of the uterine cavity.

It is associated with an increased risk of:

- miscarriage.

Hysteroscopic surgery may be considered depending on the individual situation.

However, evidence that every anatomical abnormality must be operated on is not equally strong.

Fibroids

Fibroids are extremely common.

Not every fibroid causes miscarriage.

The clinical importance depends on:

- size,
- number,
- location,
- whether the fibroid distorts the uterine cavity.

A small fibroid outside the cavity should not automatically be blamed for every pregnancy loss.

Asherman Syndrome

Adhesions inside the uterus can develop after:

- curettage,
- retained pregnancy tissue,
- infection,
- uterine surgery.

Repeated miscarriage procedures themselves can sometimes increase the risk of intrauterine adhesions.

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4. Antiphospholipid Syndrome – APS

APS is one of the most important:

treatable causes of recurrent pregnancy loss.

It is an autoimmune condition associated with:

- abnormal blood-clotting tendency,
- pregnancy complications.

Testing may include:

- lupus anticoagulant,
- anticardiolipin antibodies,
- anti-beta-2 glycoprotein I antibodies.

Diagnosis requires specific:

- clinical,
- laboratory

criteria.

It should not be diagnosed merely because one antibody test is borderline.

How Is APS Treated During Pregnancy?

For women with properly confirmed obstetric APS, treatment commonly involves:

low-dose aspirin plus heparin.

ASRM states that this combination reduces miscarriage risk and improves live-birth probability in an appropriately defined APS population.

This is a very important example of why traditional support must not replace:

cause-specific modern treatment.

Should Every Woman With Miscarriage Take Aspirin?

No.

This is a major misconception.

Some women begin:

- aspirin,
- low-molecular-weight heparin injections

after miscarriage without a diagnosis.

ASRM 2026 specifically states that empiric aspirin or anticoagulant treatment:

does not improve live birth in unexplained recurrent pregnancy loss without APS.

These medicines also carry:

- bleeding,
- bruising,
- other risks.

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5. Inherited Thrombophilia

Tests sometimes ordered include:

- Factor V Leiden,
- prothrombin gene mutation,
- protein C,

- protein S,
- antithrombin,
- MTHFR,
- homocysteine.

Current ASRM 2026 guidance does:

not recommend routine inherited-thrombophilia testing in recurrent pregnancy loss.

Routine anticoagulant treatment for hereditary thrombophilia solely to prevent recurrent miscarriage has not been shown to improve live birth.

MTHFR Is Especially Over-Tested

Patients frequently come with:

MTHFR reports

and are told this explains their miscarriages.

Current recurrent-pregnancy-loss guidelines do not recommend routine MTHFR testing as part of the RPL work-up.

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6. Thyroid Disease

Untreated overt hypothyroidism is associated with:

- miscarriage,
- adverse pregnancy outcomes.

ASRM 2026 recommends TSH evaluation particularly when:

- miscarriage tissue was euploid,
- no miscarriage chromosome testing was available,
- or thyroid risk factors/symptoms exist.

Overt thyroid disease should be appropriately treated before and during pregnancy.

What About Thyroid Antibodies?

Women with:

- normal thyroid function,

- positive thyroid antibodies

do not automatically benefit from thyroid hormone therapy.

ASRM 2026 does not recommend routine thyroid-antibody screening in RPL because good trials have not demonstrated benefit from treating euthyroid women solely because antibodies are present.

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7. Diabetes and Metabolic Health

Poorly controlled diabetes can increase:

- miscarriage risk,
- congenital abnormalities,
- other pregnancy complications.

Good glucose control:

before conception

is extremely important.

ASRM 2026 considers HbA1c testing appropriate when risk factors such as:

- PMOS,
- obesity,
- age above 40,
- symptoms of abnormal glucose metabolism

are present.

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8. PMOS / Formerly PCOS

PMOS, previously known as PCOS, may coexist with:

- metabolic dysfunction,
- infertility,
- miscarriage risk factors.

However, the diagnosis itself should not become a convenient explanation for every miscarriage.

Management should focus on:

- metabolic health,
- ovulation,
- diabetes risk,
- weight where relevant,
- other identified problems.

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9. Cervical Insufficiency and Later Pregnancy Loss

Some women experience pregnancy losses predominantly in the:

second trimester

rather than early embryonic losses.

A cervix that opens prematurely can contribute to:

- late miscarriage,
- preterm birth.

A cervical cerclage—a stitch around the cervix—may be appropriate in selected women with a history suggestive of cervical insufficiency.

RCOG recommends specialist assessment for women with previous:

- miscarriage after 16 weeks,
- very early spontaneous birth,
- certain cervical procedures.

Cerclage is:

not a routine treatment for recurrent early miscarriage.

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10. Male Factors

Recurrent miscarriage is not only a female issue.

This is increasingly important in current research.

ASRM 2026 notes that:

- paternal age,
- metabolic health

may be associated with miscarriage.

Standard semen count, motility and morphology do not predict RPL very well.

However:

increased sperm DNA fragmentation

has been associated with recurrent miscarriage.

Should Every Husband Have Sperm DNA Fragmentation Testing?

No.

ASRM 2026 states that SDF testing:

may be considered

in:

- otherwise unexplained recurrent miscarriage,
- recurrent miscarriage with infertility.

It is not a mandatory first test for every couple.

This is particularly relevant to my focused practice because male reproductive health may be overlooked when pregnancy loss is repeatedly treated only as:

“a weak uterus.”

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11. Chronic Endometritis

Chronic endometritis is a subtle inflammatory condition of the uterine lining.

It has attracted considerable interest as a possible contributor to:

- infertility,
- recurrent miscarriage.

However, the evidence is evolving.

ASRM 2026 notes that a recent high-quality randomized trial did not show improved miscarriage or live-birth outcomes from routine doxycycline treatment of biopsy-confirmed chronic endometritis in RPL patients.

Therefore:

routine antibiotics for recurrent miscarriage are not appropriate.

12. Infections

Acute severe infection can sometimes contribute to pregnancy loss.

But common recurrent-miscarriage practice should not involve repeated testing or treatment for:

- Mycoplasma,
- Ureaplasma,
- vaginal microbiome abnormalities

without an appropriate clinical indication.

ASRM 2026 specifically lists routine microbiome testing among:

tests not recommended in the standard RPL work-up.

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13. Lifestyle and Environmental Factors

Several lifestyle factors are associated with miscarriage risk.

These may include:

- cigarette smoking,
- secondhand smoke,
- obesity,
- excessive alcohol,
- very high caffeine exposure,
- recreational drugs.

ASRM 2026 strongly recommends:

smoking cessation

during preconception care.

Does Normal Exercise Cause Miscarriage?

Normal physical activity is:

not considered a cause of recurrent miscarriage.

ASRM notes that low-to-moderate exercise is not associated with miscarriage.

Women should not spend an entire pregnancy frightened that:

- walking,
- climbing normal stairs,
- normal daily activity

will automatically cause pregnancy loss.

Specific restrictions may be appropriate only when an obstetric condition requires them.

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14. Unexplained Recurrent Pregnancy Loss

Despite good investigation:

a clear cause is still not found in many couples.

This is understandably frustrating.

But unexplained does not mean:

hopeless.

ASRM 2026 estimates that approximately:

50–80%

of people with unexplained recurrent pregnancy loss may ultimately achieve success in a subsequent pregnancy without a specific RPL intervention, depending strongly on age and reproductive history.

ACOG gives a patient-friendly estimate of approximately:

65%

successful next pregnancies in unexplained recurrent pregnancy loss.

These are population estimates, not individual guarantees.

Symptoms of Recurrent Pregnancy Loss

Recurrent pregnancy loss itself generally causes:

no symptoms between pregnancies.

During a pregnancy that is miscarrying, symptoms may include:

- vaginal bleeding,
- pelvic cramps,
- lower abdominal pain,
- passage of clots,
- passage of pregnancy tissue.

Some women experience:

no symptoms at all

and pregnancy loss is discovered during ultrasound.

Does Loss of Pregnancy Symptoms Mean Miscarriage?

Not necessarily.

Symptoms such as:

- nausea,
- breast tenderness

naturally change during early pregnancy.

A reduction in symptoms alone cannot diagnose miscarriage.

Confirmation usually requires:

- ultrasound,
- sometimes serial hCG assessment.

Bleeding Does Not Always Mean Miscarriage

Bleeding in early pregnancy is relatively common.

Some women with:

- spotting,
- mild bleeding

continue to have a normal pregnancy.

However, bleeding should be medically assessed, particularly in women with previous miscarriage.

When Bleeding or Pain Is an Emergency

Seek urgent medical evaluation for:

- very heavy bleeding,
- severe abdominal pain,
- severe one-sided pelvic pain,
- shoulder-tip pain,
- dizziness,
- fainting,
- marked weakness,
- fever,
- foul vaginal discharge.

These symptoms can indicate:

- severe bleeding,
- infection,
- ectopic pregnancy

and should not be managed at home with herbal medicine.

How Is Recurrent Pregnancy Loss Diagnosed?

Modern investigation is becoming increasingly:

stepwise and targeted.

One of the biggest changes in the ASRM 2026 guideline is the emphasis on:

testing the miscarriage itself.

Step 1: Review Every Previous Pregnancy

I want to know:

- Was pregnancy confirmed only by hCG?
- Was a gestational sac seen?
- Was fetal heart activity seen?
- At what gestational age did the loss occur?
- Was the loss first trimester or later?
- Was it spontaneous?
- Was there ectopic pregnancy?
- Was it molar pregnancy?
- Was chromosome testing done?

The pattern matters.

Step 2: Chromosome Testing of Miscarriage Tissue

ASRM 2026 now recommends:

array-based chromosome analysis of miscarriage tissue

when feasible as a first step in RPL evaluation.

This can often tell us whether the loss resulted from:

- random aneuploidy,
- a structural chromosomal abnormality,
- a potentially recurrent pattern.

This can prevent unnecessary testing when a miscarriage is clearly explained by a random chromosome error.

Step 3: Evaluate the Uterine Cavity

ASRM recommends uterine-cavity evaluation for women with unexplained RPL.

Tests may include:

- 3D ultrasound,
- saline sonography,

- HSG,
- hysteroscopy,
- selected MRI.

3D ultrasonography can be particularly useful for congenital uterine abnormalities.

Step 4: Antiphospholipid Syndrome Testing

Testing should be used when clinical criteria make APS relevant.

It may include:

- lupus anticoagulant,
- anticardiolipin IgG/IgM,
- beta-2 glycoprotein antibodies.

One abnormal result is not sufficient.

Persistence usually needs confirmation:

at least 12 weeks apart

within formal diagnostic criteria.

Step 5: Thyroid Evaluation

TSH assessment may be appropriate depending on:

- symptoms,
- risk factors,
- miscarriage chromosome findings.

Treat genuine thyroid dysfunction.

Step 6: Metabolic Assessment

In selected women:

- HbA1c,
- diabetes evaluation

may be appropriate.

Step 7: Parental Chromosome Testing

Parental karyotypes are particularly useful when:

- miscarriage tissue shows an unbalanced structural rearrangement,
- or miscarriage tissue could not be tested.

Genetic counselling should accompany abnormal findings.

Step 8: Male Evaluation

I review:

- male age,
- health,
- tobacco,
- obesity/metabolic disease,
- medications,
- varicocele,
- reproductive history.

Selected unexplained RPL cases may justify:

sperm DNA fragmentation testing

and reproductive-urology assessment.

Tests That Should Not Be Ordered Routinely

Modern RPL treatment is moving away from indiscriminate “hidden cause” testing.

ASRM 2026 does not recommend routine:

- inherited-thrombophilia panels,
- MTHFR testing,
- broad autoimmune panels,
- NK-cell tests,
- endometrial-receptivity tests,

- microbiome testing,
- Mycoplasma/Ureaplasma screening,
- ovarian-reserve testing solely because of recurrent miscarriage.

More tests do not automatically mean:

better medicine.

Modern Treatment of Recurrent Pregnancy Loss

There is no universal treatment.

Treatment depends on:

the identified cause.

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1. Chromosome-Related Miscarriage

If the miscarriage shows a random chromosome abnormality:

- counselling,
- age-based prognosis,
- future pregnancy planning

may be the main management.

A random aneuploid miscarriage does not necessarily require:

- anticoagulants,
- immune treatment,
- hormone treatment.

Balanced Translocation

If one partner carries a chromosomal rearrangement, options may include:

- natural conception with prenatal testing,
- IVF with PGT-SR,
- donor gametes in selected circumstances.

Genetic counselling is essential.

Is IVF With PGT-A the Best Treatment for Every Recurrent Miscarriage?

No.

This is another major 2026 correction.

ASRM reports that:

PGT-A has not been proven to reduce miscarriage or improve live-birth rates in RPL compared with expectant management in prospective evidence.

It may be discussed selectively, particularly in older women with demonstrated aneuploid losses, but it is not a universal treatment for recurrent miscarriage.

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2. Antiphospholipid Syndrome

For properly diagnosed APS:

low-dose aspirin plus prophylactic heparin

is an evidence-based treatment pathway.

Unani supportive treatment should never replace this where APS has been confirmed.

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3. Uterine Abnormalities

Depending on the abnormality, hysteroscopic correction may be considered for:

- septum,
- submucosal fibroid,
- polyp,
- adhesions,
- retained tissue.

ASRM states that such treatment may reasonably be offered, although evidence strength differs among abnormalities.

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4. Cervical Insufficiency

Selected women with characteristic:

- second-trimester loss,
- short cervix,
- previous preterm birth

may benefit from:

cervical cerclage.

This should be planned with an obstetric specialist.

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5. Thyroid Disease

Treat:

- overt hypothyroidism,
- clinically significant thyroid dysfunction.

Do not automatically prescribe thyroid hormone merely because:

- thyroid antibodies are present,
- thyroid function is otherwise normal.

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6. Diabetes

Achieve good glucose control:

before pregnancy and throughout pregnancy.

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7. Progesterone: Who May Benefit?

Progesterone is essential for normal pregnancy physiology.

But giving progesterone to every woman with recurrent miscarriage has not consistently improved live birth.

ASRM 2026 states that vaginal progesterone:

may be considered

in early pregnancy in women with:

- vaginal bleeding,
- recurrent unexplained miscarriage

through shared clinical decision-making.

RCOG specifically recommends progesterone when a woman with a previous miscarriage develops:

bleeding in early pregnancy.

Is Routine Progesterone Testing Useful?

ASRM states that there is no evidence supporting routine checking of progesterone levels in unassisted pregnancies and supplementing solely according to that number.

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8. Psychological and Early Pregnancy Support

Recurrent pregnancy loss can produce:

- grief,
- anxiety,
- depression,
- fear of pregnancy,
- sexual anxiety,
- relationship stress.

Psychological support is now regarded as:

an essential part of RPL care.

ASRM 2026 specifically recommends offering psychological support to couples experiencing miscarriage and planning another pregnancy.

Future pregnancy care may include:

- early contact with the healthcare team,
- reassurance,
- early ultrasound where appropriate.

RCOG similarly emphasizes supportive care and access to ultrasound in subsequent pregnancies.

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9. Lifestyle and Preconception Care

Before the next pregnancy, I advise attention to:

- smoking cessation,
- balanced nutrition,
- appropriate physical activity,
- healthy metabolic control,
- folic acid,
- avoidance of recreational drugs,
- appropriate medication review.

Lifestyle optimization supports:

overall pregnancy health

but it cannot prevent every genetically abnormal pregnancy.

The Unani Concept of Recurrent Pregnancy Loss

Recurrent pregnancy loss has also been described in classical Unani medicine.

Terms include:

Kasrat-i Isqat

Habitual/recurrent abortion.

and:

Isqat-i Adi

habitual pregnancy loss.

Official CCRUM Standard Unani Treatment Guidelines describe *Kasrat-i Isqat* as a condition in which a woman conceives but repeatedly remains unable to carry the fetus for the full pregnancy.

Classical Unani Causes

Traditional Unani literature considers both:

- external,
- internal

causes.

CCRUM lists traditional external factors such as:

- potent medicines,
- strong purgation,
- excessive physical strain,
- trauma.

Internal factors historically described include:

- fetal abnormalities,
- uterine abnormalities,
- physical factors,
- psychological factors,
- excess *Rutubat*,
- *Riyah*.

Important Modern Interpretation

We should not pretend that these traditional concepts are identical to modern pathophysiology.

For example:

Rutubat is not progesterone deficiency.

Riyah is not antiphospholipid syndrome.

Du'f-e-Rahim is not a modern diagnosis of chromosomal miscarriage.

They belong to the traditional Unani physiological framework.

The modern work-up should still identify:

- aneuploidy,
- APS,
- uterine septum,
- thyroid disease,
- diabetes,
- cervical insufficiency,

- selected male factors.

Taqwiyat-i Rahim – Strengthening the Uterus

One major traditional Unani principle is:

Taqwiyat-i Rahim

or strengthening/supporting the uterus.

CCRUM's official guideline lists this among traditional therapeutic principles for habitual abortion.

This concept can be useful within supervised Unani care.

However, “uterine strengthening” should not be presented as if a tonic can overcome:

- major embryonic aneuploidy,
- untreated APS,
- severe uterine septum,
- cervical insufficiency.

Taskhin-i Rahim and Tahlil-i Riyah

Classical treatment may also refer to:

- *Taskhin-i Rahim*,
- *Tahlil-i Riyah-i Rahim*.

These are traditional concepts involving correction of uterine temperament and humoral disturbance.

They should be explained as:

classical therapeutic principles

rather than established modern mechanisms of preventing miscarriage.

Unani Diet and Lifestyle in Recurrent Miscarriage

Unani medicine places importance on:

Ilaj-bil-Ghiza

dietotherapy.

and:

Ilaj-bit-Tadbir

regimenal/lifestyle therapy.

A sensible modern-compatible preconception programme may address:

- adequate nutrition,
- anemia,
- obesity or undernutrition,
- diabetes,
- sleep,
- smoking,
- tobacco,
- stress,
- general reproductive health.

This is one of the areas where traditional whole-person care can integrate well with modern pregnancy planning.

Strong Purgatives Should Be Avoided

Interestingly, official CCRUM guidance for habitual abortion specifically advises avoiding:

strong purgatives and highly potent medicines.

This traditional caution is especially important today.

A woman trying to maintain an early pregnancy should not undergo:

- aggressive “detox”,
- strong purgation,
- unsupervised emmenagogue treatment.

Ilaj-bid-Dawa – Unani Pharmacotherapy

Classical Unani reproductive formulations are traditionally selected according to:

- Mizaj,
- uterine condition,
- digestive/metabolic health,
- previous pregnancy history.

Traditional terms such as:

- *Muqawwi-e-Rahim*,
- *Hafiz-e-Janin*,
- *Muqawwi-e-Aza-e-Tanasuliya*

may be used to describe their intended role.

But:

traditional indication is not the same as proven live-birth benefit.

Majoon-e-Hamal Ambari Alwi Khani

Majoon-e-Hamal Ambari Alwi Khani is a classical Unani formulation historically associated with:

- uterine weakness,
- habitual abortion.

A CCRUM-associated 2016 publication performed:

- physicochemical analysis,
- microscopy,
- quality-control testing,
- heavy-metal/microbial/pesticide evaluation

to scientifically standardize the formulation.

This is useful:

quality-control research.

But it is important to understand what the study did **not** prove.

It did not establish through a large randomized clinical trial that the formulation:

- prevents recurrent miscarriage,

- improves live birth,
- treats APS,
- corrects fetal aneuploidy.

Prohamal at Saira Health Care

Saira Health Care Pharmacy currently describes:

Prohamal

as a traditional Unani reproductive tonic used for male and female reproductive health and describes traditional actions including:

- uterine support,
- increased “retentive power.”

Its current product page contains a multi-ingredient formulation and specifically states that:

self-medication is not recommended.

At Saira Health Care, if such a traditional formulation is considered, I believe it should be positioned as:

individualized supportive Unani therapy

rather than a universal evidence-proven prevention for recurrent miscarriage.

Can Prohamal Prevent Every Miscarriage?

No medicine can ethically make that promise.

I have not identified a high-quality independent randomized trial showing that Prohamal reliably:

- reduces recurrent miscarriage,
- improves live birth,
- overcomes embryo aneuploidy,
- treats APS.

Therefore:

a traditional product description should not be confused with clinical-trial proof.

Herbal Pregnancy Medicines Require Special Caution

This is especially important in recurrent pregnancy loss.

Some traditional medicines used before conception may have:

- emmenagogue activity,
- uterine activity,
- pharmacologically active ingredients.

Once pregnancy is:

- suspected,
- confirmed,

all products should be reviewed.

Do not assume:

"It is herbal, so it must be safe throughout pregnancy."

Can Unani Medicine Be Useful in Recurrent Pregnancy Loss?

I believe it can have a meaningful:

supportive and integrative role

when used responsibly.

Potential areas include:

- preconception nutrition,
- constitutional/Mizaj assessment,
- management of general weakness,
- lifestyle support,
- reproductive-health counselling,
- supervised traditional uterine-support treatment,
- sexual-health care,
- male reproductive-health optimization.

But it should not replace:

- chromosome testing,

- APS treatment,
- thyroid treatment,
- diabetes management,
- surgical correction of significant anatomy,
- cerclage when indicated,
- genetic counselling.

What Does the Clinical Evidence for Unani RPL Treatment Show?

Evidence specifically for Unani treatment of recurrent pregnancy loss remains:

limited.

Much of the literature consists of:

- classical texts,
- standard treatment guidelines,
- formulation-standardization work,
- case reports.

This is not enough to calculate a scientifically reliable:

“Unani success rate for recurrent miscarriage.”

Why Case Reports Are Not Enough

A woman with unexplained recurrent miscarriage may already have a relatively good probability of a successful future pregnancy.

ASRM estimates that many such patients achieve success without a specific intervention.

Therefore, if one woman uses a traditional medicine and then delivers successfully:

we cannot automatically prove that the medicine prevented the miscarriage.

Proper trials require comparison groups and outcomes such as:

- miscarriage rate,
- clinical pregnancy,
- live birth,

- maternal safety,
- neonatal safety.

Dr. Nizamuddin Qasmi's Approach at Saira Health Care

When a patient with recurrent miscarriage consults me, I do not start by asking:

"Which uterine tonic should I give?"

I begin by asking:

"Why did the previous pregnancies fail?"

Step 1: Document Every Pregnancy Loss

I review:

- number of losses,
- sequence,
- gestational age,
- ultrasound findings,
- fetal heartbeat history,
- pathology reports,
- chromosome reports.

Step 2: Distinguish Early and Late Pregnancy Loss

Repeated six-week losses are biologically different from:

- repeated painless loss at 18–20 weeks.

Treatment therefore differs.

Step 3: Prioritize Genetic Information

Where tissue testing is feasible, chromosome analysis can provide one of the most useful explanations.

This follows the current ASRM 2026 approach.

Step 4: Evaluate Uterine Anatomy

I review:

- ultrasound,
- 3D ultrasound,
- hysteroscopy,
- other uterine-cavity imaging

when appropriate.

Step 5: Consider APS Properly

I do not advise:

- aspirin,
- heparin

automatically.

If APS is confirmed, I support evidence-based obstetric/hematology management.

Step 6: Review Thyroid and Metabolic Health

I consider:

- TSH,
- glucose/HbA1c

according to clinical indications.

Step 7: Evaluate the Male Partner

This is an important part of my approach.

I review:

- age,
- semen parameters,
- smoking,

- metabolic health,
- varicocele,
- medicines,
- fertility history.

In selected unexplained cases:

sperm DNA fragmentation testing

may be worth discussing.

This is one area where my additional work and training in:

- male infertility,
- sexual and reproductive health

is particularly relevant.

Step 8: Review Sexual and Reproductive Health as a Couple

After repeated miscarriage, some couples become afraid of:

- intercourse,
- pregnancy,
- ejaculation,
- sexual activity.

Sexual anxiety can become an additional reproductive-health problem.

Compassionate counselling matters.

Step 9: Assess Traditional Mizaj

If Unani treatment is being considered, I may assess:

- Mizaj,
- digestion,
- constitution,
- menstrual history,
- reproductive-health symptoms,

- general health.

This is:

additional individualized traditional assessment

rather than a replacement for modern investigation.

Step 10: Ilaj-bil-Ghiza

I focus on:

- adequate protein,
- balanced nutrition,
- folate,
- healthy metabolic status,
- appropriate body weight.

Step 11: Ilaj-bit-Tadbir

I address:

- sleep,
- stress,
- physical activity,
- tobacco,
- unhealthy lifestyle.

I do not prescribe:

aggressive detoxification

to a woman trying to maintain pregnancy.

Step 12: Use Traditional Medicines Carefully

If Prohamal, Majoon preparations or another traditional reproductive formulation is considered:

- it should be individualized,

- pregnancy safety should be reviewed,
- concomitant medication should be reviewed,
- self-medication should be discouraged.

Step 13: Stop Thinking Only in Terms of "Weak Uterus"

A miscarriage may be due to:

- embryonic chromosomes,
- APS,
- thyroid disease,
- uterine anatomy,
- cervical insufficiency,
- male factors.

Calling every miscarriage:

"uterine weakness"

can delay the true diagnosis.

Step 14: Refer When Necessary

I believe an integrative fertility physician should know when another specialist is needed.

Depending on the diagnosis, patients may require:

- obstetrician,
- maternal-fetal-medicine specialist,
- reproductive endocrinologist,
- genetic counsellor,
- hematologist/rheumatologist,
- reproductive urologist,
- endocrine specialist.

Step 15: Create a Plan for the Next Pregnancy

Before conception, the couple should know:

- what medicines to continue,
- what medicines to stop,
- whether folic acid is being taken,
- whether APS treatment is required,
- when to contact the doctor,
- when early ultrasound should be performed.

Step 16: Provide Early Pregnancy Support

The next pregnancy after repeated losses can be psychologically frightening.

Support may include:

- early medical contact,
- appropriately timed ultrasound,
- review of bleeding,
- medication review,
- psychological reassurance.

RCOG specifically recognizes the value of supportive specialist care in subsequent pregnancy.

Step 17: Use Progesterone Selectively

If a woman with previous miscarriage develops:

bleeding during early pregnancy,

vaginal progesterone may be appropriate after obstetric assessment.

This should be:

- prescribed appropriately,
- not self-started from an old prescription.

Saira Health Care's Contribution to Recurrent Pregnancy Loss and Infertility

Saira Health Care's current female-infertility section specifically includes:

Recurrent Abortion

among its reproductive-health topics, together with:

- irregular menstruation,
- PMOS/PCOS,
- decreased AMH,
- blocked fallopian tubes,
- unexplained infertility.

Saira Health Care describes its broader clinical model as:

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

For recurrent pregnancy loss, I consider this particularly important because:

the most responsible integrative treatment is not to replace investigation with herbs, but to combine proper investigation with safe supportive Unani care where appropriate.

About Dr. Nizamuddin Qasmi

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,
- Certificate in Urology – London, UK

and describes my clinical work as focused on:

Sexual Disorders & Infertility.

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

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

Why Male Infertility Training Matters in Recurrent Miscarriage

Traditionally, pregnancy loss was often viewed as:

entirely a female problem.

Modern evidence shows that this is incomplete.

Sperm DNA integrity may contribute in selected recurrent-loss couples.

This makes assessment of:

- male reproductive health,
- smoking,
- varicocele,
- paternal age,
- metabolic health

important in unexplained cases.

Precautions Before the Next Pregnancy

I advise couples to prepare before conception rather than waiting for a positive pregnancy test.

Important steps include:

- stop smoking,
- avoid recreational drugs,
- control diabetes,
- control thyroid disease,
- review prescription medicines,
- take appropriate folic acid,
- maintain balanced nutrition,
- review Unani/herbal medicines,
- treat identified APS appropriately.

Is Bed Rest Necessary to Prevent Miscarriage?

Routine prolonged bed rest has not been established as an effective treatment for recurrent early miscarriage.

Normal activity is generally reasonable unless:

- bleeding,
- cervical disease,
- another obstetric complication

requires individualized restriction.

Women should not be made to feel that ordinary movement caused their miscarriage.

Can Sexual Intercourse Cause Recurrent Miscarriage?

In an uncomplicated pregnancy, intercourse is not considered a routine cause of miscarriage.

Specific abstinence may be advised only when there is a particular obstetric reason.

Repeated pregnancy loss should not automatically lead to fear of normal marital intimacy.

Common Myths About Recurrent Miscarriage

Myth 1: Recurrent miscarriage always means three consecutive losses.

Fact: ASRM, ACOG and ESHRE use two or more losses; RCOG uses three but permits earlier evaluation.

Myth 2: Every early miscarriage is caused by a weak uterus.

Fact: Embryonic chromosome abnormalities are the most common cause.

Myth 3: If a woman can conceive, there cannot be a male problem.

Fact: Male genetic and sperm-DNA factors may contribute to selected recurrent-loss cases.

Myth 4: Aspirin should be taken after every miscarriage.

Fact: Empirical aspirin has not been proven beneficial for unexplained RPL without APS.

Myth 5: Heparin injections prevent every miscarriage.

Fact: They are particularly useful in confirmed APS, not as a universal treatment.

Myth 6: MTHFR causes most recurrent miscarriage.

Fact: Routine MTHFR testing is not recommended in the standard ASRM RPL evaluation.

Myth 7: Every woman needs an immune or NK-cell test.

Fact: Routine immune testing is not recommended.

Myth 8: Every woman needs antibiotics.

Fact: Routine infection/microbiome treatment is not recommended.

Myth 9: Progesterone prevents all recurrent miscarriage.

Fact: Evidence is much more specific; benefit is most relevant when early-pregnancy bleeding occurs in a woman with prior miscarriage.

Myth 10: Normal ultrasound means there is no cause.

Fact: Genetic, APS, thyroid and selected male factors may not be visible on ordinary ultrasound.

Myth 11: IVF with PGT-A always prevents miscarriage.

Fact: ASRM 2026 does not find sufficient evidence that routine PGT-A improves live birth in RPL.

Myth 12: Every uterine fibroid should be removed.

Fact: Location and cavity distortion matter.

Myth 13: Cerclage prevents early chromosomal miscarriage.

Fact: Cerclage is primarily relevant to selected cervical-insufficiency/late-loss situations.

Myth 14: Unani medicine has no role.

Fact: Unani medicine can offer meaningful individualized preconception, nutritional, lifestyle and traditional reproductive support.

Myth 15: A uterine tonic can overcome every miscarriage cause.

Fact: It cannot correct embryo aneuploidy or replace APS treatment or surgery when needed.

Myth 16: Herbal medicine is automatically pregnancy-safe.

Fact: Some traditional medicines have pharmacological or uterine effects and require professional review.

Myth 17: One successful pregnancy proves a medicine cures recurrent miscarriage.

Fact: Many women with unexplained RPL have a good natural prognosis; controlled trials are needed to prove treatment benefit.

Myth 18: Stress alone causes recurrent miscarriage.

Fact: Emotional stress deserves treatment and support, but patients should not be blamed for pregnancy loss.

Frequently Asked Questions

I have had two miscarriages. Should I be investigated?

Yes, evaluation can reasonably begin after two losses according to ASRM, ACOG and ESHRE.

What is the most common cause?

Chromosome abnormalities in the embryo, particularly for early pregnancy loss.

Why do chromosome abnormalities happen?

Most arise randomly when the egg or sperm divides.

The risk increases with maternal age.

Should miscarriage tissue be tested?

Current ASRM 2026 guidance strongly supports chromosome testing of miscarriage tissue when feasible as an early part of RPL evaluation.

Do both partners need chromosome tests?

Not automatically.

Parental karyotyping becomes particularly useful if:

- fetal tissue shows structural chromosome abnormality,
- or tissue testing was unavailable.

Should I take aspirin before pregnancy?

Only when medically indicated.

Do not self-prescribe aspirin for unexplained miscarriage.

What if I have APS?

Confirmed APS is commonly treated with:

- low-dose aspirin,
- prophylactic heparin

under specialist care.

Should I test MTHFR?

Routine MTHFR testing is not recommended as part of the ASRM recurrent-loss work-up.

Should my thyroid be checked?

TSH testing may be appropriate, especially according to miscarriage genetics, symptoms and risk factors.

Genuine hypothyroidism should be treated.

Does positive thyroid antibody mean I need thyroxine?

Not if thyroid function is normal simply because antibodies are positive.

Current ASRM evidence does not support routine treatment of euthyroid women solely for thyroid autoimmunity.

Can progesterone help?

It may be considered, especially if:

- you have previous miscarriage,
- you develop bleeding in early pregnancy.

Discuss it with your obstetrician rather than self-prescribing.

Can fibroids cause miscarriage?

Some can, particularly those:

- distorting the uterine cavity.

Not every fibroid is responsible.

Can a uterine septum cause miscarriage?

Yes, septate uterus is associated with pregnancy loss and surgery may be considered in appropriate women.

Can cervical weakness cause recurrent loss?

Yes, particularly certain:

- second-trimester,
- painless

pregnancy losses.

Can sperm cause recurrent miscarriage?

Selected male factors, especially elevated sperm DNA fragmentation, may contribute.

ASRM 2026 permits consideration of SDF testing in otherwise unexplained RPL.

Does IVF solve recurrent miscarriage?

Not automatically.

The treatment depends on the cause.

Can PGT-A prevent every miscarriage?

No.

Current evidence does not show a universal live-birth advantage from PGT-A for RPL.

Can Unani medicine help?

Unani medicine can support:

- preconception health,
- nutrition,
- general reproductive health,
- individualized traditional uterine support,

- lifestyle,
- male and female fertility wellbeing.

It should complement—not replace—cause-specific investigation and treatment.

What is recurrent miscarriage called in Unani medicine?

Traditional terms include:

Kasrat-i Isqat

and:

Isqat-i Adi.

CCRUM specifically recognizes *Kasrat-i Isqat* in its Standard Unani Treatment Guidelines.

What is Taqwiyat-i Rahim?

It is the traditional Unani principle of:

supporting/strengthening the uterus.

It is a traditional therapeutic concept rather than a laboratory-measured modern mechanism.

Does Prohamal prevent miscarriage?

Prohamal is currently described by Saira Health Care Pharmacy as a traditional reproductive tonic with uterine-support indications.

There is insufficient high-quality product-specific trial evidence to claim that it reliably prevents recurrent miscarriage.

Can I take Prohamal after becoming pregnant?

Do not automatically continue any fertility or Unani formulation after conception.

Pregnancy safety should be reviewed by the prescribing physician.

What are my chances after unexplained recurrent miscarriage?

Many women still have a good chance of success.

ASRM reports future successful pregnancy in approximately:

50–80%

of many unexplained RPL patients, while ACOG gives an approximate figure of 65%, depending strongly on age and history.

Latest Scientific Perspective: 2026

The biggest current update comes from:

ASRM's new 2026 Recurrent Pregnancy Loss Committee Opinion.

It replaces the older 2012 guidance.

Important changes include:

RPL is defined as two or more spontaneous pregnancy losses.

Biochemical hCG-confirmed losses can now count.

Chromosome analysis of miscarriage tissue is recommended early in the evaluation.

Uterine-cavity evaluation is recommended.

Parental karyotyping is more targeted.

APS testing and treatment remain important when criteria are met.

Routine inherited-thrombophilia testing is discouraged.

Routine immune/NK-cell testing is discouraged.

Routine microbiome testing is discouraged.

Sperm DNA fragmentation testing may be considered in selected unexplained cases.

Progesterone may be considered particularly in early pregnancy with bleeding.

PGT-A has not been shown to routinely improve live birth in RPL.

Psychological support is considered an essential part of care.

My Message to Patients

If you have lost two or more pregnancies, I do not want you to think only:

“My uterus is weak.”

Instead ask:

Was chromosome testing done?

At what week did the pregnancies stop?

Was there a fetal heartbeat?

Was the loss early or in the second trimester?

Is my uterine cavity normal?

Do I meet criteria for APS testing?

Is my thyroid function normal?

Is diabetes controlled?

Does my husband need further reproductive evaluation?

Could sperm DNA fragmentation be relevant?

Was there cervical insufficiency?

Do I genuinely need progesterone?

Do I genuinely need aspirin or heparin?

Would a traditional Unani fertility-support plan be appropriate for me?

Which Unani medicines are safe before conception and which must be reviewed once pregnancy occurs?

These questions help us move from:

fear and guesswork

to:

structured reproductive care.

Conclusion

Recurrent pregnancy loss is a complex reproductive condition that deserves:

- careful investigation,
- compassion,
- individualized treatment.

Modern international guidance increasingly supports beginning evaluation after:

two pregnancy losses.

The most common cause of early miscarriage is:

embryonic chromosome abnormality.

Other important causes or associations include:

- uterine abnormalities,
- antiphospholipid syndrome,
- thyroid disease,
- poorly controlled diabetes,
- cervical insufficiency in selected later losses,
- parental chromosome rearrangements,
- selected male reproductive factors.

Current ASRM 2026 guidance represents a major change toward:

targeted rather than indiscriminate investigation.

It recommends:

- chromosome testing of miscarriage tissue when feasible,
- uterine-cavity assessment,
- selective genetic evaluation,
- appropriate APS testing,
- targeted endocrine/metabolic assessment.

At the same time, it discourages routine:

- inherited thrombophilia panels,
- MTHFR testing,
- immune/NK-cell testing,
- microbiome testing,
- empiric aspirin/heparin in unexplained cases.

The **Unani system of medicine** has historically recognized recurrent miscarriage under terms such as:

Kasrat-i Isqat

and uses therapeutic principles including:

- Taqwiyat-i Rahim,
- constitutional assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa.

Official CCRUM treatment guidelines recognize this traditional framework.

At **Saira Health Care**, my approach as **Dr. Nizamuddin Qasmi** is to integrate those traditional principles responsibly with modern reproductive investigation.

I believe in:

evaluating the cause before prescribing a uterine tonic;

reviewing both partners;

using modern chromosome and uterine investigations when indicated;

treating APS, thyroid disease and diabetes according to evidence;

considering male reproductive factors where appropriate;

using individualized Unani nutrition and reproductive-health support;

using traditional medicines only under supervision;

avoiding aggressive purgation and unsafe self-medication around pregnancy;

providing psychological support after pregnancy loss;

planning early monitoring for the next pregnancy;

and referring promptly for specialist obstetric, genetic, hematological or fertility care when required.

When a patient asks me:

“Doctor, after repeated miscarriages, can I still have a healthy baby?”

my answer is:

Yes, in many cases there is a very real possibility of a successful future pregnancy. But recurrent miscarriage should not be treated with guesswork. We must first understand whether the previous losses were caused by embryo chromosomes, uterine anatomy, APS, endocrine or metabolic disease, cervical problems, male reproductive factors, or whether they remain unexplained. Unani medicine can provide individualized supportive

reproductive care, but the safest and most effective approach is to combine that support with accurate modern diagnosis and use cause-specific treatment whenever it is needed.

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About the Author

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Professional Education & Additional Training

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

Saira Health Care's public professional profile identifies Dr. Nizamuddin Qasmi's focused clinical work in **Sexual Disorders & Infertility**, including male and female reproductive-health disorders.

Medical Disclaimer

This article is intended for:

- patient education,
- reproductive-health awareness,
- general medical information.

It is not a substitute for individual medical or obstetric care.

Recurrent pregnancy loss may require evaluation by:

- obstetrician/gynecologist,
- recurrent-miscarriage specialist,
- reproductive endocrinologist,
- maternal-fetal-medicine specialist,
- genetic counsellor,
- hematologist/rheumatologist,
- reproductive urologist.

Do not independently begin:

- aspirin,
- heparin,
- progesterone,
- antibiotics,
- thyroid medicines,
- steroids,
- immune treatments,
- Unani reproductive medicines,
- Prohamal,
- Majoon preparations,

- purgatives,
- herbomineral preparations

because of previous miscarriage.

If you are currently pregnant and develop:

- vaginal bleeding,
- severe abdominal pain,
- one-sided pelvic pain,
- fainting,
- severe weakness,
- fever,
- heavy bleeding,

seek prompt medical assessment.

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

- prevention of miscarriage,
- continuation of every pregnancy,
- live birth.

Saira Health Care
www.sairahealthcare.com