

Male Infertility: Causes, Symptoms, Diagnosis, Modern Treatment and the Role of Unani Medicine

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Introduction: “Doctor, Is the Infertility Problem Really From My Side?”

When couples come to me after months or years of trying for pregnancy, I frequently hear a question such as:

“Doctor, all my wife's reports are normal. Could the problem be with me?”

Another man may say:

“My semen looks completely normal, so how can I have infertility?”

Some patients are frightened when their semen report shows:

- low sperm count,
- low motility,
- abnormal morphology,
- or even zero sperm.

Others assume that because they have:

- a strong erection,
- normal ejaculation,
- normal libido,

their fertility must also be normal.



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These are understandable misconceptions.

One of the most important things I explain to patients is:

Male fertility and male sexual performance are not the same thing.

A man can have:

- completely normal erections,
- normal sexual desire,
- normal ejaculation,

and still have a serious sperm-production problem.

Conversely, a man may experience erectile or ejaculatory difficulty while producing normal sperm.

Male infertility therefore deserves its own careful medical evaluation.

Infertility is currently defined by the World Health Organization as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**. WHO estimates that approximately **1 in 6 people of reproductive age** experience infertility at some stage of life.

Modern European guidance estimates that a male factor can be identified in approximately **half of infertile couples**, while an isolated male factor accounts for roughly one-fifth of cases.

This is why infertility should never automatically be considered:

“the woman's problem.”

At **Saira Health Care**, I consider infertility a:

couple's reproductive-health problem

and both partners should be evaluated at the same time.

What Is Male Infertility?

Male infertility means that a problem involving the male partner is contributing to difficulty achieving pregnancy.

The problem may involve:

- sperm production,
- sperm concentration,



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- sperm motility,
- sperm shape,
- sperm DNA or function,
- hormone production,
- transport of sperm,
- ejaculation,
- erection sufficient for intercourse,
- reproductive anatomy,
- or a combination of these factors.

AUA/ASRM guidelines emphasize that approximately half of infertility cases involve the male partner in whole or in part and recommend concurrent evaluation of both partners.

Male Infertility Is Not One Disease

This is one of the most important principles in my practice.

The words:

“Male Infertility”

do not identify one single disease.

Consider five patients.

Patient 1

Has:

- low sperm count,
- varicocele,
- otherwise normal reproductive function.

Patient 2

Has:

- zero sperm,
- but normal sperm production inside the testes,
- because both vas deferens are absent.



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Patient 3

Has:

- azoospermia,
- very high FSH,
- severely impaired spermatogenesis.

Patient 4

Has:

- normal sperm production,
- but retrograde ejaculation.

Patient 5

Has:

- normal semen,
- but severe erectile dysfunction preventing vaginal intercourse.

All five may present with infertility.

But their treatments are completely different.

Therefore:

The correct diagnosis matters more than simply prescribing a “sperm medicine.”

How Are Sperm Produced?

Understanding male infertility becomes easier when we understand normal sperm production.

Sperm are produced inside microscopic structures in the testes known as:

Seminiferous Tubules

The process is called:

Spermatogenesis

It begins with primitive germ cells and progresses through several stages:

Spermatogonia

↓



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Spermatocytes



Spermatids



Mature Spermatozoa

This process requires:

- healthy testicular tissue,
- functioning Sertoli cells,
- appropriate testosterone inside the testes,
- FSH,
- LH,
- normal genes,
- normal chromosomes,
- appropriate testicular temperature.

After leaving the testis, sperm pass through the:

Epididymis

where they undergo further maturation and acquire important functional characteristics such as motility.

They then travel through the:

- vas deferens,
- ejaculatory ducts,
- urethra

during ejaculation.

A problem anywhere along this pathway can cause male infertility.

Main Categories of Male Infertility

For practical understanding, causes can broadly be divided into:

Pre-Testicular Causes



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Problems with hormonal stimulation of the testes.

Testicular Causes

Problems within the testes themselves.

Post-Testicular Causes

Sperm are produced but cannot be transported or ejaculated normally.

There are also:

- sexual,
- lifestyle,
- environmental,
- medication-related,
- genetic

factors.

Common Semen Abnormalities

Patients frequently see unfamiliar terminology on semen reports.

Here are the major terms.

Oligozoospermia

Means:

Low sperm concentration.

The current WHO sixth-edition lower fifth-percentile reference value for sperm concentration is approximately:

16 million sperm/mL.

This is a reference distribution—not an absolute fertile-versus-infertile line.

Asthenozoospermia

Means:

Reduced sperm motility.



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WHO reference distributions include approximately:

- **42% total motility**
- **30% progressive motility.**

Teratozoospermia

Means an increased proportion of abnormally shaped sperm.

The WHO lower fifth-percentile reference for normal morphology using strict criteria is approximately:

4% normal forms.

This does **not** mean that 96% abnormal sperm automatically equals infertility.

Oligo-Asthen-Teratozoospermia – OAT

This means abnormalities occur together:

- reduced sperm count,
- poor motility,
- abnormal morphology.

Multiple simultaneous semen abnormalities generally carry greater clinical significance than one isolated borderline result.

AUA/ASRM guidance specifically notes that semen-analysis findings become more clinically meaningful when several parameters are abnormal.

Azoospermia

Azoospermia means:

No sperm are detected in the ejaculated semen after appropriate laboratory examination.

It may be:

Obstructive Azoospermia – OA

Sperm are produced but blocked.

or:

Non-Obstructive Azoospermia – NOA



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Sperm production is severely impaired.

These two conditions require very different treatment.

Cryptozoospermia

In some men initially labelled azoospermic, extremely rare sperm can be detected only after:

- centrifugation,
- careful examination of the semen pellet.

This is called:

Cryptozoospermia

and can significantly influence fertility treatment and sperm-preservation decisions.

Necrozoospermia

This means an abnormally high proportion of sperm are:

dead rather than merely immotile.

Motility and vitality are different measurements.

Aspermia

Aspermia means:

no semen is ejaculated.

This is completely different from azoospermia.

A man with azoospermia still usually ejaculates semen.

Current WHO Semen Reference Values

The WHO sixth-edition semen manual provides the following lower fifth-percentile distributions among fertile reference populations:

Semen parameter	WHO 2021 lower reference
------------------------	---------------------------------

Semen volume	1.4 mL
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Total sperm number **39 million/ejaculate**

Sperm concentration **16 million/mL**

Total motility **42%**

Progressive motility **30%**

Vitality **54% live sperm**

Normal morphology **4%**

Patients must understand:

These values are not pass-or-fail fertility scores.

They represent the lower fifth percentile of results obtained from men whose partners achieved natural pregnancy.

A man slightly below one value may still father a child naturally.

A man above every reference value may still experience infertility for another reason.

One Semen Analysis Is Often Not Enough

Semen parameters naturally fluctuate.

They may change because of:

- fever,
- illness,
- abstinence period,
- medications,
- laboratory variation,
- incomplete collection,
- stress,
- lifestyle.

Current EAU guidance recommends at least **two semen analyses when the baseline result is abnormal.**



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The WHO 2025 infertility guideline goes further and suggests that when one or more semen parameters are outside WHO reference distributions, repeat semen analysis should usually be performed after a minimum of approximately:

11 weeks

which roughly corresponds to a spermatogenic cycle.

Earlier reassessment may still be appropriate when clinically necessary.

Causes of Male Infertility

Male infertility can result from many conditions.

I usually explain the major causes to patients in groups.

1. Varicocele

A varicocele is enlargement of veins surrounding the testicle.

It is one of the most commonly recognized potentially correctable findings associated with male infertility.

Possible mechanisms include:

- increased scrotal temperature,
- oxidative stress,
- altered testicular circulation,
- impaired sperm production,
- sperm DNA damage.

Current WHO guidance suggests surgical or radiological treatment for selected infertile men with a **clinical varicocele**, particularly when semen parameters are abnormal.

AUA/ASRM similarly recommends considering varicocele repair in men:

- trying to conceive,
- with a palpable varicocele,
- infertility,
- and abnormal semen parameters.

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An ultrasound-only subclinical varicocele should not automatically be operated upon.

2. Hormonal Problems

Normal sperm production requires communication between:

Hypothalamus → Pituitary → Testes

Important hormones include:

- GnRH,
- FSH,
- LH,
- testosterone.

Hormonal problems may include:

- hypogonadotropic hypogonadism,
- pituitary tumors,
- hyperprolactinemia,
- severe testosterone deficiency,
- endocrine disorders.

One of the more treatable causes is:

Hypogonadotropic Hypogonadism

where insufficient FSH and LH stimulation leads to reduced sperm production.

Current EAU guidance recommends fertility-directed gonadotropin treatment with therapies such as:

- hCG,
- FSH preparations

in appropriately diagnosed men who wish to conceive.

A Critical Warning About Testosterone

Men sometimes believe:

“My testosterone is low, so testosterone injections will improve my sperm.”



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This can be a serious mistake.

External testosterone suppresses:

- GnRH,
- LH,
- FSH,
- intratesticular testosterone

and may result in:

- severe oligozoospermia,
- or complete azoospermia.

AUA/ASRM states clearly:

Testosterone monotherapy should not be prescribed to men interested in current or future fertility.

Current EAU guidance also states:

Do not use testosterone therapy for treatment of male infertility.

This point is particularly important for men using:

- gym steroids,
- testosterone injections,
- testosterone gels,
- bodybuilding hormones.

3. Genetic and Chromosomal Causes

Genetic abnormalities are especially important in:

- azoospermia,
- very severe oligozoospermia,
- testicular failure,
- maturation arrest.

Examples include:

- Klinefelter syndrome,



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- Y-chromosome microdeletions,
 - chromosomal translocations,
 - CFTR mutations,
 - specific gene mutations affecting spermatogenesis.
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Klinefelter Syndrome

The common pattern is:

47,XXY

instead of the usual 46,XY chromosome arrangement.

Many affected men have severe impairment of sperm production.

However, the AUA/ASRM 2024 guideline notes that small areas of sperm production may still be found with micro-TESE in approximately **50–60% of selected 47,XXY men**.

Therefore, diagnosis does not automatically mean every possibility of biological fatherhood is lost.

Y-Chromosome Microdeletions

The Y chromosome contains important sperm-production regions:

- AZFa
- AZFb
- AZFc.

The **2024 AUA/ASRM amendment** updated the threshold for Y-chromosome testing.

Y-chromosome microdeletion analysis is recommended particularly in men with:

- primary infertility,
- azoospermia,
- or sperm concentration **≤1 million/mL**

when accompanied by:

- elevated FSH,
- testicular atrophy,
- or impaired sperm production.



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This is an important change from older recommendations that used a higher sperm-count threshold.

Why the Type of Y Deletion Matters

Complete:

- AZFa,
- AZFb,
- AZFab,
- or AZFabc

deletions have an extremely poor sperm-retrieval prognosis.

AUA/ASRM reports that sperm have not been retrieved with micro-TESE in complete AZFa or AZFb-related deletions.

By contrast, in azoospermic men with an isolated:

AZFc deletion

sperm may be found by micro-TESE in roughly half of cases.

However, male offspring can inherit the infertility-related Y deletion, so genetic counselling is important.

Karyotype Testing

The 2024 AUA/ASRM guideline recommends karyotype testing for men with:

- primary infertility,
- azoospermia,
- or sperm concentration **<5 million/mL**

when accompanied by:

- elevated FSH,
 - testicular atrophy,
 - or evidence of impaired sperm production.
-

CFTR Testing



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AUA/ASRM recommends **CFTR carrier testing**, including the 5T allele, in men with:

- congenital absence of the vas deferens,
- or idiopathic obstructive azoospermia.

If a CFTR mutation is identified in the man, evaluation of the female partner is important before assisted reproduction because of potential cystic-fibrosis risk in offspring.

4. Undescended Testes – Cryptorchidism

When one or both testes fail to descend normally during childhood, future sperm production may be impaired.

The risk is greater when:

- both testes were undescended,
- treatment occurred late,
- testicular growth was abnormal.

A childhood history therefore remains important even decades later.

5. Testicular Injury or Torsion

Severe injury can damage:

- seminiferous tubules,
- blood supply,
- sperm-producing cells.

Testicular torsion is particularly important because prolonged loss of blood flow can permanently damage testicular tissue.

6. Mumps Orchitis and Other Testicular Infections

Severe inflammation of the testes may interfere with sperm production.

Possible causes include:

- mumps orchitis,
- severe bacterial infection,
- epididymo-orchitis,



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- tuberculosis.

Uncomplicated infection does not automatically produce infertility, but severe bilateral disease deserves follow-up.

7. Cancer Treatment

Chemotherapy and radiotherapy can damage germ cells.

The effect depends on:

- drug type,
- cumulative dose,
- radiation location,
- age,
- baseline testicular health.

Whenever possible, men facing gonadotoxic treatment should discuss:

sperm cryopreservation before treatment.

8. Obstruction of the Reproductive Tract

Some men produce sperm normally but sperm cannot reach the semen.

Potential obstruction sites include:

- epididymis,
- vas deferens,
- ejaculatory ducts.

Causes include:

- congenital absence of the vas,
- infection,
- previous surgery,
- vasectomy,
- trauma,
- ejaculatory-duct obstruction.



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These patients may have:

Obstructive Azoospermia

despite normal testicular sperm production.

9. Ejaculatory Duct Obstruction

Obstruction near the prostate may sometimes produce:

- low semen volume,
- acidic semen,
- azoospermia or severe sperm reduction.

The 2024 AUA/ASRM amendment recognizes selective use of:

- transrectal ultrasound,
- or pelvic MRI

when semen findings strongly suggest ejaculatory-duct obstruction rather than using this imaging routinely in every infertile man.

10. Retrograde Ejaculation

Normally semen exits through the penis.

In retrograde ejaculation, semen moves backward into the:

bladder.

The patient may have:

- very little semen,
- no visible semen,
- cloudy urine after orgasm.

Causes include:

- diabetes-related nerve damage,
- prostate surgery,
- neurological disorders,
- certain medications.



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A post-ejaculation urine test can help diagnose this condition.

Treatment may include medication, urine preparation for sperm recovery, or sperm retrieval depending on the cause. AUA/ASRM recognizes several fertility-treatment options for retrograde ejaculation.

11. Erectile Dysfunction

Erectile dysfunction can cause infertility when a man cannot consistently achieve or maintain an erection sufficient for vaginal intercourse.

However:

ED does not necessarily mean sperm production is abnormal.

Treatment should address the sexual problem separately while evaluating semen when fertility is desired.

12. Ejaculatory Disorders

Infertility may occur with:

- anejaculation,
- retrograde ejaculation,
- delayed ejaculation,
- spinal-cord injury,
- neurological disorders.

AUA/ASRM notes that selected men may benefit from:

- penile vibratory stimulation,
 - electroejaculation,
 - sympathomimetic medicines,
 - surgical sperm retrieval.
-

13. Premature Ejaculation

Premature ejaculation by itself usually does not reduce sperm production.

However, fertility can be affected if ejaculation consistently occurs:



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- before vaginal penetration,
- or in a way preventing semen deposition.

This is different from a sperm-quality problem.

14. Sexual Frequency and Timing

Pregnancy requires intercourse during the fertile period.

A couple may mistakenly believe infertility exists when intercourse is:

- very infrequent,
- poorly timed,
- or absent because of sexual dysfunction.

Good infertility evaluation should therefore include a respectful sexual history.

15. Smoking and Tobacco

Tobacco can increase:

- oxidative stress,
- toxic chemical exposure,
- sperm DNA damage,
- and abnormalities of semen.

WHO's 2025 infertility guideline specifically emphasizes tobacco cessation as part of infertility prevention and fertility-promoting lifestyle care.

16. Alcohol and Recreational Drugs

Heavy alcohol use may negatively affect:

- testicular function,
- hormones,
- liver metabolism,
- sexual function.

Recreational drugs can also interfere with reproductive health.



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Avoiding harmful substances is an important part of fertility treatment.

17. Obesity and Metabolic Disease

Obesity can affect:

- testosterone,
- estrogen,
- insulin resistance,
- inflammation,
- scrotal temperature,
- erections.

Diabetes may influence:

- erectile function,
- ejaculation,
- hormones,
- oxidative stress.

Healthy weight and metabolic control therefore support reproductive as well as general health.

18. Excessive Heat

Normal sperm production requires a cooler testicular environment.

Repeated unnecessary exposure to:

- hot tubs,
- very high-temperature saunas,
- occupational heat

may temporarily impair sperm in susceptible men.

This does not mean men need extreme cooling practices.

Reasonable heat avoidance is sufficient.



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19. Environmental and Occupational Exposures

Possible reproductive toxins include:

- pesticides,
- solvents,
- heavy metals,
- radiation,
- industrial chemicals,
- endocrine-disrupting chemicals.

Current guidelines recognize environmental and occupational history as part of a complete infertility assessment, while also acknowledging that evidence for many individual exposures remains limited.

20. Idiopathic Male Infertility

Sometimes:

- examination is normal,
- hormones are normal,
- standard genetic tests are normal,
- no clear reproductive disease is found,

yet semen remains abnormal.

This is often called:

Idiopathic Male Infertility

EAU guidance notes that historically approximately **30–40% of men with abnormal fertility evaluation** may have no clearly identifiable male cause using routine investigations. Modern research increasingly suggests roles for:

- oxidative stress,
 - environmental endocrine disruption,
 - sperm DNA injury,
 - genetic and epigenetic abnormalities.
-



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Symptoms of Male Infertility

The most common symptom is:

Failure to achieve pregnancy.

Many men otherwise feel completely healthy.

However, associated findings may provide clues.

These can include:

- low libido,
- erectile dysfunction,
- ejaculation problems,
- reduced semen volume,
- testicular pain,
- scrotal swelling,
- varicocele,
- unusually small testes,
- reduced facial or body hair,
- gynecomastia,
- recurrent genital infection,
- previous undescended testes.

But:

Most sperm abnormalities cannot be felt or seen.

You cannot identify:

- low sperm count,
- low motility,
- abnormal morphology

from symptoms alone.

Male Infertility Is Not the Same as Impotence

This deserves emphasis.



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A man with:

zero sperm

may still have:

- strong erections,
- normal orgasm,
- normal ejaculation.

And a man with severe erectile dysfunction may have:

excellent sperm production.

At Saira Health Care, I consider correcting this misconception an important part of patient education.

How Is Male Infertility Diagnosed?

Diagnosis should be structured.

The WHO 2025 guideline and current EAU recommendations emphasize:

- history,
 - physical examination,
 - standardized semen analysis,
 - targeted further investigation,
 - simultaneous evaluation of the female partner.
-

Step 1: Reproductive History

I ask about:

- duration of infertility,
- previous pregnancies,
- previous partners or children,
- frequency of intercourse,
- erectile function,
- ejaculation,



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- childhood diseases,
- undescended testes,
- testicular injury,
- infection,
- fever,
- surgery,
- medications,
- smoking,
- alcohol,
- anabolic steroids,
- occupational exposures,
- chemotherapy,
- radiotherapy,
- family history.

Step 2: Physical Examination

Examination may assess:

- testicular size,
- testicular consistency,
- epididymis,
- vas deferens,
- varicocele,
- penis,
- secondary sexual characteristics,
- signs of hormonal disease.

This is why a semen report should not replace proper clinical examination.

Step 3: Semen Analysis



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The initial male fertility evaluation should include standardized semen analysis.

It assesses:

- volume,
- sperm concentration,
- total sperm number,
- motility,
- progressive motility,
- morphology,
- vitality where indicated,
- pH,
- other findings.

WHO recommends using the latest standardized laboratory manual.

Step 4: Repeat Abnormal Semen Testing

As discussed earlier, abnormal results should generally be confirmed.

WHO 2025 suggests repeat testing after at least approximately:

11 weeks

when one or more semen parameters are abnormal.

EAU recommends at least two consecutive analyses when the baseline study is abnormal.

Step 5: Hormonal Evaluation

Common investigations include:

- FSH,
- testosterone,
- LH.

Additional testing may include:

- prolactin,
- estradiol,



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- thyroid tests

according to the clinical situation.

AUA/ASRM recommends FSH and testosterone particularly when there is:

- oligozoospermia,
 - azoospermia,
 - testicular atrophy,
 - erectile or libido problems,
 - signs of endocrine disease.
-

Step 6: Genetic Testing

Appropriate patients may need:

- karyotype,
- Y-chromosome microdeletion testing,
- CFTR testing,
- genetic counselling.

These tests can:

- identify a cause,
 - change sperm-retrieval recommendations,
 - identify inherited risks,
 - prevent unnecessary treatment.
-

Step 7: Ultrasound

Scrotal ultrasound is not automatically required for every infertile man.

It may be useful when:

- physical examination is uncertain,
- testicular disease is suspected,
- a mass is present,
- varicocele assessment requires clarification,



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- testicular volume needs evaluation.

Similarly, TRUS or pelvic MRI is used selectively when ejaculatory-duct obstruction is suspected.

Step 8: Sperm DNA Fragmentation

Sperm DNA fragmentation should not replace routine semen analysis.

Current EAU guidance supports its selective use especially in:

- recurrent pregnancy loss,
- failed ART,
- unexplained male infertility.

AUA/ASRM does not recommend it as a routine initial test for every infertile couple.

Step 9: Post-Ejaculatory Urine Testing

This becomes useful when:

- semen volume is very low,
 - no semen is ejaculated,
 - retrograde ejaculation is suspected.
-

Step 10: Testicular Biopsy Is Not Routine

Older approaches sometimes used diagnostic testicular biopsy simply to distinguish obstructive from non-obstructive azoospermia.

Current guidelines generally advise against routine diagnostic biopsy for this purpose alone.

Clinical assessment, hormones, semen findings and genetics can usually guide the diagnosis.

When surgical sperm retrieval is required, tissue may simultaneously provide histological information.

Treatment of Male Infertility

There is no single:

“Male Infertility Treatment.”



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Treatment should match the cause.

1. Lifestyle Improvement

WHO's 2025 guideline recommends healthy lifestyle measures such as:

- healthy diet,
- physical activity,
- tobacco cessation

for people planning or attempting pregnancy.

For men, I commonly advise:

- stop smoking,
- avoid anabolic steroids,
- reduce heavy alcohol,
- control diabetes,
- achieve reasonable body weight,
- sleep adequately,
- exercise regularly,
- minimize unnecessary reproductive heat,
- improve diet quality.

These measures improve general reproductive health but are not substitutes for specific treatment of:

- obstruction,
 - severe genetics,
 - azoospermia,
 - varicocele,
 - hormonal disease.
-

2. Treat Hormonal Causes

When hypogonadotropic hypogonadism is present, fertility-directed hormone therapy may restore sperm production.



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Current EAU guidance strongly supports appropriate gonadotropin treatment for these men.

This is one of the clearest examples where identifying the exact cause can convert apparently severe infertility into a treatable condition.

3. Treat Hyperprolactinemia

If elevated prolactin is caused by an appropriate pituitary disorder, dopamine-agonist treatment may help restore reproductive hormonal function.

Current EAU guidance supports dopamine-agonist therapy for proven hyperprolactinemia.

4. Treat Infection

When a genuine infection exists:

- antibiotics,
- STI treatment,
- partner treatment where necessary

may be required.

But:

antibiotics are not routine sperm boosters.

They should not be prescribed simply because semen parameters are abnormal.

5. Varicocele Repair

Selected infertile men with:

- clinical varicocele,
- abnormal semen,

may benefit from:

- microsurgical varicocelectomy,
- or radiological embolization.

WHO now specifically supports intervention over observation in selected infertile men with clinical varicocele.



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6. Reconstructive Surgery for Obstruction

When sperm production is normal but a reproductive duct is blocked, microsurgical reconstruction may restore sperm to the ejaculate.

Depending on the site, procedures may include:

- vasovasostomy,
- vasoepididymostomy,
- treatment of ejaculatory-duct obstruction.

AUA/ASRM recognizes reconstruction and sperm retrieval as appropriate options in selected obstructive disease.

7. Treatment of Ejaculatory Dysfunction

Selected patients may benefit from:

- medication,
- penile vibratory stimulation,
- electroejaculation,
- sperm retrieval.

The treatment depends entirely on the neurological or anatomical cause.

8. IUI – Intrauterine Insemination

In IUI:

- semen is processed,
- concentrated motile sperm are placed inside the uterus around ovulation.

It may be useful for:

- mild male-factor infertility,
- selected ejaculation or cervical issues,
- unexplained infertility.

However, very poor total motile sperm numbers reduce success.

AUA/ASRM advises discussing IVF/ICSI when repeatedly low total motile sperm count makes IUI less effective.



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9. IVF – In Vitro Fertilization

During IVF:

- eggs are retrieved,
- sperm and eggs are brought together in the laboratory.

It may be required when:

- male factor is significant,
 - female factors coexist,
 - simpler treatments have failed,
 - age or ovarian reserve makes delay undesirable.
-

10. ICSI – Intracytoplasmic Sperm Injection

ICSI revolutionized severe male-factor infertility.

During ICSI:

one viable sperm is injected directly into one egg.

This can bypass severe problems involving:

- sperm concentration,
- motility,
- morphology.

A man does not need millions of high-quality sperm for ICSI.

He needs usable viable sperm.

11. Sperm Retrieval in Obstructive Azoospermia

When obstruction prevents sperm from reaching semen but sperm production remains normal, sperm may be retrieved from:

- epididymis,
- or testis

for ICSI.



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AUA/ASRM supports either epididymal or testicular sperm retrieval in obstructive azoospermia.

12. Micro-TESE for Non-Obstructive Azoospermia

For men with NOA who wish to pursue biological fatherhood, the principal established retrieval operation is:

Microdissection Testicular Sperm Extraction – micro-TESE

AUA/ASRM recommends micro-TESE for men with NOA undergoing surgical sperm retrieval.

Under an operating microscope, the surgeon searches for small seminiferous tubules that may still contain focal sperm production.

Sperm retrieval does not guarantee:

- fertilization,
- pregnancy,
- or live birth.

But it can provide a route to biological fatherhood in selected men previously considered untreatable.

13. Fertility Preservation

Sperm freezing should be discussed before treatments likely to damage fertility, including:

- chemotherapy,
- pelvic or testicular radiotherapy,
- certain major surgeries.

Cryopreservation may also be appropriate when very rare sperm are detected in men with severe spermatogenic failure.

Supplements and Antioxidants: What Does the Evidence Say?

Many products marketed for male infertility contain:

- zinc,
- selenium,



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- CoQ10,
- carnitine,
- vitamins C and E,
- herbal antioxidants.

Some individual studies report improvements in semen parameters.

However, AUA/ASRM states that the benefits of supplements such as antioxidants and vitamins are of:

questionable clinical utility

and evidence is currently insufficient to recommend a specific universal product.

Therefore:

supplements should support proper fertility care—not replace diagnosis.

Male Infertility in the Unani System of Medicine

The Unani system of medicine has a long tradition of addressing:

- reproductive health,
- sexual function,
- semen disorders,
- general debility,
- dietary health,
- reproductive-organ function.

The traditional framework considers factors such as:

- **Mizaj**
- **Akhlat**
- digestive health,
- nutrition,
- general strength,
- sleep,
- activity,



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- emotional health,
- reproductive function.

However, it is important to distinguish classical concepts from modern microscopic diagnoses.

Classical Unani physicians did not have:

- semen microscopes,
- chromosome testing,
- hormone assays,
- micro-TESE,
- DNA fragmentation testing.

Therefore:

A classical Unani diagnosis should not be artificially equated with every modern sperm disorder.

Qillat-i-Mani in Unani Medicine

CCRUM's Standard Unani Treatment Guidelines discuss:

Qillat-i-Mani

as a traditional condition involving reduced seminal production.

Classical causes include concepts such as:

- general debility,
- inadequate nutrition,
- abnormalities of the functional state or Mizaj of reproductive organs.

Treatment principles include:

- nutritional support,
- improving digestion,
- and therapy individualized according to the patient's traditional diagnosis.

However:

Qillat-i-Mani is not automatically identical to every modern case of male infertility.

For example:



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- complete AZFa deletion,
- vasal agenesis,
- retrograde ejaculation,
- severe varicocele

are specific modern diagnoses that require specific management.

Mizaj and Male Fertility

In Unani medicine:

Mizaj

describes the traditional constitutional and functional temperament of the individual.

In my practice, this can be considered alongside modern fertility information such as:

- semen analysis,
- hormones,
- testicular examination,
- varicocele,
- sexual function,
- general health.

This is one area where Unani medicine can contribute particularly well:

individualization.

Two men with the same sperm count may have completely different:

- health,
 - nutrition,
 - body constitution,
 - sleep,
 - metabolic condition,
 - sexual function,
 - underlying diagnosis.
-



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Akhlat and the Traditional Humoral Framework

Classical Unani medicine describes:

- Dam,
- Balgham,
- Safra,
- Sauda.

These are traditional physiological concepts.

They should not be presented as direct equivalents of:

- FSH,
- testosterone,
- sperm concentration,
- genetics,
- sperm DNA.

A scientifically responsible integrative approach respects the traditional model without confusing it with modern laboratory biology.

Asbab-e-Sitta Zarooriya and Fertility

Unani medicine traditionally emphasizes essential determinants of health involving:

- environment,
- food and drink,
- physical activity and rest,
- psychological state,
- sleep and wakefulness,
- retention and elimination.

Many of these areas overlap meaningfully with modern fertility guidance.

For example:

Food

Modern reproductive medicine recognizes:



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- obesity,
- diabetes,
- nutritional imbalance,
- metabolic health.

Activity

Regular physical activity supports:

- cardiovascular health,
- metabolic health,
- weight.

Sleep

Sleep influences:

- endocrine,
- metabolic,
- psychological health.

Environment

Modern infertility care also considers:

- smoking,
- occupational chemicals,
- reproductive toxins,
- heat.

This provides a useful bridge between traditional preventive medicine and contemporary fertility care.

Major Unani Treatment Approaches

Traditional Unani care uses several broad modalities.

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bit-Tadbir



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Regimenal therapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical treatment

This is an important reminder that Unani medicine is not simply:

“herbs instead of surgery.”

When surgery is required, responsible integrated medical care should recognize that need.

Ilaj-bil-Ghiza in Male Infertility

Diet cannot correct every cause of infertility.

But nutrition can support:

- metabolic health,
- sperm production,
- general vitality,
- micronutrient adequacy.

I commonly recommend a balanced diet emphasizing:

- vegetables,
- fruits,
- pulses,
- whole grains,
- nuts,
- seeds,
- adequate protein,
- healthy fats.

I advise reducing:

- tobacco,
- excessive alcohol,



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- sugary drinks,
- repeated fried foods,
- ultra-processed foods.

For men with:

- diabetes,
- obesity,
- metabolic syndrome,

this aspect of treatment becomes especially important.

Ilaj-bit-Tadbir

Regimenal treatment may focus on:

- activity,
- adequate rest,
- sleep,
- stress,
- weight control,
- general reproductive health.

These measures can complement modern treatment.

Ilaj-bid-Dawa

Traditional Unani medicines are selected according to:

- the individual's Mizaj,
- general health,
- semen findings,
- associated symptoms,
- reproductive diagnosis.

At Saira Health Care, individualized male-infertility treatment may include selected formulations such as:



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Spermogenic Powder

and:

Dr. Qasmi's Nuskha No. 129 – Vitasem Max

where clinically appropriate.

Spermogenic Powder

Saira Health Care Pharmacy currently lists **Spermogenic Powder** as Dr. Qasmi's formulation used in its male reproductive-health programme for conditions including:

- oligospermia,
- reduced sperm motility,
- abnormal sperm morphology,
- and broader male-fertility concerns.

The published ingredient list includes traditional herbs such as:

- Asgand Nagori,
- Kaunch Beej,
- Khulanjan,
- Maror Phali,
- Salab preparations,
- Satawar,
- Musli Safed,
- Darchini

among others.

In my clinical approach, such a formulation may be used as part of:

individualized fertility-support care

rather than automatically prescribing the same treatment to every infertile man.

Dr. Qasmi's Nuskha No. 129 – Vitasem Max

Saira Health Care currently lists **Dr. Qasmi's Nuskha No. 129 – Vitasem Max** as a Unani preparation used particularly for:



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- general weakness,
- vitality,
- and semen-quality support.

Its formulation contains multiple traditional ingredients and mineral preparations and the pharmacy advises:

- physician-directed use,
- avoidance of self-medication,
- use only in prescribed doses.

This is especially important with complex traditional formulations.

Are These Medicines Proven to Cure Every Form of Male Infertility?

No responsible medical article should make that claim.

Male infertility includes:

- genetic disease,
- obstruction,
- hormone deficiency,
- complete Y-chromosome deletions,
- varicocele,
- retrograde ejaculation,
- sexual dysfunction,
- azoospermia,
- and many other conditions.

It would be biologically impossible for one formulation to correct all of these in the same way.

Therefore:

Unani medicines should be used according to the diagnosis—not instead of the diagnosis.

What Does Scientific Research on Unani Male-Fertility Treatment Show?

There is published Unani research relevant to semen abnormalities.



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A CCRUM-associated retrospective analysis examined **126 patients with idiopathic oligospermia** treated in four Unani study groups.

The authors reported that different treatment groups showed changes in:

- semen volume,
- sperm count,
- motility,
- and other parameters.

This suggests that traditional Unani treatment of male infertility deserves continued scientific study.

However:

this was a retrospective analysis—not a modern randomized trial proving a universal cure.

The patients had:

oligospermia

not every type of male infertility.

Therefore, results cannot automatically be applied to:

- obstructive azoospermia,
- complete AZFa deletion,
- maturation arrest,
- vasal agenesis,
- genetic flagellar disease.

Why Available Unani Research Is Encouraging but Still Limited

The existing literature gives us reasons to continue investigating:

- traditional male-fertility formulations,
- dietotherapy,
- regimenal treatment.

But limitations include:

- small sample sizes,
- older study methodology,



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- lack of placebo control in some studies,
- semen parameters rather than live birth as outcomes,
- heterogeneous formulations.

Therefore, I prefer the medically responsible conclusion:

Unani male-fertility treatment has promising supportive evidence in selected semen disorders, but stronger modern clinical trials are needed.

Dr. Nizamuddin Qasmi's Special Individualized Male-Infertility Approach

At Saira Health Care, I believe infertility treatment should follow a structured pathway rather than automatically dispensing a fertility package.

Step 1: Evaluate Both Partners

The female partner should not be assumed normal simply because the man's semen report is abnormal.

Likewise, a man should not be ignored simply because a female cause has already been identified.

WHO and major fertility guidelines support concurrent couple evaluation.

Step 2: Take a Complete Reproductive History

I assess:

- duration of infertility,
- previous pregnancies,
- intercourse,
- sexual dysfunction,
- childhood reproductive conditions,
- surgeries,
- infection,
- medications,
- lifestyle.



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Step 3: Review the Semen Analysis Properly

I do not focus only on:

sperm count.

I review:

- volume,
 - total sperm number,
 - concentration,
 - progressive motility,
 - total motility,
 - morphology,
 - vitality,
 - other findings.
-

Step 4: Repeat an Abnormal Report When Necessary

This prevents treating temporary abnormalities as permanent infertility.

Step 5: Examine the Patient

I assess:

- testicular size,
 - testicular consistency,
 - epididymis,
 - vas deferens,
 - varicocele,
 - hormonal signs.
-

Step 6: Evaluate Hormones

Where appropriate:



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- FSH,
- LH,
- testosterone,
- prolactin

are considered.

Step 7: Identify Genetic Risk

Men with:

- azoospermia,
- severe oligozoospermia,
- impaired sperm production

may require genetic testing according to current guidelines.

Step 8: Identify Correctable Causes

I look specifically for:

- clinical varicocele,
 - infection,
 - hormonal disease,
 - testosterone suppression,
 - anabolic steroids,
 - obesity,
 - diabetes,
 - reproductive-tract obstruction.
-

Step 9: Evaluate Lifestyle and General Health

I ask about:

- smoking,
- alcohol,



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- sleep,
 - activity,
 - diet,
 - stress,
 - occupational exposures.
-

Step 10: Add Individualized Unani Care

Where suitable, I may integrate:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- individualized Ilaj-bid-Dawa,
- Spermogenic,
- Nuskha No. 129,
- or other appropriately selected medicines.

The prescription depends on the patient.

Step 11: Monitor Treatment Objectively

Treatment success should be measured through:

- repeat semen analysis,
- hormones where relevant,
- clinical findings,
- reproductive outcome.

A patient simply feeling:

“more power”

does not prove that sperm production has improved.

Step 12: Preserve Rare Sperm When Necessary



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If sperm become detectable in a previously azoospermic or severely oligospermic man, sperm cryopreservation may be worth discussing.

Severe sperm production can fluctuate.

Step 13: Refer for Surgery When Appropriate

This includes:

- clinical varicocele repair,
- reproductive-tract reconstruction,
- sperm retrieval,
- ejaculatory-duct treatment.

Referral should never be considered a failure of Unani medicine.

It is part of responsible patient care.

Step 14: Do Not Delay ART Unnecessarily

This becomes particularly important when the female partner has:

- advanced reproductive age,
- low ovarian reserve,
- tubal disease,
- other time-sensitive fertility factors.

The objective is:

pregnancy for the couple—not merely improving a laboratory number.

Step 15: Use IUI, IVF or ICSI According to the Couple's Needs

Some patients can continue trying naturally.

Others may benefit from:

- IUI.

Others need:

- IVF/ICSI.



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Men with NOA may require:

- micro-TESE + ICSI.

Treatment should progress according to the real reproductive situation.

Male Infertility and General Health

Infertility evaluation can sometimes uncover conditions important beyond fertility, including:

- hormonal disease,
- genetic disorders,
- testicular abnormalities,
- metabolic disease.

Current EAU guidance recommends a complete medical assessment of infertile men rather than treating semen analysis as an isolated laboratory problem.

Therefore:

male infertility can be an opportunity to evaluate a man's wider health.

Psychological Impact of Male Infertility

Male infertility can cause:

- anxiety,
- depression,
- shame,
- loss of confidence,
- relationship tension,
- fear of social stigma.

I want to say something very clearly to patients:

Infertility does not define masculinity.

Sperm count does not determine:

- sexual worth,
- character,



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- strength,
- ability to love,
- or value as a husband.

WHO's 2025 guideline recognizes the psychological burden of infertility and emphasizes psychosocial support as an important component of fertility care.

Common Myths About Male Infertility

Myth 1: Infertility is mainly a woman's problem.

Fact: Male factors are involved in approximately half of infertile couples.

Myth 2: Thick semen means fertility is good.

Fact: Semen appearance cannot tell you sperm count, motility or morphology.

Myth 3: Normal erections mean sperm must be normal.

Fact: Sexual performance and sperm production are different functions.

Myth 4: Low sperm count means pregnancy is impossible.

Fact: Fertility depends on the degree of abnormality and both partners. Natural or assisted pregnancy may remain possible.

Myth 5: One abnormal semen report means permanent infertility.

Fact: Semen fluctuates and abnormal findings usually require confirmation.

Myth 6: WHO values are strict fertile/infertile cut-offs.

Fact: They represent lower fifth-percentile values from fertile reference populations.

Myth 7: Testosterone injections improve sperm.

Fact: External testosterone can suppress sperm production and cause azoospermia.



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Myth 8: Every varicocele requires surgery.

Fact: Treatment is directed mainly at clinically significant varicocele in appropriate infertile men with abnormal semen.

Myth 9: Every azoospermia patient has no sperm anywhere.

Fact: In NOA, focal sperm production may still be found with micro-TESE in selected men.

Myth 10: Every azoospermia patient can be cured by medicine.

Fact: Causes include obstruction, genetics, testicular failure and hormonal disease; treatment must follow the cause.

Myth 11: Every man with infertility needs antibiotics.

Fact: Antibiotics treat infection, not semen numbers.

Myth 12: Supplements cure male infertility.

Fact: Current AUA/ASRM evidence considers the clinical benefit of most supplements uncertain.

Myth 13: Unani medicine has no scientific role in male infertility.

Fact: Unani medicine offers structured dietotherapy, regimenal treatment and individualized pharmacotherapy, and some published studies report improvements in semen parameters. However, stronger trials are still required.

Myth 14: One Unani medicine can cure every male infertility diagnosis.

Fact: Genetic, anatomical, hormonal and lifestyle causes require different treatment.

Frequently Asked Questions

What is male infertility?

Male infertility means a male reproductive factor contributes to failure to achieve pregnancy.



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How common is infertility?

WHO estimates that approximately **1 in 6 people of reproductive age** experience infertility during their lifetime.

How often is the male responsible?

A male factor is identified in approximately half of infertile couples.

What is the most important male infertility test?

A properly performed:

semen analysis

is the fundamental initial laboratory test.

What sperm count is considered normal?

WHO's current lower fifth-percentile sperm concentration is approximately:

16 million/mL.

This is a reference point, not an absolute fertility threshold.

What is normal sperm motility?

WHO's reference distribution is approximately:

- **42% total motility**
 - **30% progressive motility.**
-

What is normal sperm morphology?

The WHO lower fifth-percentile reference for normal forms is approximately:

4%.

Can a man with 10 million sperm/mL become a father?

Yes.

The probability depends on:

- total sperm number,
- motility,
- morphology,
- duration of infertility,
- female fertility.

A concentration below WHO reference is not the same as zero fertility.

Can azoospermia be treated?

Sometimes.

Treatment depends completely on whether azoospermia is:

- obstructive,
 - hormonal,
 - genetic,
 - or due to testicular sperm-production failure.
-

Can sperm be found in NOA?

Yes in selected men.

Micro-TESE is the recommended sperm-retrieval procedure for men with NOA undergoing surgical retrieval.

Can a complete AZFa or AZFb deletion be treated with micro-TESE?

Current evidence indicates sperm retrieval is essentially unsuccessful, so surgery is generally not recommended.

Can an AZFc deletion still have sperm?

Yes.



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In azoospermic men with isolated AZFc deletion, sperm may be found with micro-TESE in approximately half of cases.

Can low hormones cause infertility?

Yes.

Hypogonadotropic hypogonadism is an important example and may respond to appropriate gonadotropin treatment.

Should I take testosterone if my level is low?

Not if you are actively seeking fertility without specialist guidance.

External testosterone can suppress sperm production.

Does varicocele cause infertility?

It can contribute in some men, but many men with varicocele remain fertile.

Can varicocele surgery improve fertility?

Selected infertile men with a clinical varicocele and abnormal semen may benefit.

Can smoking affect sperm?

Yes.

Smoking and tobacco exposure are recognized modifiable reproductive-health risks.

Does masturbation cause male infertility?

Normal masturbation is not considered a cause of chronic male infertility.

Does frequent ejaculation reduce fertility?

Frequent ejaculation may temporarily alter semen concentration, but normal sexual activity does not cause permanent male infertility.



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Can obesity affect fertility?

Yes in some men through:

- hormonal,
- metabolic,
- inflammatory,
- sexual

mechanisms.

Can Unani medicine help male infertility?

Unani medicine may provide meaningful individualized support through:

- diet,
- regimen,
- lifestyle,
- reproductive-health pharmacotherapy.

Its usefulness depends on the diagnosis.

It should not replace:

- surgery for obstruction,
- appropriate hormones for endocrine disease,
- genetic counselling,
- micro-TESE,
- IVF/ICSI

when these are medically indicated.

What is Spermogenic?

Spermogenic is a Dr. Qasmi formulation used within Saira Health Care's individualized male reproductive-health programmes for conditions including semen-quality abnormalities.

Is Spermogenic proven to cure all male infertility?



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No.

The current product listing describes broad reproductive indications, but I do not identify robust independent randomized evidence demonstrating that it cures every form of male infertility or guarantees pregnancy.

What is Nuskha No. 129?

Dr. Qasmi's Nuskha No. 129 – Vitasem Max is a Unani preparation currently used for general vitality and semen-quality support within individualized care.

Can Unani treatment replace IVF?

Not when IVF or ICSI is medically required.

The best treatment may combine traditional supportive care with modern assisted reproduction.

Latest Scientific Perspective: 2025–2026

Male-infertility care has changed considerably in recent years.

WHO's First Global Infertility Guideline – November 2025

On **28 November 2025**, WHO published its first global guideline dedicated to the prevention, diagnosis and treatment of infertility.

It contains 40 recommendations addressing:

- prevention,
- diagnosis,
- male and female treatment,
- lifestyle,
- IUI,
- IVF,
- psychosocial care.

For male assessment, WHO emphasizes:



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- history,
 - physical examination,
 - standardized semen analysis,
 - repeat testing when abnormal,
 - simultaneous female evaluation.
-

Updated Semen-Testing Strategy

WHO now suggests repeating abnormal semen analysis after at least:

11 weeks

rather than interpreting one abnormal report as definitive.

This is one of the most useful practical developments for patients.

2024 AUA/ASRM Genetic Update

The major genetic change was refinement of the threshold for:

Y-chromosome microdeletion testing

to azoospermia or sperm concentration:

≤1 million/mL

in men with clinical evidence of impaired sperm production.

This replaces the older broader threshold in previous AUA recommendations.

Genetic Medicine Is Becoming Increasingly Important

New research continues to identify specific genes responsible for previously unexplained:

- azoospermia,
- maturation arrest,
- severe oligozoospermia,
- motility disorders.

The future of male-infertility medicine will increasingly involve:

- more precise genetic diagnosis,



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- individualized reproductive counselling,
- better prediction of sperm-retrieval potential.

But genetic testing must remain clinically targeted rather than indiscriminately ordered.

Micro-TESE Remains Central for NOA

Current AUA/ASRM guidance continues to recommend:

micro-TESE

for men with non-obstructive azoospermia undergoing sperm retrieval.

This is currently much more established than experimental approaches such as:

- stem-cell treatment,
 - in-vitro spermatogenesis.
-

Stem-Cell Treatment Is Still Experimental

Research into:

- spermatogonial stem cells,
- testicular organoids,
- germ-cell transplantation,
- in-vitro sperm production

is exciting.

However:

There is no established stem-cell cure for routine male infertility in 2026.

Patients should be cautious of clinics promising guaranteed sperm production through unproven regenerative procedures.

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, male infertility forms an important part of our focused work in:

Sexual Disorders & Infertility

Saira Health Care's current public profile identifies me, **Dr. Nizamuddin Qasmi**, as Founder and Chief Physician and lists clinical work involving:

- male infertility,
- oligospermia,
- azoospermia,
- asthenospermia,
- abnormal morphology,
- varicocele,
- sexual dysfunction.

Our current educational material emphasizes an individualized approach combining:

- traditional Unani assessment,
- lifestyle,
- modern semen analysis,
- fertility investigations,
- and appropriate referral.

Why Saira Health Care's Combined Sexual-Health and Infertility Focus Matters

Male infertility often overlaps with:

- erectile dysfunction,
- premature ejaculation,
- low libido,
- hormonal disease,
- testicular problems,
- varicocele,
- anxiety.

A clinic focusing on both sexual and reproductive health can distinguish:

“I cannot perform intercourse”

from:

“I can perform intercourse but my sperm are abnormal.”

These are not the same diagnosis.



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Education Is an Important Part of Our Contribution

Many patients reach us after being told:

“Nil sperm means no chance.”

Others are told:

“Take this powder and every azoospermia will be cured.”

Others believe:

“Thick semen means sperm are good.”

Others have taken testosterone injections believing they were fertility treatment.

At Saira Health Care, I believe correcting such misinformation is itself part of treatment.

A Responsible Integrative Philosophy

I do not believe patients should have to choose between:

Unani medicine

and:

modern reproductive medicine.

Both should be used according to the problem.

If the patient has poor diet and metabolic health

Unani dietotherapy and lifestyle care may be especially valuable.

If the patient has hypogonadotropic hypogonadism

He needs correct hormonal treatment.

If he has a clinical varicocele with appropriate infertility indications

Surgical or radiological repair should be discussed.

If there is reproductive-tract obstruction

Reconstruction or sperm retrieval may be necessary.

If there is a genetic abnormality

Genetic counselling becomes essential.

If there is NOA



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micro-TESE and ICSI may be appropriate.

If semen parameters are mildly abnormal without a severe structural or genetic cause

individualized Unani pharmacotherapy and reproductive-health support may reasonably form part of the plan.

This is what I consider:

responsible integrative fertility care.

About Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with a focused specialist 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 current published professional profile confirms my BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK, and describes my focused practice in sexual disorders and infertility.

Current Saira Health Care professional material additionally lists the **Masters in Male Infertility – MasterHealthPro (HealthPro)** and **Integrated Sexual and Reproductive Health – ISRH, UNFPA** within the physician profile used for its clinical educational articles.

My Final Message to Men Facing Infertility

If you have been trying for pregnancy without success, do not automatically assume:

“The problem must be with my wife.”

And if your semen report is abnormal, do not immediately assume:



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"I can never become a father."

Instead ask:

Has my semen analysis been repeated properly?

What is my sperm concentration?

What is my total sperm number?

How is progressive motility?

How is morphology?

Are the sperm alive?

Do I have a varicocele?

Are my testes normal?

What are my FSH, LH and testosterone?

Have I used testosterone or anabolic steroids?

Do I need genetic testing?

Could there be an obstruction?

Could the sperm problem be hormonal?

How is my wife's fertility?

Would lifestyle and individualized Unani treatment be reasonable?

Do I need varicocele repair?

Would IUI help?

Do we need IVF/ICSI?

If sperm are absent, could micro-TESE be appropriate?

These questions lead to rational treatment.

The question:

"Which one medicine cures male infertility?"

does not.

Conclusion



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Male infertility is a broad reproductive-health condition in which a problem involving the male partner contributes to difficulty achieving pregnancy.

Approximately **one in six people worldwide** experiences infertility during reproductive life, and male factors contribute to roughly half of infertile couples.

Male infertility can result from:

- low sperm count,
- low motility,
- abnormal morphology,
- azoospermia,
- hormonal disease,
- varicocele,
- genetic abnormalities,
- testicular disease,
- reproductive-tract obstruction,
- ejaculation disorders,
- erectile dysfunction,
- infections,
- smoking,
- anabolic steroids,
- obesity,
- environmental exposure,
- cancer treatment,
- or unexplained factors.

Diagnosis begins with:

- detailed reproductive history,
- physical examination,
- semen analysis.

Current WHO semen reference distributions include:

- volume: **1.4 mL**



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- concentration: **16 million/mL**
- total sperm number: **39 million**
- total motility: **42%**
- progressive motility: **30%**
- vitality: **54%**
- normal morphology: **4%**.

These are not strict fertile/infertile cut-offs.

Abnormal semen results should generally be confirmed, with WHO 2025 suggesting repeat testing after approximately **11 weeks** when appropriate.

Further evaluation may include:

- FSH,
- LH,
- testosterone,
- genetic testing,
- ultrasound,
- post-ejaculatory urine examination,
- selected sperm DNA fragmentation testing.

The 2024 AUA/ASRM guideline recommends:

- karyotype testing in appropriate men with azoospermia or sperm concentration **<5 million/mL**
- Y-chromosome testing particularly with azoospermia or sperm concentration **≤1 million/mL**

when evidence of impaired sperm production is present.

Treatment depends on the cause.

Appropriate options may include:

- lifestyle improvement,
- smoking cessation,
- treatment of infection,
- gonadotropin therapy for hypogonadotropic hypogonadism,



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- clinical varicocele repair,
- reconstructive surgery,
- treatment of ejaculatory disorders,
- IUI,
- IVF,
- ICSI,
- surgical sperm retrieval,
- micro-TESE.

External testosterone should **not** be used as fertility treatment because it can suppress spermatogenesis.

For NOA, micro-TESE remains the principal recommended surgical retrieval technique when biological sperm retrieval is appropriate.

The **Unani system of medicine** can provide meaningful individualized support through:

- Mizaj assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- nutritional improvement,
- lifestyle correction,
- general reproductive-health support.

CCRUM's Unani guidelines discuss traditional male reproductive conditions such as **Qillat-i-Mani**, while a retrospective Unani study involving 126 patients with idiopathic oligospermia reported improvements in different semen parameters across several treatment groups.

These findings support continued investigation of Unani male-fertility treatment but do **not** establish that every genetic, obstructive or severe testicular cause can be cured by herbal medicine.

At **Saira Health Care**, formulations including:

- **Spermogenic Powder**
- **Dr. Qasmi's Nuskha No. 129 – Vitasem Max**



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may be incorporated into an individualized fertility programme according to the patient's diagnosis and overall health.

They should not be interpreted as universal guaranteed cures.

My approach at Saira Health Care can therefore be summarized as:

Evaluate both partners.

Confirm the semen abnormality.

Find the underlying cause.

Assess hormones and reproductive anatomy.

Use genetic testing when appropriate.

Avoid fertility-suppressing testosterone.

Correct smoking, obesity, diabetes and harmful exposures.

Treat infection appropriately.

Repair significant varicocele when indicated.

Use individualized Unani treatment rationally.

Monitor semen objectively.

Preserve rare sperm where appropriate.

Use IUI, IVF, ICSI or micro-TESE without unnecessary delay when indicated.

And never promise pregnancy from one semen number, one medicine or one treatment system.

For every man concerned about fertility, my central message is:

Male infertility is often treatable or manageable, and even severe sperm abnormalities do not automatically close every route to biological fatherhood. The most important step is an accurate diagnosis followed by individualized, evidence-aware and compassionate care.

Medical Disclaimer

This article is intended for general medical education and reproductive-health awareness.

It is not a substitute for:

- individual medical consultation,
- physical examination,



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- semen analysis,
- hormone testing,
- genetic counselling,
- imaging,
- urological assessment,
- or individualized infertility treatment.

No particular:

- Unani medicine,
- herbal formulation,
- supplement,
- food,
- lifestyle intervention,
- surgical procedure,
- IVF cycle,
- or sperm-retrieval operation

can guarantee pregnancy or live birth.

Do not independently start or stop:

- testosterone,
- anabolic steroids,
- fertility hormones,
- antibiotics,
- Unani medicines,
- herbal medicines,
- mineral preparations,
- or supplements

without qualified professional guidance.

Men with:

- azoospermia,



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- severe oligozoospermia,
- testicular atrophy,
- significant hormonal abnormalities,
- suspected genetic infertility,
- reproductive-tract obstruction,
- persistent infertility

should receive appropriate specialist evaluation.

Where:

- varicocele repair,
- reconstructive surgery,
- micro-TESE,
- IUI,
- IVF,
- or ICSI

is medically indicated, timely referral should form part of responsible integrative fertility care.



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