

Anovulatory Infertility

Causes of Absent or Irregular Ovulation, PCOS/PMOS, Hormonal Disorders, Diagnosis, Ovulation Induction, Fertility Treatment and an Integrative Unani Approach

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Introduction: “Doctor, My Periods Are Irregular — Am I Ovulating Properly?”

One of the most common questions women ask me during an infertility consultation is:

“Doctor, my periods do not come regularly. Does that mean I am not producing eggs?”

Another woman may tell me:

“My periods come every month, but pregnancy is still not happening. Can I still have an ovulation problem?”

And another may have been taking different “fertility medicines” for months without anyone first establishing **why she is not ovulating**.

These are important questions because successful pregnancy requires more than simply having menstrual bleeding.

For natural conception, an ovarian follicle must develop properly, a mature egg must be released, sperm must reach that egg, fertilization must occur, and the resulting embryo must reach and implant within a receptive uterus.

When an egg is not released from the ovary, the condition is called **anovulation**. When ovulation occurs only occasionally or unpredictably, we commonly use the term **oligo-ovulation**.



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If failure of regular ovulation prevents pregnancy, we describe the problem as **anovulatory infertility**.

Ovulatory disorders are an important cause of female infertility. ASRM estimates that ovulatory dysfunction is identified in about 15% of infertile couples and may account for up to 40% of infertility in women.

The encouraging part is that anovulatory infertility is not one single disease. Many causes are **diagnosable and treatable**, and treatment can sometimes restore natural ovulation rather than requiring IVF immediately.

The central principle I explain to my patients is:

We should not simply stimulate the ovary. We should first understand why normal ovulation has stopped.

That difference is the foundation of safe and effective fertility care.

What Is Ovulation?

Every menstrual cycle begins with communication between the brain and the ovaries.

The hypothalamus in the brain releases **gonadotropin-releasing hormone, or GnRH**.

GnRH stimulates the pituitary gland to release two important reproductive hormones:

FSH — Follicle-Stimulating Hormone

and

LH — Luteinizing Hormone.

FSH supports the growth of ovarian follicles. Each follicle contains an immature egg.

Usually, one follicle becomes dominant.

As it grows, it produces increasing amounts of estradiol.

When hormonal signalling is appropriate, a mid-cycle rise or **surge of LH** triggers release of the mature egg from the ovary.

That event is ovulation.

After the egg is released, the remaining follicle becomes the **corpus luteum**, which produces progesterone.

Progesterone helps prepare the uterine lining for implantation.

Therefore, normal fertility depends on coordinated communication between:



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hypothalamus → pituitary gland → ovary → uterus.

A disturbance anywhere along this system can interfere with ovulation.

What Is Anovulation?

Anovulation means that a mature egg is **not released during a menstrual cycle**.

This can occur occasionally even in otherwise healthy women.

A single anovulatory cycle does not automatically mean infertility.

The problem becomes clinically important when ovulation is repeatedly absent or infrequent.

A woman with chronic anovulation may have:

very irregular menstrual periods, very long cycles, extremely infrequent bleeding, or complete absence of menstruation.

Some women can still experience bleeding even when ovulation has not occurred.

Therefore:

Menstrual bleeding does not always prove that ovulation occurred.

Conversely, women with predictable monthly cycles are generally likely to be ovulating. NICE's updated 2026 fertility guideline specifically states that regular monthly menstrual cycles usually indicate ovulation, although selected cases may still require confirmation.

Anovulation, Oligo-Ovulation and Amenorrhea Are Not the Same

These terms are often used interchangeably by patients, but they describe different things.

Anovulation means no egg release.

Oligo-ovulation means ovulation occurs, but less frequently or unpredictably.

Amenorrhea means menstruation is absent.

Amenorrhea often accompanies anovulation, but they are not identical.

For example, a woman may experience irregular breakthrough bleeding from an estrogen-stimulated endometrium without having ovulated.

Another woman with very irregular cycles may still ovulate occasionally.

This distinction matters because occasional spontaneous ovulation means natural pregnancy can still occur unexpectedly.

How Does Anovulation Cause Infertility?

For natural fertilization, sperm require an egg.

If no mature egg is released, there is no egg available in the fallopian tube for sperm to fertilize.

Therefore, complete chronic anovulation can prevent natural conception even when:
the fallopian tubes are open,
the uterus is healthy,
and the male partner's semen analysis is normal.

Oligo-ovulation creates a different problem.

Pregnancy may still be possible, but fertile windows occur less often and can be difficult to predict.

A woman who ovulates only four or five times in a year has far fewer opportunities for natural conception than someone ovulating approximately monthly.

The Menstrual Cycle Can Give Important Clues

Menstrual history is one of the simplest and most valuable fertility investigations.

In most ovulatory women, cycles are relatively predictable.

ASRM notes that ovulatory cycles generally occur every **21–35 days**. Women with oligomenorrhea or amenorrhea are more likely to have an ovulatory disorder.

However, cycle length alone does not diagnose the cause.

One woman with irregular periods may have PCOS.

Another may be underweight and exercising intensely.

Another may have high prolactin.

Another may have thyroid disease.

Another may be approaching ovarian insufficiency.

The appearance of the menstrual calendar may be similar.



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The biology can be completely different.

Major Causes of Anovulatory Infertility

Modern fertility care requires cause-based treatment.

The important causes include PCOS/PMOS, functional hypothalamic amenorrhea, obesity and metabolic dysfunction, hyperprolactinemia, thyroid disease, hypothalamic or pituitary disease, primary ovarian insufficiency, reproductive ageing, certain medications, major systemic illness and less common adrenal or androgen-producing disorders.

ASRM's current amenorrhea guidance emphasizes that disorders involving the hypothalamus, pituitary, ovaries, thyroid and reproductive tract account for most clinically important menstrual disturbances.

PCOS/PMOS — The Most Common Cause of Anovulation

The single most important cause of chronic anovulation worldwide is **polycystic ovary syndrome (PCOS)**.

WHO's January 2026 fact sheet estimates that PCOS affects approximately **10–13% of reproductive-age women** and identifies it as the most common cause of anovulation globally and a leading cause of infertility.

Some international guideline resources began using the new term **Polyendocrine Metabolic Ovarian Syndrome (PMOS)** in May 2026 for the condition previously known as PCOS. WHO publications currently still commonly use “PCOS,” so I use **PCOS/PMOS** here to keep the terminology understandable.

Why Does PCOS/PMOS Cause Anovulation?

In PCOS/PMOS, the ovaries often begin developing several follicles, but normal selection and maturation of a dominant follicle may fail.

The follicles can remain arrested at an intermediate stage.

Hormonal abnormalities can involve:

excess androgen activity,

abnormal LH/FSH signalling,

insulin resistance,



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and altered ovarian follicular function.

The result can be:

irregular follicular development → infrequent ovulation → irregular menstruation → infertility.

Women can present very differently.

One may be overweight and have insulin resistance.

Another may have a normal body weight.

One may have obvious hirsutism and acne.

Another may have very few outward signs.

This variability is one reason PCOS should not be diagnosed simply because an ultrasound says **“polycystic ovaries.”**

How Is PCOS/PMOS Diagnosed?

The international evidence-based guideline uses a diagnosis based on at least two of three major features, after excluding other causes:

ovulatory dysfunction,
clinical or biochemical hyperandrogenism, and
polycystic ovarian morphology.

In adults, AMH can sometimes be used in the diagnostic algorithm as an alternative marker of polycystic ovarian morphology, but the guideline specifically states that **AMH should not be used as a single standalone diagnostic test for PCOS.**

Importantly, when irregular menstrual cycles and hyperandrogenism are already present, an ovarian ultrasound is not always necessary to establish the diagnosis.

That helps prevent overdiagnosis.

“Polycystic Ovary” Does Not Mean You Have Dangerous Ovarian Cysts

The name is unfortunately confusing.

The small follicles seen on ultrasound in PCOS are usually immature ovarian follicles, not pathological cysts that necessarily need surgical removal.

A woman should therefore not undergo ovarian surgery merely because an ultrasound report mentions multiple small follicles.



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PCOS is fundamentally a **hormonal and metabolic reproductive disorder**, not simply a disease caused by cysts.

Insulin Resistance and PCOS

Insulin resistance is common in PCOS/PMOS.

When the body's tissues respond poorly to insulin, the pancreas may produce more insulin to compensate.

High insulin levels can increase ovarian androgen production and interact with other hormonal disturbances that impair normal follicular maturation.

This helps explain why metabolic health is relevant to reproductive health.

However, not every woman with PCOS is overweight or insulin-resistant, so treatment should not assume that every patient has the same metabolic phenotype.

Chronic Anovulation and the Endometrium

Repeated anovulation affects more than fertility.

When ovulation does not occur, normal cyclic progesterone production may also be absent.

The endometrium can therefore remain exposed to estrogen without regular progesterone opposition.

Over time, very infrequent menstrual bleeding can increase the risk of **endometrial hyperplasia** and, over the long term, endometrial cancer in some women with PCOS. WHO highlights this risk particularly in women with infrequent or irregular menstruation.

This is why chronic menstrual irregularity deserves medical attention even when pregnancy is not currently desired.

Functional Hypothalamic Amenorrhea

The opposite metabolic picture can also stop ovulation.

Some women develop **functional hypothalamic amenorrhea (FHA)** because the brain reduces GnRH signalling.

Common triggers include:



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insufficient energy intake,
significant weight loss,
excessive physical exercise,
psychological stress,
or combinations of these factors.

A 2025 systematic review describes FHA as a multifactorial disorder involving psychological stress, energy deficiency, weight loss and excessive activity relative to energy intake.

This tells us something very important:

Anovulation can occur both when metabolic energy is excessive and when energy availability is too low.

Therefore, telling every anovulatory woman simply to “lose weight” can be harmful.

How Low Energy Availability Stops Ovulation

Reproduction requires energy.

When the brain perceives inadequate energy availability or severe physiological stress, it can reduce pulsatile GnRH release.

FSH and LH signalling then decline.

Estradiol production decreases.

Follicular development becomes impaired.

Ovulation can stop.

Menstrual periods may become irregular and eventually disappear.

This is not the ovary being “lazy.”

It is a neuroendocrine adaptation to an environment in which the body does not perceive adequate energy availability for reproduction.

Functional Hypothalamic Amenorrhea Also Affects Bone Health

FHA should not be treated only as a fertility problem.

Prolonged estrogen deficiency can reduce bone mineral density.



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Recent 2026 evidence continues to confirm substantial skeletal consequences of FHA, including impaired bone mineral density and increased fracture risk.

Therefore, a woman with prolonged absent periods after significant weight loss, excessive exercise or restrictive eating should not simply wait until she wishes to become pregnant before seeking medical evaluation.

Treatment of Functional Hypothalamic Anovulation

The first objective is to correct the underlying energy imbalance where possible.

NICE's new March 2026 fertility guideline advises women with hypogonadotropic hypogonadism and anovulatory infertility to increase body weight toward a healthy range if BMI is below 18.5 kg/m² and to moderate excessive exercise where relevant.

For women who require ovulation induction, NICE recommends **gonadotrophins with LH activity or GnRH therapy**, depending on the cause and clinical setting.

This treatment strategy is fundamentally different from PCOS treatment.

Giving the same medicine to both conditions would ignore the underlying physiology.

Hyperprolactinemia

Prolactin is produced by the pituitary gland.

It plays a normal physiological role during breastfeeding.

When prolactin becomes abnormally elevated outside pregnancy and lactation, it can suppress GnRH and interfere with FSH and LH secretion.

The result can include:

irregular periods,

amenorrhea,

low estrogen,

reduced sexual desire,

and anovulatory infertility.

ASRM recommends prolactin measurement as part of the evaluation of amenorrhea or significant menstrual irregularity.



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A Woman Does Not Need Breast Discharge to Have High Prolactin

Many patients believe hyperprolactinemia must cause milk discharge from the breast.

That is incorrect.

ASRM notes that only about one-third of women with hyperprolactinemia have galactorrhea, so the absence of breast discharge cannot exclude the diagnosis.

Symptoms can also include headaches or visual disturbances when a larger pituitary lesion is present.

Mildly Elevated Prolactin Should Be Confirmed

Prolactin can temporarily increase due to stress, sleep, exercise, breast stimulation, eating and some medications.

Therefore, a mildly abnormal result should often be repeated under appropriate conditions before diagnosing hyperprolactinemia.

ASRM also emphasizes the importance of considering **macroprolactin**, a biologically less active form that can produce an elevated laboratory result without producing typical hormonal effects.

This prevents unnecessary treatment and imaging.

Treatment of Hyperprolactinemic Anovulation

When true hyperprolactinemia is responsible for ovulatory dysfunction, treatment targets the cause.

The newest WHO infertility guideline recommends **cabergoline over bromocriptine** for infertility due to hyperprolactinemic ovulatory dysfunction. NICE's March 2026 guideline independently recommends cabergoline for ovulatory disorders due to hyperprolactinemia.

Pituitary disease may require endocrinological evaluation and MRI.

Again, the treatment is not simply an “ovulation tablet.”

The prolactin disorder is treated so that normal reproductive signalling can recover.

Thyroid Disease and Anovulation



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Both hypothyroidism and hyperthyroidism can disrupt menstrual regularity and contribute to chronic anovulation.

ASRM recommends **TSH testing** during the evaluation of amenorrhea and significant menstrual irregularity because thyroid disease may be present even when obvious thyroid symptoms are absent.

Treating clinically significant thyroid disease may allow normal ovulation to resume.

A woman with thyroid-related anovulation therefore requires thyroid treatment rather than repeatedly increasing doses of ovulation-induction medicines.

Primary Ovarian Insufficiency

Anovulation can also occur because the ovaries themselves are losing follicular function.

Primary ovarian insufficiency (POI) describes loss or severe impairment of ovarian function before the usual age of menopause.

Women may develop:

irregular periods,

amenorrhea,

hot flushes,

vaginal dryness,

reduced estrogen,

high FSH,

and infertility.

POI is biologically very different from PCOS.

In PCOS there may be many follicles but difficulty selecting and releasing a mature egg.

In POI there may be a significant loss of functioning ovarian follicles.

That means conventional ovulation-induction treatment is much less effective in true established ovarian insufficiency.

Perimenopause and Reproductive Ageing

Ovulation becomes less predictable as ovarian ageing progresses.

Women may experience shorter cycles initially and later irregular or skipped cycles.

Egg quantity and chromosomal competence also decline with age.

Therefore, a woman in her late 30s or 40s with irregular ovulation should not spend years treating the cycle alone without considering age-related fertility decline.

NICE's 2026 guideline emphasizes maternal age as the first predictor of overall pregnancy potential and cautions that AMH is not a test of natural-conception probability.

Obesity and Anovulation

Excess body weight can interfere with ovulation, particularly in women with PCOS/PMOS.

Insulin resistance, increased androgen signalling, inflammation and altered hormonal feedback may contribute.

This does not mean every woman with obesity is anovulatory.

Nor should fertility care be reduced to repeatedly telling a woman to lose weight.

WHO's 2025 infertility guideline recommends lifestyle measures such as healthy diet, physical activity and weight management as part of PCOS care.

The 2023 international PCOS guideline similarly emphasizes lifestyle management while explicitly cautioning clinicians to recognize and reduce **weight stigma**.

That balance is important.

Metabolic health deserves treatment without making the patient feel blamed for infertility.

Rapid Weight Loss Can Also Stop Ovulation

A woman does not have to be clinically underweight to develop energy-deficiency-related anovulation.

Rapid weight loss, restrictive dieting or intense exercise can disturb hypothalamic signalling even before BMI becomes extremely low.

This is why I ask not only:

“What is your weight?”

but also:



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“Has your weight changed significantly?”

The direction and speed of change can be clinically important.

Stress and Ovulation

Psychological stress can contribute to hypothalamic reproductive dysfunction in some women, particularly when combined with low energy availability, inadequate sleep or excessive exercise.

But it is important not to tell an infertile woman:

“Just relax and you will become pregnant.”

That is neither scientifically adequate nor compassionate medical care.

Stress may be one contributor.

It does not explain PCOS, POI, thyroid disease, hyperprolactinemia or many other causes of infertility.

Medications Can Disturb Ovulation

Several medications can influence reproductive hormones.

Examples include certain antipsychotics that increase prolactin, some antiepileptic drugs, chemotherapy, long-term hormonal treatments and other agents affecting hypothalamic or pituitary function.

ASRM includes medication effects among recognized causes of secondary amenorrhea.

A patient should not abruptly stop an essential prescription medication.

The correct approach is to identify the potential association and coordinate any medication changes with the original prescriber.

Androgen-Secreting Disorders and Other Less Common Causes

Most women with irregular periods and excess facial hair have PCOS/PMOS.

But rapidly developing severe hyperandrogenism requires a different level of investigation.



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ASRM recommends considering ovarian or adrenal androgen-producing tumors, non-classic congenital adrenal hyperplasia, Cushing syndrome and other less common disorders when androgen excess is marked or progresses rapidly.

This is why the history matters.

Gradual hirsutism developing over years is very different from rapid virilization developing within months.

Signs That May Suggest Anovulation

A woman may have an ovulation disorder when periods occur very infrequently, disappear completely or become highly unpredictable.

Other clues depend on the cause.

PCOS may produce acne or hirsutism.

Hyperprolactinemia may produce galactorrhea.

Hypothalamic amenorrhea may follow weight loss or excessive exercise.

POI may produce hot flushes and vaginal dryness.

Thyroid disease may cause weight, temperature or energy changes.

But some women have surprisingly few symptoms.

Therefore, symptoms guide investigation but do not replace appropriate testing.

Can a Woman Have Regular Periods and Still Not Ovulate?

Yes, although persistent anovulation is much less common when cycles are predictably regular.

The 2023 international PCOS guideline specifically acknowledges that **ovulatory dysfunction can occur even with apparently regular menstrual cycles**, and serum progesterone may be used when confirmation is needed.

WHO's 2025 infertility guideline similarly recommends mid-luteal serum progesterone when confirmation of ovulation is clinically appropriate.

How Is Ovulation Confirmed?

There is no reason to make ovulation assessment unnecessarily complicated.



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For women with regular cycles and no clinical reason to suspect anovulation, menstrual history may already be strongly reassuring.

When ovulation requires confirmation, the newest WHO guidance favors **mid-luteal serum progesterone** rather than routine ultrasound solely to prove ovulation. The sample is generally taken approximately **seven days before the expected next menstrual period**, not automatically on “day 21” for every woman.

This distinction is important.

A woman with a 35-day cycle should not necessarily have the test performed on cycle day 21.

The timing needs to follow the expected luteal phase.

Why “Day 21 Progesterone” Can Be Misleading

The phrase **day-21 progesterone** assumes a classic 28-day cycle with ovulation around day 14.

But real menstrual cycles vary.

If a woman ovulates on day 21 of a long cycle and her progesterone is measured that same day, the result may appear low simply because it was measured too early.

That can lead to an incorrect diagnosis of anovulation.

WHO therefore describes the test more accurately as **mid-luteal progesterone approximately seven days before the expected next period**.

What If the Progesterone Result Suggests No Ovulation?

One abnormal progesterone level should be interpreted cautiously.

Ovulation can vary from cycle to cycle and test timing may be wrong.

WHO recommends repeating the measurement in a subsequent cycle when the first result suggests anovulation, to reduce the risk of misdiagnosis.

This is a good example of why one blood-test result should not automatically define a woman's reproductive future.

Ovulation-Prediction Kits

Home urine LH kits can be helpful for some women trying to identify the fertile period.



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But they have limitations.

In PCOS/PMOS, basal LH can sometimes be elevated, potentially producing confusing or repeated positive results.

An LH surge also indicates the body's hormonal attempt to trigger ovulation; it does not provide direct proof that the follicle actually ruptured.

Therefore, ovulation-prediction kits can help with timing but should not be treated as a definitive diagnostic test when infertility is being investigated.

Follicular Monitoring by Ultrasound

Serial transvaginal ultrasound can follow:

follicular growth,

dominant-follicle development,

endometrial changes,

and evidence consistent with ovulation.

It is particularly valuable during monitored ovulation-induction treatment.

However, WHO's newest infertility guideline does not recommend routine ultrasound over appropriately timed serum progesterone simply to confirm spontaneous ovulation in an otherwise normal evaluation.

Ultrasound becomes more useful when we need anatomical information or are monitoring treatment response.

Basal Body Temperature

A slight rise in basal body temperature can occur after ovulation because progesterone increases body temperature.

While historically used extensively, basal temperature charts are less reliable and can create unnecessary stress.

They can suggest retrospectively that ovulation may have occurred, but they are not usually the best modern diagnostic method for infertility.

Blood Tests in Suspected Anovulatory Infertility

The correct tests depend on the presentation.



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WHO's 2025 guideline recommends assessment of the **hypothalamic-pituitary-ovarian axis**, including hormones such as FSH and LH and, in selected cases, estradiol and testosterone. TSH and prolactin may also be appropriate according to the clinical picture.

The aim is not to order every reproductive hormone available.

It is to identify the biological level at which normal ovulation is being disrupted.

FSH and LH

FSH and LH can be particularly useful when periods are absent.

If FSH is high and estradiol low, ovarian insufficiency becomes more concerning.

If FSH and LH are low or inappropriately normal together with low estrogen, hypothalamic or pituitary dysfunction becomes more likely.

In PCOS, gonadotropins may be within the normal range and should not be interpreted using a simplistic LH-to-FSH ratio.

No one ratio diagnoses PCOS.

Prolactin

Prolactin is especially important when periods are absent or very irregular.

Persistent hyperprolactinemia requires investigation of possible causes such as:
medications,
thyroid disease,
or pituitary disorders.

ASRM recommends MRI evaluation when prolactin remains persistently elevated and no simpler explanation accounts for it.

TSH

Thyroid-stimulating hormone is a simple but important test in menstrual disorders.

Both excess and deficiency of thyroid hormone can disturb reproductive function.

The thyroid should therefore be corrected appropriately rather than simply stimulating the ovaries around an untreated endocrine disorder.



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Androgen Testing

When hirsutism, acne or other signs of androgen excess accompany irregular menstruation, testing may include total and free testosterone.

The 2023 international PCOS guideline recommends accurate testosterone methods where available and warns that severe or rapidly progressive androgen excess warrants investigation for disorders other than PCOS.

AMH Is Not an Ovulation Test

AMH is frequently misunderstood.

A woman may say:

“My AMH is high, so I must be ovulating well.”

or:

“My AMH is low, so I cannot ovulate.”

Neither statement is necessarily correct.

AMH reflects aspects of ovarian follicle number and is useful in predicting ovarian response to fertility treatment.

NICE's 2026 guideline specifically advises **not using AMH to predict the chance of natural conception.**

AMH can contribute to PCOS diagnosis in appropriate adults, but it is not a standalone test of ovulation or fertility.

Pelvic Ultrasound

Ultrasound can assess:

ovarian morphology,

antral follicles,

uterine structure,

endometrial thickness,

fibroids,

ovarian cysts,



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and other pelvic abnormalities.

In PCOS, however, ultrasound is only one component of diagnosis.

A woman should not be labelled with PCOS merely because her ovaries contain several follicles.

A Fertility Evaluation Must Look Beyond Ovulation

This is particularly important.

Imagine that we successfully induce ovulation in a patient whose fallopian tubes are both blocked.

Pregnancy still cannot occur naturally.

Or imagine the patient's partner has severe male-factor infertility.

Restoring ovulation alone may not be enough.

WHO's 2025 treatment algorithm for anovulatory PCOS specifically advises considering tubal patency and assessing the male partner, including semen analysis, rather than treating ovulation in isolation.

At Saira Health Care, I consider this couple-based approach essential.

When Should a Woman Seek Fertility Evaluation?

The general definition of infertility remains failure to achieve pregnancy after **12 months or more of regular unprotected intercourse**. WHO reaffirmed this definition in 2025.

However, a woman with obvious menstrual irregularity or amenorrhea should not necessarily wait 12 months.

ASRM recommends earlier evaluation when a known condition associated with infertility exists, including irregular cycles, oligomenorrhea and amenorrhea. Evaluation is generally started after six months in women aged 35 or older and more immediately in women over 40.

NICE's 2026 guidance similarly recommends specialist assessment at presentation when there is a known or suspected fertility factor or when the woman is aged 36 years or older.

Treatment of Anovulatory Infertility



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There is no universal ovulation medicine.

Treatment depends upon **why ovulation is failing**.

This is one of the most important principles in this article.

A patient with PCOS should not be treated exactly like someone with functional hypothalamic amenorrhea.

A patient with hyperprolactinemia needs different treatment again.

And a woman with established primary ovarian insufficiency may require completely different fertility counselling.

Treatment of PCOS/PMOS-Related Anovulatory Infertility

The most important recent change in international fertility care is the strong preference for **letrozole** over older first-line strategies in PCOS-associated anovulatory infertility.

WHO's first global infertility guideline, published in November 2025, suggests **letrozole over clomiphene citrate or metformin** for women with infertility caused by PCOS-related ovulatory dysfunction. WHO also suggests letrozole alone rather than routinely combining it with metformin for first-line ovulation induction.

The 2023 international PCOS guideline independently recommends letrozole as the **first-line pharmacological treatment for ovulation induction** when anovulation due to PCOS is the main fertility problem and no other infertility factor is present.

How Letrozole Works

Letrozole is an aromatase inhibitor.

It temporarily reduces estrogen production.

The hypothalamic-pituitary system responds by increasing endogenous FSH stimulation.

This encourages ovarian follicular development.

Because its effect is temporary, estrogen production can subsequently rise as the dominant follicle develops.

The objective is ideally **single-follicle ovulation**, not production of many eggs.

Letrozole is used off-label for ovulation induction in some countries, and local regulatory practice should be considered.



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Letrozole Is Not a Medicine to Take Without Monitoring

Although oral ovulation-induction medicines are widely used, treatment should follow proper diagnosis.

A clinician needs to consider:

pregnancy exclusion,

the cause of anovulation,

potential contraindications,

tubal status where relevant,

the partner's semen analysis,

and whether monitoring is necessary.

Ovulation induction should not mean repeatedly taking tablets indefinitely without confirming what they are achieving.

What About Clomiphene Citrate?

Clomiphene citrate has been used for ovulation induction for decades.

It stimulates pituitary release of gonadotropins by blocking estrogen feedback.

It remains an important option in appropriate situations.

But current WHO and international PCOS guidance generally prefer letrozole for first-line pharmacological induction of ovulation in PCOS because reproductive outcomes are more favorable overall.

Where letrozole cannot be used because off-label prescribing is not permitted, WHO suggests **clomiphene citrate with metformin** over either clomiphene or metformin alone in the specified PCOS infertility pathway.

What Is the Role of Metformin?

Metformin improves insulin sensitivity and is particularly valuable for metabolic features of PCOS in selected patients.

It can sometimes improve menstrual regularity and ovulation.

But it is not the preferred stand-alone fertility drug when the objective is ovulation induction.

The 2023 international guideline emphasizes metformin primarily for metabolic indications and recognizes letrozole as the preferred first-line pharmacological infertility treatment.

This helps clarify a common misconception:

PCOS infertility is not automatically treated by metformin alone.

Lifestyle Treatment in PCOS/PMOS

Lifestyle care is a core part of PCOS management.

WHO recommends a healthy diet, regular physical activity and appropriate weight management.

For women with excess body weight, clinically meaningful improvement in metabolic health can sometimes improve menstrual regularity and responsiveness to fertility treatment.

But lifestyle care should not become an excuse to postpone fertility treatment indefinitely—particularly in older women or those with additional fertility factors.

Age and reproductive time remain important.

What Happens When Oral Ovulation Medicines Fail?

If appropriate oral treatment does not result in successful pregnancy, the next step depends on why it failed.

Was ovulation never achieved?

Did ovulation occur but pregnancy not occur?

Are the tubes open?

Is semen normal?

How old is the woman?

How long has infertility continued?

These questions need answering before simply increasing treatment intensity.



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Gonadotrophin Ovulation Induction

Injectable gonadotrophins directly stimulate ovarian follicular development.

They can be highly effective.

They also require substantially more careful monitoring.

WHO's 2025 guideline suggests **gonadotrophins over laparoscopic ovarian drilling** for PCOS-related infertility after unsuccessful oral pharmacological therapy.

But gonadotrophins can recruit several follicles simultaneously.

That creates two important risks:

multiple pregnancy and **ovarian hyperstimulation syndrome (OHSS)**.

NICE explicitly advises counselling women about these risks before gonadotrophin ovulation induction.

Why Ultrasound Monitoring Matters During Gonadotrophin Treatment

When injectable gonadotrophins are used, ovarian response can be unpredictable.

If too many follicles develop, continuing the cycle may create an unacceptable risk of twins, triplets or even higher-order multiple pregnancy.

The aim is controlled ovulation, not maximal ovarian stimulation.

This is why gonadotrophin treatment should be performed with appropriate clinical and ultrasound monitoring.

Laparoscopic Ovarian Drilling

Laparoscopic ovarian drilling is a surgical treatment historically used in selected women with medication-resistant PCOS.

Small areas of ovarian tissue are treated surgically to alter androgen-producing ovarian physiology.

It can sometimes restore ovulation.

However, surgery has risks including adhesions and potential ovarian injury.

WHO's newest guideline prefers gonadotrophin therapy over ovarian drilling after failure of oral medications, although the recommendation is conditional because evidence quality remains limited.



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Therefore, drilling should not be an automatic second step in every patient.

When Is IVF Considered in PCOS-Related Anovulatory Infertility?

IVF is usually not the first treatment required when isolated anovulation from PCOS is the only problem.

Many women become pregnant after successful ovulation induction.

WHO suggests IVF when appropriate oral therapies and gonadotrophin treatment have been unsuccessful, unless another factor—such as severe male infertility or tubal disease—creates an earlier independent indication for IVF.

That is a very important distinction.

Failure to ovulate does not automatically mean IVF.

Hyperprolactinemia Treatment

If elevated prolactin is suppressing ovulation, treatment is directed at restoring normal prolactin signalling.

WHO and NICE currently favor **cabergoline** for hyperprolactinemia-related ovulatory dysfunction.

Once prolactin normalizes, menstrual cycles and ovulation can sometimes return without separate ovulation-induction medicine.

Hypothalamic Anovulation Treatment

When low energy availability, excessive exercise or marked weight loss is suppressing the reproductive axis, treatment begins by correcting that environment.

This may mean:

improving calorie and nutrient intake,

restoring appropriate body weight,

reducing excessive exercise,

addressing disordered eating,

and reducing severe psychological stress.



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A 2025 systematic review supports nutritional intervention as a central treatment in FHA while acknowledging that the exact energy prescription and recovery timeline remain individualized.

When fertility treatment remains necessary, GnRH or gonadotrophin therapy can induce ovulation in appropriately selected patients.

Thyroid-Related Anovulation

When clinically significant thyroid disease is responsible for menstrual dysfunction, treatment should target the thyroid condition.

This may permit the hypothalamic-pituitary-ovarian axis to recover.

Simply adding an ovulation-stimulating drug before correcting clinically important thyroid dysfunction can be incomplete treatment.

Primary Ovarian Insufficiency Requires Different Counselling

Ovulation-induction tablets are designed to stimulate follicles that can respond.

In established POI, follicular activity may be very limited or intermittent.

Spontaneous ovulation can occasionally occur, but predictable restoration of fertility with ordinary ovulation-induction drugs is not comparable to PCOS treatment.

These patients deserve specialist counselling about their actual ovarian function and reproductive options rather than repeated empirical stimulation.

IUI and Anovulatory Infertility

Intrauterine insemination, or IUI, does not itself correct anovulation.

The ovary must first produce and release an egg.

In selected couples, ovulation induction may be combined with timed intercourse or IUI.

Which approach is reasonable depends on semen quality, cervical factors, duration of infertility, age and other findings.

If the male partner has normal semen and intercourse can occur normally, many patients with isolated anovulation do not automatically need IUI simply because fertility medicine is being used.

IVF and ICSI Are Not the Same

IVF involves fertilization of eggs outside the body.

ICSI involves directly injecting a single sperm into an egg.

Anovulation alone does **not** automatically require ICSI.

ICSI is generally selected for sperm-related fertilization indications or other specific reproductive circumstances.

Therefore, a woman with an ovulatory disorder and a partner with normal semen may eventually need IVF, but not necessarily ICSI.

The Male Partner Still Matters

This is one of the areas I emphasize strongly at Saira Health Care.

Imagine spending six months successfully inducing ovulation in a woman and only afterward discovering that her husband has severe oligozoospermia.

Those months could have been used more intelligently if both partners had been evaluated from the beginning.

WHO's current infertility pathway specifically includes semen analysis of the male partner during management of anovulatory infertility.

Infertility is a **couple-level reproductive condition** even when one obvious female factor has already been found.

Sexual Function Can Also Affect Fertility

Some couples with ovulatory disorders become so focused on fertile days that intercourse becomes stressful.

A woman with painful intercourse may avoid penetration.

A man may develop erectile or ejaculatory difficulty when intercourse becomes scheduled.

Another couple may have low desire after years of fertility treatment.

These issues matter.

Having successful ovulation does not produce pregnancy if intercourse cannot occur during the fertile period and no assisted conception is being used.



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This is one reason a practice focused on both **sexual disorders and infertility** can look at the reproductive problem more broadly.

How Often Should Intercourse Occur?

There is no requirement for intercourse every day throughout the entire menstrual cycle.

In ovulatory treatment, the clinician may identify an appropriate fertile period based on follicular development or the ovulation trigger.

For natural cycles, regular intercourse throughout the cycle generally prevents excessive pressure on one “perfect” day.

A fertility plan should support the couple's relationship rather than turning intimacy into a laboratory procedure whenever possible.

What Is an hCG Trigger Injection?

During monitored ovulation induction, a follicle may be allowed to develop until it reaches appropriate maturity.

An injection of **human chorionic gonadotropin, hCG**, can then mimic the biological action of the natural LH surge and trigger final oocyte maturation and ovulation.

This helps time intercourse, IUI or egg retrieval.

It does not treat the underlying cause of anovulation.

It is a tool within a monitored treatment cycle.

Does Every Cycle Need an hCG Trigger?

No.

Some women ovulate spontaneously after oral induction.

Others require a trigger for treatment coordination.

The decision depends upon the protocol, ultrasound findings and reproductive plan.

There is no benefit in adding injections merely because they make the treatment appear more intensive.

Pregnancy Is Not Guaranteed After Ovulation Returns



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This is another important counselling point.

Successful ovulation solves **one part** of the fertility problem.

Pregnancy also requires:

functional fallopian tubes,

adequate sperm,

successful fertilization,

embryo development,

and implantation.

Therefore, if a patient ovulates repeatedly after treatment but does not conceive, I do not simply continue the same treatment indefinitely.

The rest of the fertility evaluation must be reconsidered.

Anovulatory Infertility and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine**, I believe anovulatory infertility is an area where traditional principles can be meaningfully integrated with modern reproductive endocrinology—but only when the biological cause is understood properly.

Official CCRUM material describes four principal Unani treatment modalities:

Ilaj-bil-Tadbir — Regimental Therapy

Ilaj-bil-Ghiza — Dietotherapy

Ilaj-bil-Dawa — Pharmacotherapy

Ilaj-bil-Yad — Surgical or procedural treatment

CCRUM also describes **Izala-i-Sabab**, removal or correction of the causative factor, as a core principle of Unani treatment.

For me, **Izala-i-Sabab is particularly relevant to anovulatory infertility.**

How I Apply Izala-i-Sabab to Anovulation

Consider several women who all have irregular periods.

One has PCOS/PMOS with insulin resistance.

One is underweight and exercising intensely.



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One has hyperprolactinemia from a pituitary disorder.

One has hypothyroidism.

One has primary ovarian insufficiency.

And another is taking medication that raises prolactin.

All may appear to have the same complaint:

“My periods do not come regularly.”

But they cannot appropriately receive the same treatment.

The Unani principle of identifying the causative factor before prescribing treatment fits very naturally with modern reproductive endocrinology.

Ilaj-bil-Ghiza — Dietotherapy

Diet can have a meaningful supportive role in anovulatory infertility, particularly when nutritional or metabolic factors are contributing.

In a woman with PCOS/PMOS and metabolic dysfunction, dietary treatment may support:

better metabolic health,

appropriate weight management,

improved insulin sensitivity,

and general preconception health.

In functional hypothalamic amenorrhea, however, the goal may be almost the opposite.

The woman may require **more adequate energy and nutrition**, not calorie restriction.

This is an excellent example of why the same “fertility diet” should never be prescribed to every woman.

The diet must follow the diagnosis.

There Is No Universal “Ovulation Diet”

No particular food, herb, seed or beverage has been proven to induce reliable ovulation in every cause of anovulatory infertility.

A woman with hyperprolactinemia needs treatment of hyperprolactinemia.



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A woman with severe hypogonadotropic hypogonadism may need gonadotropin or GnRH treatment.

A woman with POI cannot regenerate her ovarian reserve simply by eating a specific food.

Diet can be therapeutically useful, but it needs realistic goals.

Ilaj-bil-Tadbir — Lifestyle and Regimental Care

This is one area where a responsible Unani approach can integrate naturally with modern evidence.

CCRUM recognizes regimental and lifestyle-based treatment within Unani practice.

Modern fertility guidelines also emphasize:

healthy physical activity,

appropriate nutrition,

metabolic health,

weight management where relevant,

and correction of excessive exercise or energy deficiency where relevant.

The important word is **appropriate**.

A patient with PCOS and obesity may benefit from one form of lifestyle intervention.

A thin athlete with hypothalamic amenorrhea may require the exact opposite.

Sleep and Daily Routine

Sleep, stress and daily routine can influence metabolic and neuroendocrine health.

Improving sleep will not cure ovarian insufficiency or remove a pituitary tumor.

But in women with PCOS, metabolic dysfunction or functional hypothalamic suppression, optimizing sleep and overall health can form part of comprehensive care.

This is where holistic management has practical value.

Ilaj-bil-Dawa — Unani Pharmacotherapy



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Unani medicine contains traditional formulations used for menstrual and reproductive complaints.

CCRU-related institutional activity also shows ongoing research interest in Unani treatment of conditions such as **PCOS with secondary amenorrhea**, including clinical-study activity.

However, a research project or small study should not be interpreted as proof that a formulation reliably induces ovulation or improves live-birth rates.

At present:

High-quality evidence does not establish one Unani formulation as a universally proven treatment for anovulatory infertility.

Therefore, I consider Unani pharmacotherapy most responsibly as an **individualized supportive component**, chosen according to the patient's condition while objective ovulation and fertility outcomes continue to be monitored.

Why Objective Monitoring Matters in Unani Fertility Treatment

A patient may tell me:

“Doctor, after treatment I feel stronger and my digestion has improved.”

That may be meaningful for general health.

But if infertility treatment is the goal, we still need to know:

Did menstrual cycles become regular?

Did ovulation actually occur?

Was a mature follicle documented if monitoring was needed?

Did progesterone confirm ovulation?

Are the tubes functional?

Is semen adequate?

Feeling healthier and becoming fertile are related but not identical outcomes.

This is why I prefer to combine traditional individualized care with measurable reproductive assessment.

Unani Medicine and PCOS/PMOS



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The potential supportive role of Unani medicine is especially relevant in PCOS/PMOS because the condition commonly involves reproductive, metabolic and lifestyle components.

A comprehensive plan can address:

dietary quality,

physical activity,

metabolic health,

sleep,

stress,

menstrual regularity,

and other associated complaints.

But if the immediate aim is pregnancy and the woman remains anovulatory, modern evidence currently supports letrozole as first-line pharmacological ovulation induction when PCOS is the cause and no other infertility factor is present.

The two approaches do not need to be presented as competitors.

Supportive Unani care can be integrated while proven reproductive treatment is used where necessary.

Unani Medicine and Functional Hypothalamic Amenorrhea

Here, careful nutrition and lifestyle assessment becomes particularly important.

A woman whose reproductive axis has shut down because of inadequate energy intake should not be placed on weight-loss treatment.

She may require:

nutritional restoration,

reduced excessive exercise,

better sleep,

psychological support,

and, if pregnancy remains desired after correction of underlying factors, specialist ovulation-induction treatment.

This illustrates the value of individualized rather than formula-based care.



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Unani Medicine and Hyperprolactinemia

Hyperprolactinemia is another condition where laboratory diagnosis should guide treatment.

If a pituitary adenoma is causing increased prolactin, appropriate endocrine treatment is required.

A supportive Unani programme should not delay:

repeat prolactin testing,

macroprolactin assessment where relevant,

pituitary imaging,

or dopamine-agonist therapy.

WHO and NICE currently favor cabergoline for hyperprolactinemic ovulatory infertility.

When Unani Care Should Not Delay Modern Fertility Treatment

This is particularly important when:

the woman is approaching advanced reproductive age,

ovarian reserve is declining,

there is primary ovarian insufficiency,

both tubes are blocked,

a major pituitary disorder is present,

severe male-factor infertility is present,

or several appropriately monitored ovulation-induction cycles have already failed.

In these circumstances, reproductive time can be more valuable than another prolonged empirical treatment cycle.

Good integrative medicine should recognize that.

The Saira Health Care Approach to Anovulatory Infertility

At **Saira Health Care**, I approach anovulatory infertility as a **diagnostic problem before it becomes a prescription problem**.



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My clinical goal is not simply:

“Give something to release an egg.”

The goal is to identify why normal ovulation is not occurring and build treatment around that cause.

Saira Health Care's published materials describe the clinic's approach as individualized and patient-centred, integrating traditional knowledge, lifestyle guidance and contemporary reproductive understanding, with a focused practice in sexual disorders and infertility.

Step One: Understand the Menstrual Pattern

I first ask:

When did menstruation begin?

Were cycles ever regular?

How often are periods occurring now?

Did irregularity begin suddenly?

Has there been weight gain?

Weight loss?

Intensive exercise?

Recent illness?

Medication use?

Symptoms of excess androgens?

Breast discharge?

Hot flushes?

These questions often tell me which endocrine pathway deserves attention first.

Step Two: Exclude Pregnancy

This may sound obvious, but pregnancy is always an important first consideration when menstruation stops.

ASRM's 2024 amenorrhea guidance specifically begins evaluation by excluding pregnancy.



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Step Three: Determine Whether Ovulation Is Actually Absent

If menstrual history already strongly suggests chronic anovulation, extensive confirmation may not always be necessary.

If cycles appear regular but there is still a reason to question ovulation, appropriately timed **mid-luteal progesterone** can be used.

WHO's newest guideline recommends repeating an apparently anovulatory result in another cycle when appropriate rather than making a permanent diagnosis from one measurement.

Step Four: Identify the Hormonal Pattern

The next task is understanding where the disturbance lies.

FSH and LH help identify ovarian versus central hormonal disorders.

Estradiol helps assess estrogen status.

TSH evaluates thyroid function.

Prolactin helps identify pituitary-related suppression.

Androgens are particularly useful when PCOS or another hyperandrogenic disorder is suspected.

This is much more useful than ordering a standard “female hormone package” without considering the patient's symptoms.

Step Five: Evaluate for PCOS/PMOS Properly

If PCOS is suspected, I look at:

menstrual pattern,

clinical or biochemical androgen excess,

and ovarian morphology when required.

A high AMH or “polycystic” appearance alone should not create the diagnosis.

The modern PCOS guideline requires a complete diagnostic framework and exclusion of mimicking conditions.



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Step Six: Consider the Patient's Metabolic Health

When PCOS/PMOS is present, I also pay attention to:

weight,

blood pressure,

glucose metabolism,

family history of diabetes,

and other metabolic risk factors.

WHO's 2026 PCOS guidance recognizes increased risks of insulin resistance, type 2 diabetes and obesity in affected women.

Infertility treatment should improve long-term health as well as achieve ovulation.

Step Seven: Assess the Fallopian Tubes When Appropriate

Restoring ovulation will not overcome bilateral tubal blockage.

WHO's fertility pathway therefore includes consideration of tubal-patency assessment before or during treatment planning.

Testing may involve HSG or HyCoSy depending upon the patient and available expertise. WHO considers both acceptable methods for assessment of suspected tubal disease.

Step Eight: Assess the Male Partner

This is essential.

At Saira Health Care, because my focused practice covers both sexual disorders and infertility, I consider it particularly important that female anovulation not distract from possible male infertility.

A semen analysis can prevent months of inappropriate treatment.

WHO's algorithm explicitly places male-partner assessment alongside treatment of PCOS-associated anovulatory infertility.

Step Nine: Understand the Couple's Sexual Health

I also ask whether intercourse can occur comfortably and regularly.

Fertility can be affected by:



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vaginismus,
painful intercourse,
low sexual desire,
erectile dysfunction,
ejaculatory problems,
or performance anxiety during timed intercourse.

These conditions may coexist with anovulation and require their own treatment.

Step Ten: Choose the Least Complex Effective Fertility Treatment

If PCOS is the only fertility factor, appropriately monitored ovulation induction may be enough.

If hyperprolactinemia is causing anovulation, prolactin treatment may restore fertility.

If hypothalamic suppression is present, nutritional and neuroendocrine recovery becomes central.

If additional tubal or male factors exist, IUI or IVF/ICSI may be considered earlier.

This is why the same fertility treatment should never be copied from one patient to another.

Step Eleven: Use Unani Treatment as Integrated Support

At Saira Health Care, I integrate Unani principles where appropriate into:

nutrition,
lifestyle,
general metabolic health,
sleep,
stress,
menstrual-health support,
and individualized treatment.

But the response is judged objectively.

If ovulation is not returning, we need to know.



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If reproductive time is being lost, the strategy needs to change.

Step Twelve: Know When to Refer

A responsible infertility clinic should recognize when specialist reproductive endocrinology, gynecology, endocrinology, pituitary imaging, advanced fertility treatment or IVF is required.

No one treatment system should become a reason to delay necessary care.

Saira Health Care's Contribution in Sexual Disorders and Infertility

Saira Health Care's existing public educational material describes its clinical model as combining individualized Unani assessment with contemporary understanding of infertility and sexual health. The clinic's public profile lists work involving irregular menstruation, PCOS/PMOS, female fertility concerns and male infertility among its reproductive-health areas.

For anovulatory infertility, I consider the clinic's contribution especially relevant in five interconnected areas.

The first is **accurate differentiation**: irregular menstruation does not automatically mean PCOS.

The second is **couple-based infertility evaluation**: ovulation, tubes and semen all matter.

The third is **sexual-health assessment**: timed intercourse is not effective when pain, vaginismus, erectile problems or ejaculation disorders interfere with intimacy.

The fourth is **integrative lifestyle and Unani support** when appropriate.

And the fifth is recognizing when modern ovulation induction, endocrinology or assisted reproductive technology is necessary.

Why I Avoid “100% Ovulation Cure” Claims

Anovulatory infertility includes fundamentally different diseases.

A woman with PCOS may respond extremely well to ovulation induction.

A woman with hyperprolactinemia may resume ovulation after appropriate prolactin treatment.

A woman with hypothalamic amenorrhea may recover after nutritional rehabilitation.



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A woman with primary ovarian insufficiency may have a much more difficult fertility prognosis.

Therefore, no responsible clinician can promise identical outcomes for all anovulatory patients.

A good fertility plan provides:

accurate diagnosis, realistic probabilities and timely escalation when necessary.

Common Mistakes I Encourage Patients to Avoid

One of the most frequent mistakes is assuming irregular periods automatically mean PCOS.

Another is relying on an ultrasound alone to diagnose PCOS.

Some women take repeated letrozole or clomiphene cycles without checking whether the tubes are open or whether the male partner has a normal semen analysis.

Others use metformin for months despite having no appropriate metabolic or reproductive indication.

Some women with low body weight and hypothalamic amenorrhea are incorrectly told to lose more weight.

Another mistake is believing that a high AMH guarantees fertility.

And some women spend years trying dietary supplements or herbal products while reproductive age continues advancing.

The better approach is always:

diagnose first, then choose treatment.

Frequently Asked Questions About Anovulatory Infertility

What is anovulatory infertility?

It is infertility caused by failure to release an egg regularly from the ovary.

Is anovulation common?

Yes. Ovulatory dysfunction accounts for a substantial proportion of female infertility. ASRM estimates it may account for up to 40% of infertility in women.

What is the most common cause?

PCOS/PMOS is the most common cause of anovulation worldwide and a leading cause of infertility.

Can I have periods without ovulating?

Yes. Bleeding can occur without successful ovulation.

Can I ovulate even if periods are irregular?

Yes. Women with oligomenorrhea can ovulate occasionally, which is why pregnancy can still occur unexpectedly.

Can regular periods occur without ovulation?

Occasionally. Regular cycles strongly suggest ovulation, but selected women can have ovulatory dysfunction despite apparently regular menstruation.

What is the best test to confirm ovulation?

When confirmation is clinically required, WHO recommends an appropriately timed **mid-luteal serum progesterone**, approximately seven days before the expected next period.

Should progesterone always be checked on day 21?

No. Day 21 is appropriate only for certain cycle lengths. The more accurate concept is about seven days before the expected next period.

Does high AMH mean I am fertile?

No. AMH is useful for ovarian-response assessment and selected diagnostic purposes, but NICE advises against using it to predict natural conception.

Does low AMH mean I am not ovulating?

Not necessarily. Ovulation and ovarian reserve are related but different concepts.

Is letrozole first-line treatment for PCOS infertility?

Yes, current WHO and international PCOS guidance favor letrozole as first-line pharmacological ovulation induction in anovulatory infertility caused by PCOS when no other infertility factor is present.

Is metformin the main fertility medicine for PCOS?

Not generally. Metformin has important metabolic uses and may have reproductive roles in selected patients, but letrozole is preferred for first-line ovulation induction.

Can high prolactin stop ovulation?



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Yes. Hyperprolactinemia can suppress reproductive hormonal signalling and cause irregular menstruation, amenorrhea and infertility.

Which medicine is preferred for hyperprolactinemic ovulatory infertility?

WHO 2025 and NICE 2026 favor cabergoline over bromocriptine.

Can being underweight stop ovulation?

Yes. Low energy availability, significant weight loss and excessive exercise can cause functional hypothalamic amenorrhea.

Can obesity stop ovulation?

It can contribute, particularly in PCOS/PMOS and metabolic dysfunction.

Can thyroid disease cause anovulation?

Yes. Both hypo- and hyperthyroidism can disturb menstruation and ovulation.

Does every woman with anovulation need IVF?

No. Many causes can be treated without IVF.

When is IVF considered?

IVF is considered when simpler appropriate treatment fails or another factor such as severe tubal disease, major male-factor infertility or reproductive age makes IVF more suitable. WHO suggests IVF after unsuccessful oral therapy and gonadotrophins for isolated PCOS-related anovulatory infertility.

Can Unani medicine help anovulatory infertility?

Unani medicine can be useful as an **individualized supportive and integrative approach**, particularly for nutrition, metabolic health, lifestyle, sleep, stress and associated menstrual-health concerns. CCRUM officially recognizes cause-oriented treatment, dietotherapy, regimental therapy and pharmacotherapy.

However, there is currently no high-quality evidence that one specific Unani formulation reliably induces ovulation or improves live-birth rates across all causes of anovulatory infertility.

A Message to My Patients

When a woman comes to me and says:

“Doctor, my periods are irregular. Please give me medicine for egg formation.”



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I explain that before prescribing anything, we need to know **why** her egg is not being released.

If she has PCOS, the treatment may involve metabolic care and ovulation induction.

If she has very high prolactin, we should treat the prolactin disorder.

If she has severe weight loss and hypothalamic amenorrhea, telling her to diet more would worsen the condition.

If she has thyroid disease, thyroid treatment matters.

If she has primary ovarian insufficiency, repeatedly giving ordinary ovulation medicines may not solve the fundamental problem.

And even after we restore ovulation, we still need to remember the fallopian tubes and male partner.

That is why I tell patients:

Anovulation is a symptom of a reproductive problem, not the final diagnosis.

Finding the cause is what makes treatment scientific.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Professional Education and 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 currently published material lists these qualifications and training and describes Dr. Nizamuddin Qasmi's clinical focus as sexual disorders and infertility.

In female infertility, this focused reproductive-health work includes understanding ovulatory disorders while also examining the couple's broader reproductive and sexual-health situation.



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The purpose of the consultation is not simply to increase the number of medicines being used.

It is to determine:

whether ovulation is occurring, why it is abnormal, whether other fertility factors exist, and which treatment offers the most rational pathway toward pregnancy.

When reproductive endocrinology, pituitary treatment, advanced gynecology, ovulation-induction monitoring, IUI or IVF is required, appropriate specialist collaboration should be part of comprehensive care.

The Special Integrative Approach at Saira Health Care

At Saira Health Care, the individualized approach to anovulatory infertility brings together **modern fertility assessment and appropriate Unani supportive care.**

A woman is not treated simply as “PCOS,” “irregular periods” or “infertility.”

Her menstrual history, reproductive age, hormonal pattern, ovarian function, metabolic health, nutritional state, sexual health and partner's fertility all need consideration.

In a PCOS patient, treatment may focus heavily on metabolic health and evidence-based ovulation induction.

In hypothalamic amenorrhea, adequate nutrition and restoration of energy balance may be central.

In hyperprolactinemia, endocrine treatment may be decisive.

In a woman with sexual pain or vaginismus, successful ovulation must be accompanied by appropriate sexual-health treatment.

And where modern fertility treatment is necessary, Unani care should complement rather than delay it.

This cause-based, whole-person approach is consistent both with contemporary infertility care and with the Unani principle of **Izala-i-Sabab.**

What the Latest 2025–2026 Evidence Has Changed

Several developments are particularly important for patients and healthcare professionals.

WHO published its **first global guideline for the prevention, diagnosis and treatment of infertility in November 2025**, providing specific modern recommendations for



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diagnosing ovulatory dysfunction and treating PCOS-related and hyperprolactinemic infertility.

For PCOS-associated anovulatory infertility, WHO now favors **letrozole over clomiphene or metformin** as first-line pharmacological treatment.

When oral treatment fails, WHO favors **gonadotrophins over laparoscopic ovarian drilling**, followed by IVF when appropriate treatment remains unsuccessful.

For hyperprolactinemic infertility, WHO and the new 2026 NICE fertility guideline favor **cabergoline**.

For hypogonadotropic anovulation, NICE's 2026 update emphasizes correction of low weight/excessive exercise and use of GnRH or gonadotrophins with LH activity when ovulation induction is required.

And diagnostically, WHO recommends appropriately timed **mid-luteal progesterone approximately seven days before the expected next period**, with repeat testing when the first result appears anovulatory and diagnostic uncertainty remains.

These updates reinforce one central principle:

Treat the cause of anovulation—not simply the absence of ovulation.

Conclusion

Anovulatory Infertility is one of the most important and often treatable causes of difficulty becoming pregnant.

It occurs when the ovaries fail to release a mature egg regularly.

The most common cause is **PCOS/PMOS**, but anovulation can also result from functional hypothalamic amenorrhea, weight or energy imbalance, hyperprolactinemia, thyroid disease, hypothalamic or pituitary disorders, primary ovarian insufficiency, reproductive ageing, medications and other endocrine diseases.

Correct diagnosis begins with menstrual history.

If ovulation requires confirmation, current WHO guidance recommends appropriately timed mid-luteal progesterone rather than automatically relying on a “day-21” test or ultrasound. Hormonal investigations are then selected according to the clinical picture.

The treatment must follow the cause.

For **PCOS/PMOS**, letrozole is currently preferred as first-line pharmacological ovulation induction when no other major infertility factor exists.

For **hyperprolactinemia**, cabergoline is currently preferred.



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For **functional hypothalamic or hypogonadotropic anovulation**, correcting inadequate energy availability, low weight or excessive exercise is central, and specialist GnRH or gonadotrophin treatment can be used when fertility treatment is required.

When appropriate oral treatment is unsuccessful in PCOS, gonadotrophins can be considered with careful monitoring because of the risks of multiple pregnancy and OHSS. IVF becomes appropriate when lower-complexity treatment fails or another significant fertility factor is present.

From the **Unani perspective**, the principles of **Izala-i-Sabab, Ilaj-bil-Ghiza, Ilaj-bil-Tadbir and Ilaj-bil-Dawa** provide a useful individualized framework for treating the person as a whole.

The most useful role of Unani medicine is to support **nutrition, metabolic health, lifestyle, sleep, stress, menstrual health and overall reproductive well-being**, while modern investigation identifies the actual endocrine and fertility disorder.

No responsible treatment should claim that one Unani or herbal medicine can reliably correct every form of anovulation.

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

Confirm whether ovulation is truly abnormal, identify why it is abnormal, assess the entire couple, correct reversible causes, integrate appropriate Unani supportive care and use evidence-based ovulation induction or assisted reproduction when necessary.

When a patient asks me:

“Doctor, if I am not ovulating, can I still become pregnant?”

my answer is:

In many cases, yes. Anovulatory infertility is frequently treatable—but the success of treatment depends on identifying the correct cause and choosing the correct therapy for that cause.

The goal should never be simply to make a follicle appear on ultrasound.

The real goal is:

safe ovulation, healthy conception and the best realistic opportunity for a successful pregnancy.

Medical Disclaimer: This article is intended for medical education and general patient awareness. Anovulatory infertility requires individualized evaluation. Irregular or absent menstruation can have several causes, and treatment differs substantially between



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PCOS/PMOS, hypothalamic amenorrhea, hyperprolactinemia, thyroid disease and ovarian insufficiency. Patients should not begin letrozole, clomiphene, metformin, cabergoline, gonadotrophins, hormonal medicines, herbal preparations or Unani medicines solely on the basis of online information. Ovulation-induction medicines can have important risks and should be used under appropriate medical supervision. No conventional, Unani, herbal, surgical or assisted-reproductive treatment can guarantee conception or live birth.



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