Sperm Agglutination: Causes, Diagnosis, Fertility Effects, Modern Treatment and the Role of Unani Medicine

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Introduction: "Doctor, My Semen Report Says Positive Agglutination. What Does It Mean?"

When a patient comes to me with a semen-analysis report showing:

Sperm Agglutination – Positive

he is often confused.

Some men ask me:

"Doctor, does this mean all my sperm are sticking together?"

Others ask:

"Is agglutination caused by infection?"

Another patient may say:

"My sperm count is normal, but my report says agglutination ++. Is this why my wife is not getting pregnant?"

And many patients immediately search the internet and conclude:

"Positive agglutination means anti-sperm antibodies."

This is not always correct.

Sperm agglutination is a laboratory finding in which **motile spermatozoa stick directly to one another**.

They may stick:

- head-to-head,
- tail-to-tail,
- tail-tip-to-tail-tip,
- or in a mixed pattern.

The current **WHO Laboratory Manual for the Examination and Processing of Human Semen, Sixth Edition**, defines true sperm agglutination specifically as **motile sperm sticking to each other**. Sperm attached to mucus, debris, other cells, or immotile sperm simply sticking together should instead be described as **aggregation**, not agglutination.

This distinction is extremely important.

Sperm agglutination and sperm aggregation are not the same thing.

At **Saira Health Care**, when I see positive agglutination, I do not immediately prescribe a "sperm-unclumping medicine."

My approach is:

Confirm the finding, determine its severity, look at sperm count and motility, search for anti-sperm antibodies or other causes when appropriate, treat reversible problems, support overall reproductive health, and use IUI/IVF/ICSI when necessary.

What Is Sperm Agglutination?

Sperm agglutination refers to:

direct attachment of motile sperm to other motile sperm.

Under the microscope, the sperm may appear to be:

- shaking together,
- moving as a group,
- pulling against one another,
- or becoming almost immobilized when the agglutinate is large.

WHO describes sperm in an agglutinated group as sometimes showing vigorous or almost frantic movement even though effective forward progression becomes restricted.

This can reduce the ability of sperm to:

- move normally,

- progress through cervical mucus,
- reach the egg,
- participate in fertilization.

However:

the effect on fertility depends on how severe the agglutination is and what is causing it.

Agglutination Is Not the Same as Aggregation

This is perhaps the most important educational point in this article.

True Sperm Agglutination

Means:

- motile sperm stick directly to one another.

Examples:

- head-to-head,
- tail-to-tail,
- head-to-tail,
- mixed patterns.

Sperm Aggregation

Means:

- sperm become associated with mucus,
- cellular debris,
- non-sperm cells,
- or immotile sperm accumulate nonspecifically.

WHO specifically states that motile sperm sticking to:

- cells,
- debris,

or immotile sperm sticking to each other should **not** be scored as sperm agglutination.

Therefore, if a semen report simply says:

“clumping present”

I first want to know:

Was this true sperm-to-sperm agglutination or merely nonspecific aggregation?

Why Does This Difference Matter?

Because the causes and implications may be different.

True agglutination can raise suspicion for:

Anti-Sperm Antibodies – ASA

whereas nonspecific aggregation may be seen with:

- mucus,
- debris,
- inflammatory cells,
- abnormal liquefaction,
- increased semen viscosity,
- sample characteristics.

Treating these conditions as though they were identical can lead to unnecessary medicines and incorrect counselling.

Types of Sperm Agglutination

WHO describes several attachment patterns.

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1. Head-to-Head Agglutination

Sperm heads stick together while the tails remain relatively free.

The tails may continue moving, causing the cluster to shake.

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2. Tail-to-Tail Agglutination

The sperm tails attach while the heads remain more freely mobile.

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3. Tail-Tip-to-Tail-Tip Agglutination

Attachment occurs mainly at the ends of the tails.

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4. Mixed Agglutination

There may be combinations of:

- head-to-head,
- tail-to-tail,
- head-to-tail attachment.

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5. Tangle-Type Agglutination

Heads and tails become:

- entangled,
- enmeshed,

forming irregular clusters.

WHO recommends recording both:

- the degree,
- and major type of sperm agglutination.

WHO Grading of Sperm Agglutination

WHO provides a useful descriptive grading system.

Grade 1 – Isolated

Fewer than approximately:

10 sperm per agglutinate

with many free sperm remaining.

Grade 2 – Moderate

Approximately:

10–50 sperm per agglutinate

with free sperm still present.

Grade 3 – Large

More than approximately:

50 sperm per agglutinate

although some sperm remain free.

Grade 4 – Gross

Essentially:

all sperm are agglutinated

with interconnected sperm clusters.

This is the most severe form.

Does "Agglutination +" Mean the Same Thing in Every Laboratory?

Not always.

Some laboratories report:

-
    -
- ++
- +++
- ++++

while others use:

- Grade 1
- Grade 2
- Grade 3
- Grade 4.

Therefore, when I review the patient's report, I prefer to understand:

- what grading system the laboratory used,

- what percentage of sperm remains free,
- whether motility is reduced,
- whether agglutination is true sperm-to-sperm attachment.

One laboratory's:

"++"

should not automatically be assumed to equal another laboratory's:

"Grade 2."

Does Sperm Agglutination Mean Infertility?

Not automatically.

A man with mild isolated agglutination may still have:

- high sperm concentration,
- excellent progressive motility,
- normal morphology,
- enough free motile sperm

to achieve natural conception.

Another man with:

- gross agglutination,
- poor motility,
- extensive anti-sperm antibodies,
- low total motile sperm count

may face significant difficulty achieving pregnancy.

Therefore:

sperm agglutination is one fertility parameter—not a complete fertility diagnosis.

Does Positive Agglutination Mean the Sperm Are Dead?

No.

In fact, WHO defines agglutination in relation to:

motile sperm.

The sperm may still be alive and actively moving.

Agglutination is therefore very different from:

Necrozoospermia

where a high proportion of sperm are actually non-viable.

Is Sperm Agglutination the Same as Low Sperm Motility?

No.

These are different findings.

Asthenozoospermia

Means:

reduced sperm motility.

Agglutination

Means:

motile sperm are sticking together.

Severe agglutination may **cause or worsen apparent motility problems** because sperm cannot progress effectively.

But a man can have:

- low motility without agglutination,
- or agglutination while many individual sperm remain actively motile.

Is Sperm Agglutination the Same as Abnormal Morphology?

No.

Morphology describes:

sperm shape.

Agglutination describes:

sperm sticking together.

They are separate laboratory findings.

Is Sperm Agglutination the Same as Thick Semen?

No.

A man can have:

- increased semen viscosity,
- poor liquefaction

without true sperm agglutination.

Likewise, sperm can agglutinate in otherwise normally liquefied semen.

Patients frequently say:

“Doctor, my semen is thick, so the sperm must be stuck together.”

This cannot be determined visually.

Only microscopic semen examination can diagnose sperm agglutination.

What Causes Sperm Agglutination?

There is no single cause.

The most important possible causes and associated conditions include:

1. Anti-sperm antibodies
2. Previous vasectomy or vasectomy reversal
3. Genital-tract infection or inflammation
4. Testicular or reproductive surgery
5. Testicular trauma
6. Reproductive-tract obstruction
7. Epididymal or testicular inflammation
8. Selected varicocele-associated immune changes
9. Unexplained or idiopathic factors

However:

positive agglutination alone cannot tell us which of these is responsible.

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1. Anti-Sperm Antibodies: The Most Important Association

The most familiar association is:

Anti-Sperm Antibodies – ASA

Sperm contain antigens that are normally separated from the immune system by protective barriers.

If these barriers are disrupted, the immune system may produce antibodies directed against sperm.

These antibodies can attach to sperm and produce:

- agglutination,
- reduced motility,
- impaired cervical-mucus penetration,
- impaired sperm-egg interaction.

A 2024 review emphasizes that sperm agglutination may suggest anti-sperm antibodies but is **not sufficient on its own to diagnose immunological infertility**. ASA can also exist without visible agglutination.

This means:

Agglutination can suggest ASA, but agglutination does not prove ASA.

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2. Blood-Testis Barrier Disruption

Developing sperm are normally protected from inappropriate immune recognition.

Disruption can occur because of:

- trauma,
- surgery,
- obstruction,
- inflammation.

The latest 2026 reproductive-immunology review describes disruption of the protective reproductive barrier from:

- trauma,
- obstruction,

- inflammation

as a central mechanism behind anti-sperm-antibody development.

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3. Vasectomy

Vasectomy is one of the most strongly studied conditions associated with ASA.

The sperm-producing system continues to make sperm, but the vas deferens is blocked.

Over time, sperm antigens may become exposed to immune tissues.

A 2025 systematic review involving more than **23,000 participants** identified vasectomy and vasectomy reversal among the most frequently investigated factors related to anti-sperm-antibody formation.

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4. Vasectomy Reversal

Even if sperm return to semen after successful:

- vasovasostomy,
- vasoepididymostomy,

anti-sperm antibodies may remain.

In some men this can contribute to:

- agglutination,
- reduced sperm function,
- continued infertility.

But ASA should not automatically be blamed when pregnancy does not occur after reversal.

The female partner and all semen parameters must still be evaluated.

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5. Genital-Tract Infection

Possible infections include:

- epididymitis,
- epididymo-orchitis,
- urethritis,
- sexually transmitted infections,

- prostate-associated infection.

Infection may affect fertility through:

- inflammation,
- oxidative stress,
- impaired motility,
- altered seminal environment,
- and potentially increased anti-sperm-antibody production.

A 2026 systematic review and meta-analysis of male genitourinary infections found significant average reductions in:

- semen volume,
- concentration,
- progressive motility,
- total sperm count,
- morphology

in infected compared with non-infected groups, although study heterogeneity was substantial.

However:

positive agglutination does not prove bacterial infection.

Therefore, I do not give antibiotics simply because a report says:

“Agglutination positive.”

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6. Epididymitis and Epididymo-Orchitis

Inflammation of the epididymis can alter the environment through which sperm:

- mature,
- are stored,
- travel.

Severe inflammation may also expose sperm antigens and contribute to immune responses.

A patient with agglutination plus:

- testicular pain,

- epididymal swelling,
- burning urination,
- urethral discharge,
- fever

requires evaluation for infection rather than only fertility supplements.

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7. Testicular Trauma

Significant injury can disrupt:

- the blood-testis barrier,
- testicular structures.

This may expose sperm antigens and increase the possibility of anti-sperm-antibody formation.

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8. Previous Testicular or Genital Surgery

Procedures involving:

- testes,
- epididymis,
- vas deferens,
- inguinal region

have been investigated as potential ASA-associated conditions.

The 2025 systematic review identified:

- genital/inguinal surgery,
- hernia repair

among repeatedly investigated associations.

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9. Reproductive-Tract Obstruction

Obstruction involving:

- epididymis,

- vas deferens

may increase immune exposure to sperm.

This is particularly relevant in:

- post-inflammatory obstruction,
- congenital structural disease,
- postoperative obstruction.

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10. Varicocele

Varicocele is associated primarily with effects such as:

- increased testicular temperature,
- oxidative stress,
- altered testicular function.

Some studies have also reported associations between varicocele and anti-sperm antibodies.

The 2025 systematic review of ASA causes included varicocele among the commonly investigated conditions but also emphasized that the evidence for several associations remains inconsistent.

Therefore:

a man with agglutination should not automatically be told that his varicocele caused it.

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11. Smoking

Smoking can adversely affect male reproductive health through:

- oxidative stress,
- toxic exposure,
- sperm dysfunction.

Interestingly, a large 10-year retrospective study published in 2025 reported an association between smoking and pathological anti-sperm-antibody levels.

That study also identified:

- agglutination,
- impaired motility

as some of the most revealing semen findings associated with ASA.

This does not prove smoking directly causes agglutination in every patient, but stopping tobacco is sensible fertility care.

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12. Idiopathic Agglutination

Sometimes a man has:

- no vasectomy,
- no obvious infection,
- no significant surgery,
- no major trauma,
- no clearly identified immunological cause.

Agglutination may then remain:

idiopathic or unexplained.

This does not mean the laboratory finding is imaginary.

It means the precise cause has not been identified.

Symptoms of Sperm Agglutination

Sperm agglutination usually causes:

no physical symptoms.

A man cannot feel:

- Grade 1,
- Grade 2,
- or Grade 4 sperm agglutination.

The most common clinical presentation is:

difficulty achieving pregnancy.

Does Sperm Agglutination Cause Sexual Weakness?

No.

A man may have sperm agglutination while having:

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

Agglutination is primarily a:

fertility laboratory finding.

It is not a measurement of sexual performance.

Can Semen Look Normal?

Absolutely.

The semen may appear:

- white,
- thick,
- normal in amount,
- completely ordinary.

Sperm agglutination cannot be diagnosed with the naked eye.

How Is Sperm Agglutination Diagnosed?

The diagnosis begins with:

a properly performed semen analysis.

Step 1: Use a Standardized Semen Laboratory

The current WHO sixth-edition semen manual is intended to standardize:

- semen collection,
- laboratory handling,
- motility analysis,
- morphology,

- sperm agglutination,
- extended investigations.

Poor laboratory technique can lead to poor interpretation.

Step 2: Confirm True Agglutination

The laboratory should distinguish:

True agglutination

motile sperm sticking directly to sperm.

from:

aggregation

sperm sticking to:

- mucus,
- cells,
- debris.

This distinction should appear in a high-quality report.

Step 3: Record the Pattern

The report ideally identifies:

- head-to-head,
- tail-to-tail,
- tail-tip,
- mixed,
- tangle.

Step 4: Record the Severity

The degree should be described using an accepted laboratory method.

WHO's descriptive scale includes:

- isolated,

- moderate,
- large,
- gross agglutination.

Step 5: Review the Whole Semen Analysis

This is essential.

I review:

- semen volume,
- sperm concentration,
- total sperm number,
- progressive motility,
- total motility,
- morphology,
- vitality where needed,
- liquefaction,
- viscosity,
- leukocytes or pus cells when relevant.

A patient with:

mild agglutination + 70 million sperm/mL + good progressive motility

has a very different fertility picture from:

gross agglutination + 3 million sperm/mL + poor motility.

Step 6: Repeat an Abnormal Semen Analysis When Appropriate

Semen findings can vary.

If the finding is:

- unexpected,
- clinically important,
- inconsistent with previous reports,

repeat testing may be useful.

I do not like making major fertility decisions from one poorly performed semen analysis.

Step 7: Look for Signs of Infection

I ask about:

- burning urination,
- urethral discharge,
- painful ejaculation,
- epididymal pain,
- previous STI,
- fever,
- urinary infection.

Testing may include:

- urine examination,
- STI testing,
- culture

according to clinical findings.

Step 8: Consider Anti-Sperm-Antibody Testing in Selected Cases

AUA/ASRM specifically advises:

against routine ASA testing in the initial evaluation of every infertile man.

ASA testing is more appropriate when it may actually influence treatment—for example:

- substantial sperm agglutination,
- vasectomy reversal,
- sperm autoimmunity suspicion,
- unexplained significant motility impairment.

The 2026 reproductive-immunology literature similarly describes ASA testing as a:

targeted diagnostic tool rather than universal screening.

MAR Test

One of the main tests is:

Mixed Antiglobulin Reaction – MAR

The test evaluates whether motile sperm carry surface:

- IgG,
- IgA

antibodies.

WHO describes the MAR test as:

- quick,
- inexpensive,
- sensitive

for screening sperm-bound antibodies.

Immunobead Test

The:

Immunobead Binding Test – IBT

can also identify:

- antibody class,
- binding location.

Direct antibody testing is generally more informative than simply measuring serum antibodies when sufficient sperm are available.

Agglutination Is Not a Positive MAR Test

This deserves emphasis.

A patient may have:

positive sperm agglutination

but:

negative clinically significant ASA testing.

Likewise, ASA may exist without obvious agglutination.

Therefore:

“Agglutination Positive” and “Anti-Sperm Antibody Positive” are not interchangeable diagnoses.

How Does Agglutination Affect Fertility?

The effect varies.

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1. Reduced Effective Forward Movement

Even when tails are moving vigorously, attached sperm may be unable to progress efficiently.

This may reduce:

effective progressive motility.

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2. Fewer Freely Motile Sperm

When sperm are trapped in large clusters, fewer independent sperm remain available to:

- enter the cervix,
- travel through the uterus,
- reach the fallopian tube.

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3. Impaired Cervical-Mucus Penetration

When agglutination is related to anti-sperm antibodies, sperm may have particular difficulty moving through:

cervical mucus.

The 2026 review identifies impaired:

- motility,
- cervical-mucus penetration

among major mechanisms of ASA-associated infertility.

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4. Impaired Sperm-Egg Interaction

Certain sperm-bound antibodies may interfere with:

- zona pellucida interaction,
- sperm-oocyte binding,
- fertilization.

Therefore severe immunological infertility may affect conventional fertilization even when sperm reach the egg.

Can Natural Pregnancy Occur With Agglutination?

Yes.

Especially when:

- agglutination is mild,
- many free motile sperm remain,
- sperm concentration is satisfactory,
- female fertility is favorable.

Therefore:

positive agglutination does not automatically mean IVF is required.

Modern Treatment of Sperm Agglutination

There is no single universal:

“sperm agglutination tablet.”

Treatment depends on the cause and fertility severity.

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1. Confirm the Diagnosis First

Before treatment, establish:

- true agglutination vs aggregation,
- severity,
- sperm concentration,

- motility,
- whether clinically relevant ASA is suspected.

This avoids unnecessary treatment.

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2. Treat Documented Infection

If investigation identifies:

- bacterial infection,
- STI,
- epididymitis,
- prostatitis

appropriate antimicrobial treatment may be necessary.

Antibiotics should target the actual infection.

Antibiotics should not be prescribed simply because agglutination is present.

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3. Treat Significant Inflammation Appropriately

Inflammatory reproductive disease should be evaluated and treated according to its cause.

The goal is to protect:

- testicular function,
- epididymal function,
- semen quality.

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4. Stop Tobacco

Because smoking can worsen:

- oxidative stress,
- sperm function,

and has been associated with pathological ASA levels in recent data, I advise smoking cessation in fertility patients.

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5. Improve General Reproductive Health

I advise:

- healthy diet,
- regular physical activity,
- adequate sleep,
- healthy weight,
- control of diabetes,
- reduction of excessive alcohol,
- avoidance of anabolic steroids.

These steps do not mechanically separate attached sperm, but they improve the broader reproductive environment.

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6. Sperm Washing

Semen processing can:

- remove seminal plasma,
- separate sperm from debris,
- enrich for motile sperm.

This is useful before:

- IUI,
- IVF,
- ICSI.

However:

washing does not reliably remove antibodies already strongly attached to the sperm surface.

Therefore sperm preparation is not the same thing as:

curing anti-sperm antibodies.

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7. Timed Natural Conception

When agglutination is mild and sufficient free progressive sperm remain, the couple may continue:

- appropriately timed natural intercourse

depending on:

- female age,
- infertility duration,
- ovarian reserve,
- tubal status.

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8. IUI – Intrauterine Insemination

IUI can be useful in selected cases.

During IUI:

1. semen is processed,
2. motile sperm are concentrated,
3. the preparation is placed directly inside the uterus.

This bypasses:

the cervix and cervical mucus.

Therefore it may be helpful when:

- mild or moderate antibody-associated sperm problems mainly affect mucus penetration.

A major 2026 review considers IUI a reasonable option in lower levels of sperm autoimmunization, whereas very high antibody binding is much less favorable for IUI.

When Is IUI Less Suitable?

IUI may be less successful when there is:

- severe agglutination,
- very low total motile sperm count,
- extensive sperm-bound antibodies,
- severe additional semen abnormalities,

- major female-factor infertility.

The treatment decision should be couple-specific.

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9. IVF – In Vitro Fertilization

During conventional IVF:

- prepared sperm are placed around retrieved eggs.

The sperm still need to:

- reach the egg,
- bind to the zona,
- penetrate normally.

Clinically important sperm-bound antibodies may interfere with some of these steps.

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10. ICSI – Intracytoplasmic Sperm Injection

ICSI is particularly important in severe immunological sperm problems.

During:

ICSI

one selected viable sperm is injected directly into one egg.

This bypasses many steps affected by sperm antibodies:

- cervical-mucus penetration,
- natural sperm transport,
- zona pellucida penetration,
- some sperm-egg binding mechanisms.

The 2026 *Fertility and Sterility* review identifies ICSI as the key strategy for men with very high sperm autoimmunization because it mechanically bypasses the immune barrier.

Does ICSI Cure Agglutination?

No.

This is important.

ICSI may:

bypass the fertility effect

of severe agglutination or antibody binding.

It does not necessarily:

- remove the antibodies,
- make the semen report normal.

The aim is:

successful fertilization and pregnancy

rather than merely normalizing a laboratory word.

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11. What About Corticosteroids?

Historically, corticosteroids were sometimes prescribed to reduce anti-sperm-antibody production.

However, routine systemic immunosuppression is not generally the preferred modern treatment because:

- fertility benefits are inconsistent,
- potentially significant side effects can occur.

Potential steroid complications include:

- elevated blood glucose,
- increased infection risk,
- weight gain,
- blood-pressure changes,
- mood effects,
- bone effects

depending on dose and duration.

Therefore, I do not believe every patient with agglutination should automatically be placed on steroids.

Can Sperm Agglutination Be Cured?

Patients often want a simple yes or no.

My answer is:

Many cases can be treated or meaningfully improved, particularly when a reversible cause is identified.

For example:

If there is a treatable infection

appropriate treatment may improve the semen environment.

If smoking and poor lifestyle are major contributors

correcting them may improve overall sperm health.

If agglutination is mild

natural conception may still occur.

If antibody-associated agglutination is severe

IUI or especially ICSI may bypass the fertility problem.

But:

there is no one guaranteed medicine that permanently eliminates every form of sperm agglutination.

The word “cure” should therefore be used carefully.

Sperm Agglutination Treatment at Saira Health Care

Saira Health Care currently identifies:

Positive Agglutination

among the male-fertility conditions addressed within Dr. Nizamuddin Qasmi's focused sexual-health and infertility practice.

At Saira Health Care, I approach sperm agglutination as an:

individualized fertility problem

rather than giving every patient the same prescription.

Treatment and meaningful improvement may be possible in many patients after identifying the actual underlying problem.

My Approach at Saira Health Care

Step 1: Verify That It Is True Agglutination

I ask:

"Are motile sperm actually sticking to each other, or does the report only mention aggregation or clumping?"

This prevents misdiagnosis.

Step 2: Determine the Grade

I assess:

- mild,
- moderate,
- large,
- gross agglutination.

Severe agglutination has greater potential fertility significance.

Step 3: Review Sperm Motility

I examine:

- progressive motility,
- total motility.

Agglutination can affect effective forward progression.

Step 4: Review Sperm Count

If sperm count is:

- high,

mild agglutination may still leave a substantial free motile sperm population.

If sperm count is already very low, the same degree of agglutination becomes more clinically important.

Step 5: Review Morphology and Vitality

The complete semen profile matters.

I do not treat one word on the report in isolation.

Step 6: Ask About Infection

I look for:

- urinary symptoms,
- discharge,
- pain,
- fever,
- STI history.

When appropriate, I arrange:

- urine,
- culture,
- STI testing.

Step 7: Look for Immune Risk Factors

I ask about:

- vasectomy,
- reversal,
- testicular injury,
- previous surgery,
- obstruction,
- orchitis.

Step 8: Consider Anti-Sperm-Antibody Testing Only When Useful

I may consider:

- MAR,

- immunobead testing

when the result could alter management.

I do not routinely order every test available.

Step 9: Evaluate Varicocele Where Appropriate

A clinically significant varicocele may coexist with:

- low count,
- poor motility,
- oxidative stress.

It should be assessed independently rather than assumed to be the cause of agglutination.

Step 10: Evaluate the Female Partner

This is essential.

A man may spend a year treating mild agglutination while his wife has:

- blocked fallopian tubes,
- severe endometriosis,
- low ovarian reserve.

Fertility treatment must always consider:

both partners.

Step 11: Correct Lifestyle Factors

I address:

- smoking,
- alcohol,
- obesity,
- poor diet,
- uncontrolled diabetes,
- poor sleep,

- inactivity,
- steroid use.

Step 12: Add Individualized Unani Treatment

Where clinically suitable, I may integrate:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- individualized Unani pharmacotherapy,
- selected male-fertility formulations.

The aim is to support:

- semen quality,
- reproductive health,
- lifestyle,
- general constitutional health.

Step 13: Repeat Semen Testing

Treatment response should be judged by:

- reduction in agglutination,
- better progressive motility,
- improved free motile sperm population,
- improved other semen parameters where abnormal.

Step 14: Do Not Delay ART When Necessary

If the wife has:

- advancing reproductive age,
- low ovarian reserve,

or the male partner has severe antibody-mediated agglutination, waiting indefinitely may reduce the couple's overall pregnancy chance.

Step 15: Use IUI or ICSI Appropriately

The objective is not simply:

"Make the semen report perfect."

The objective is:

help the couple achieve pregnancy safely and realistically.

Sperm Agglutination in the Unani System of Medicine

The Unani system has a long tradition of managing:

- male reproductive weakness,
- semen disorders,
- general infertility,
- nutrition,
- lifestyle,
- sexual health.

However, scientific accuracy is important.

Classical Unani physicians did not have:

- microscopes capable of grading sperm agglutination,
- MAR testing,
- immunobead assays,
- modern immunology.

Therefore:

there is no classical Unani diagnosis that should be claimed as an exact equivalent of modern microscopic sperm agglutination.

I believe this distinction should be stated openly.

Unani Medicine Is an Individualized System

The Unani system considers:

Mizaj – Temperament

along with:

- diet,
- digestion,
- sleep,
- activity,
- psychological condition,
- general vitality,
- reproductive health.

Official Ministry of AYUSH material identifies the traditional Unani framework of:

Asbab-e-Sitta Zarooriya

the six essential determinants of health, including:

- air/environment,
- food and drink,
- physical movement and rest,
- psychological movement and rest,
- sleep and wakefulness,
- retention and elimination.

These principles can be useful in comprehensive fertility care.

Traditional Humoral Framework

Classical Unani medicine discusses the four Akhlat:

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

These are traditional physiological concepts.

They should not be falsely equated with:

- anti-sperm IgG,
- anti-sperm IgA,
- sperm-agglutination grades,
- bacterial infection.

Modern immunology and classical Unani humoral theory are different frameworks.

Four Major Unani Therapeutic Approaches

Official AYUSH material describes four principal forms of Unani treatment:

Ilaj-bit-Tadbir

Regimenal Therapy

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgery

This framework is particularly useful for an integrative fertility clinic.

Ilaj-bil-Ghiza: Dietotherapy

Diet cannot physically separate sperm that are already antibody-bound.

However, a healthy diet may support:

- metabolic health,
- antioxidant balance,
- general spermatogenesis,
- sperm membrane health.

I commonly recommend:

- vegetables,
- seasonal fruit,

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

I advise reducing:

- tobacco,
- excessive alcohol,
- excessive sugar,
- ultra-processed foods,
- repeated deep-fried foods.

Ilaj-bit-Tadbir

Regimenal care may include:

- regular appropriate physical activity,
- weight management,
- good sleep,
- stress management,
- reduction of harmful lifestyle exposure.

These measures can support:

the whole patient's reproductive health

even if they do not directly remove antibodies from sperm.

Ilaj-bid-Dawa

Traditional Unani pharmacotherapy is individualized.

At Saira Health Care, the medicine plan may depend on whether the patient also has:

- low sperm count,

- reduced motility,
- general reproductive weakness,
- other semen abnormalities.

Dr. Qasmi's Spermogenic Powder

Saira Health Care Pharmacy currently lists:

Spermogenic

as Dr. Qasmi's herbal formulation used in male reproductive-health programmes for concerns including:

- decreased sperm motility,
- low sperm count,
- abnormal semen parameters.

The published formulation includes traditional ingredients such as:

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

among others.

In an agglutination patient who also has:

- poor motility,
- low count,
- general fertility-health concerns,

Spermogenic may be considered as part of individualized supportive treatment.

However:

I do not present Spermogenic as a scientifically proven medicine that directly breaks sperm agglutination or removes anti-sperm antibodies.

There is currently no high-quality independent product-specific clinical trial demonstrating that it consistently:

- eliminates sperm agglutination,
- converts MAR-positive sperm to negative,
- removes sperm-bound IgG/IgA,
- guarantees pregnancy.

Its role is better described as:

supportive male-fertility therapy within an individualized programme.

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

Another formulation used in Saira Health Care's male reproductive practice is:

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

which the current pharmacy listing describes as a:

Unani preparation

for male health, general weakness and semen-quality support.

It contains multiple traditional herbal and mineral ingredients.

The pharmacy correctly advises:

- no self-medication,
- physician-directed dosage,
- avoiding overdose.

Nuskha No. 129 may be considered when appropriate for:

- constitutional support,
- semen-quality concerns,
- general vitality.

But:

it should not be described as a proven anti-sperm-antibody or anti-agglutination drug.

What Does Scientific Unani Research Show?

There is published Unani research in:

male infertility and oligospermia

but not strong specific research on laboratory-confirmed sperm agglutination.

A CCRUM-associated retrospective study involving:

126 men with idiopathic oligospermia

reported changes in:

- semen volume,
- sperm count,
- motility

with several traditional Unani treatment groups.

This supports continued investigation of Unani male-fertility treatments.

However:

oligospermia research cannot be used as proof that Unani medicine eliminates sperm agglutination or anti-sperm antibodies.

This distinction is necessary for professional medical publication.

Why I Still Consider Unani Medicine Useful

Unani care may contribute through:

- individualized nutrition,
- lifestyle correction,
- reproductive-health support,
- improvement of associated semen abnormalities,
- general constitutional management,
- sexual-health care.

For some patients:

agglutination is only one part of a larger reproductive-health problem.

That is where holistic management can be particularly valuable.

Can Hijama Cure Sperm Agglutination?

There is currently no high-quality clinical evidence showing that:

Hijama directly eliminates sperm agglutination or sperm-bound antibodies.

If regimenal therapy is used for general health under appropriate supervision, it should not replace:

- semen analysis,
- ASA testing where appropriate,
- infection treatment,
- ART when needed.

How Long Does Treatment Take?

There is no universal time period.

It depends on:

- underlying cause,
- degree of agglutination,
- sperm count,
- motility,
- infection,
- antibody status,
- couple fertility factors.

When the treatment aims to improve broader sperm health, several months may be required because new sperm production itself takes many weeks.

But:

no scientifically responsible clinic should promise that every sperm agglutination case will be cured in exactly one, three, six or eight months.

Can Positive Agglutination Become Negative?

Yes, in some men.

The result may improve when:

- an underlying reversible problem is treated,
- the semen environment improves,
- associated inflammation resolves.

In other patients, persistent antibody-mediated agglutination may remain.

Even then:

successful conception may still be possible through appropriate fertility treatment.

Is Agglutination Reversible After Infection Treatment?

It may improve when infection or inflammation is genuinely contributing.

But the response is not guaranteed.

Anti-sperm antibodies formed after tissue-barrier disruption may persist even after the original infection has resolved.

Is There a Permanent Cure for Anti-Sperm Antibodies?

There is currently no universally proven oral medicine that permanently eliminates all sperm-bound antibodies.

Modern fertility management often focuses on:

- treating the underlying cause,
- maximizing usable sperm,
- bypassing the antibody effect with ART when necessary.

Can IUI Cure Agglutination?

No.

IUI does not necessarily eliminate agglutination permanently.

It is a:

fertility treatment strategy

that may help selected couples achieve pregnancy by:

- processing sperm,
- bypassing cervical mucus.

Can ICSI Overcome Severe Agglutination?

In many severe immune-associated cases:

yes, it can bypass much of the fertility barrier.

ICSI directly injects a selected sperm into the egg.

Current 2026 reproductive literature considers it especially useful when sperm autoimmunization is extensive.

But ICSI does not guarantee:

- fertilization,
- pregnancy,
- live birth.

Sperm Agglutination and Total Motile Sperm Count

One percentage should not dictate treatment.

For example:

Patient A

- sperm concentration: 80 million/mL
- good progressive motility
- mild Grade 1 agglutination

may still have millions of useful free motile sperm.

Patient B

- sperm concentration: 3 million/mL
- poor progressive motility
- Grade 3 agglutination

has a much more significant male-factor problem.

This is why treatment should not be based merely on:

“Agglutination +”

Sperm Agglutination and Female Age

This factor is often overlooked.

Consider:

Couple A

Male has moderate agglutination.

Female partner is 26 with:

- normal ovulation,
- normal ovarian reserve,
- open tubes.

There may be reasonable time for conservative management.

Couple B

Male has the same agglutination.

Female partner is 39 with declining ovarian reserve.

Waiting many months for a perfectly normal semen report may not be the best strategy.

This is why:

male-fertility treatment must always be couple-centered.

Treatment Success Stories: How They Should Be Presented Responsibly

Saira Health Care treats patients with:

- positive sperm agglutination,
- low sperm count,
- low motility,
- other male-fertility abnormalities.

Patients may experience meaningful improvements following individualized care.

However, for a professional disease article, I believe success stories should be documented responsibly.

A good case report should ideally include:

1. baseline semen analysis,

2. agglutination grade,
3. sperm concentration,
4. progressive motility,
5. infection status if relevant,
6. ASA testing where appropriate,
7. treatment received,
8. follow-up semen analysis,
9. reproductive outcome,
10. patient consent.

I do not believe statements such as:

“100% cure of sperm agglutination”

should be published without scientifically valid evidence.

What Should Be Considered Treatment Success?

Success is not always simply:

“Agglutination became zero.”

For one patient, success may mean:

- Grade 3 becomes Grade 1.

For another:

- progressive motility improves.

For another:

- infection is identified and treated.

For another:

- sufficient free sperm become available for IUI.

For another:

- ICSI results in fertilization and pregnancy despite persistent antibody-associated agglutination.

These can all represent meaningful clinical success.

Sperm Agglutination Myths

Myth 1: Sperm agglutination means sperm are dead.

Fact: True agglutination involves motile sperm sticking together.

Myth 2: Agglutination and aggregation are the same.

Fact: WHO clearly distinguishes the two.

Myth 3: Any semen clump seen with the naked eye is sperm agglutination.

Fact: Agglutination is a microscopic laboratory finding.

Myth 4: Positive agglutination proves anti-sperm antibodies.

Fact: Agglutination raises suspicion but cannot diagnose ASA by itself.

Myth 5: Negative agglutination means anti-sperm antibodies are impossible.

Fact: ASA may occur without visible agglutination.

Myth 6: Every agglutination patient has an infection.

Fact: Infection is one possible contributing factor, not a universal cause.

Myth 7: Every patient needs antibiotics.

Fact: Antibiotics should treat a diagnosed bacterial infection.

Myth 8: Thick semen means sperm are agglutinated.

Fact: Semen viscosity and sperm-to-sperm agglutination are different laboratory findings.

Myth 9: Agglutination always causes infertility.

Fact: Mild agglutination can coexist with natural fertility.

Myth 10: Agglutination means sperm count is low.

Fact: Count and agglutination are different parameters.

Myth 11: Steroids are the standard treatment for every agglutination patient.

Fact: Routine systemic steroid treatment is not preferred because benefit is inconsistent and adverse effects may occur.

Myth 12: One herbal medicine can break every sperm agglutinate.

Fact: The cause must first be identified.

Myth 13: Positive agglutination means IVF is immediately necessary.

Fact: Mild cases may be managed conservatively or with IUI depending on the couple.

Myth 14: Severe agglutination means pregnancy is impossible.

Fact: IVF/ICSI can provide effective fertility options in selected severe cases.

Frequently Asked Questions

What does sperm agglutination mean?

It means:

motile sperm are sticking directly to one another.

What is the difference between agglutination and aggregation?

Agglutination:

- motile sperm stick to sperm.

Aggregation:

- sperm are associated with mucus, debris, cells, or immotile sperm.

What does sperm agglutination Grade 1 mean?

Small isolated clusters containing fewer than approximately:

10 sperm

with many free sperm remaining.

What is Grade 2?

Approximately:

10–50 sperm per agglutinate

with free sperm remaining.

What is Grade 3?

Large agglutinates containing more than approximately:

50 sperm

although some sperm remain free.

What is Grade 4?

Gross agglutination in which essentially:

all sperm are agglutinated into interconnected clusters.

Is + agglutination serious?

Mild isolated agglutination may have limited fertility impact if:

- count,
- motility,
- female fertility

are otherwise favorable.

Is ++ agglutination curable?

It may improve depending on the cause.

The entire semen analysis and couple fertility status should be assessed.

Is +++ agglutination serious?

Large agglutinates can reduce the number of free progressively motile sperm and deserve appropriate evaluation.

What is the main cause?

Anti-sperm antibodies are an important association, but:

not every agglutination is caused by ASA.

What test detects anti-sperm antibodies?

Common tests include:

- MAR,
- immunobead testing.

Should every man with agglutination undergo MAR testing?

Not necessarily.

Testing should be selected when it will affect treatment.

Can infection cause agglutination?

Genital infection and inflammation can contribute to poor semen quality and antibody development in selected men.

But positive agglutination alone does not diagnose infection.

Does sperm agglutination lower motility?

It may reduce effective:

progressive motility

because sperm are physically attached.

Can a man with agglutination father a child naturally?

Yes.

Especially in mild cases with sufficient free motile sperm and favorable female fertility.

Can sperm washing help?

Laboratory washing can:

- select usable motile sperm,
- prepare semen for IUI/IVF.

It may not reliably remove strongly attached antibodies.

Can IUI help?

Yes, in selected mild or moderate cases where sufficient motile sperm remain.

Can IVF help?

Yes.

The most appropriate technique depends on:

- antibody level,
- semen quality,
- female factors.

Is ICSI useful in severe agglutination?

Yes.

ICSI can bypass many sperm-antibody-related barriers to fertilization and is particularly useful in severe immunological infertility.

Can Unani medicine help sperm agglutination?

Unani medicine may contribute through:

- individualized reproductive-health care,

- dietotherapy,
- regimenal therapy,
- lifestyle correction,
- support of associated semen abnormalities.

Current evidence does not establish a specific Unani medicine as a universal direct cure for sperm agglutination.

What is the role of Spermogenic?

At Saira Health Care, Spermogenic may form part of an individualized male-fertility programme when agglutination is accompanied by:

- reduced motility,
- low sperm count,
- other semen-quality concerns.

Does Spermogenic directly remove anti-sperm antibodies?

There is currently insufficient high-quality clinical evidence to make that claim.

What is the role of Nuskha No. 129?

Nuskha No. 129 – Vitasem Max may be used for:

- general male reproductive-health,
- vitality,
- semen-quality support

when individually appropriate.

Can Saira Health Care treat positive sperm agglutination?

Yes, **Saira Health Care evaluates and treats patients presenting with positive sperm agglutination as part of its focused male-infertility practice.**

The treatment is individualized according to:

- agglutination grade,

- motility,
- sperm count,
- infection status,
- possible anti-sperm antibodies,
- associated male-factor conditions,
- female-partner fertility.

Meaningful improvement or successful fertility management may be possible in many patients, but no clinic should guarantee that every underlying cause will be permanently cured.

Latest Scientific Perspective: 2025–2026

Several developments are particularly important for interpreting sperm agglutination today.

2025: Large Study of Anti-Sperm Antibodies

A 10-year retrospective study published in *Andrology* in 2025 found that:

- sperm agglutination,
- impaired motility

remain among the most informative semen findings associated with anti-sperm antibodies.

The study also reported an association between:

- smoking,
- pathological ASA levels.

This strengthens the case for targeted ASA investigation in selected men with meaningful agglutination.

2025: Systematic Review of Causes of ASA

A systematic review involving:

51 studies and 23,108 participants

investigated possible conditions associated with anti-sperm-antibody production.

Frequently studied factors included:

- infections,
- vasectomy/reversal,
- varicocele,
- cryptorchidism,
- genital/inguinal surgery,
- HPV,
- bacterial findings.

The authors emphasized that evidence for many individual associations remains inconsistent.

This means clinicians should avoid simplistic statements such as:

“Agglutination is caused by infection.”

2026: Modern ASA Management Has Shifted Toward ICSI

A May 2026 *Fertility and Sterility* review reports that sperm autoimmunity affects approximately:

5–12% of infertile men

and emphasizes that ASA testing has evolved from routine screening toward:

targeted triage.

The review suggests that IUI can remain reasonable at lower levels of sperm autoimmunization, whereas extensive binding substantially reduces IUI usefulness and makes:

ICSI

the most dependable method for bypassing the immune barrier.

2026: Infection Evidence Has Also Become More Precise

A 2026 systematic review and meta-analysis found that male genitourinary infections were associated on average with reductions in several semen parameters, including:

- sperm concentration,
- progressive motility,

- total sperm count,
- morphology.

However, substantial heterogeneity remained, reminding us that:

not every infected man becomes infertile and not every abnormal semen result indicates infection.

Dr. Nizamuddin Qasmi and Saira Health Care

I am:

Dr. Nizamuddin Qasmi

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

My professional education and additional training include:

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

Saira Health Care's public physician profile identifies my focused work in sexual disorders and infertility and specifically includes:

Positive Agglutination

among the male reproductive conditions addressed in the practice.

Saira Health Care's current professional educational material also lists:

- Certificate in Urology – London, UK,
- Masters in Male Infertility – MasterHealthPro,
- Integrated Sexual and Reproductive Health – ISRH, UNFPA

within my professional byline.

Saira Health Care's Contribution to Sexual Disorders & Infertility

Saira Health Care describes its model as:

- patient-centered,
- individualized,
- rooted in Unani medical principles,
- combined with modern diagnostic understanding,
- lifestyle guidance,
- appropriate referral.

This approach is especially relevant to sperm agglutination because the same semen finding can represent very different biological situations.

Consider Three Patients

Patient 1

Has:

- mild Grade 1 agglutination,
- good sperm count,
- good motility,
- no infection.

He may not require aggressive treatment.

Patient 2

Has:

- large agglutination,
- reduced progressive motility,
- positive ASA.

He may require immunological fertility counselling and potentially:

- IUI,
- ICSI.

Patient 3

Has:

- aggregation rather than true agglutination,
- high viscosity,
- genital infection.

His treatment should target the underlying semen environment and infection.

The same prescription cannot logically treat all three.

Why Correct Diagnosis Is Our Most Important Contribution

I believe one of the most valuable things Saira Health Care can provide is correcting misconceptions such as:

“Every sperm cluster is agglutination.”

“Every agglutination is infection.”

“Every agglutination is anti-sperm antibodies.”

“Agglutination means the sperm are dead.”

“A positive report means pregnancy is impossible.”

“One herbal medicine cures every positive agglutination.”

None of these is medically accurate.

My Final Message to Patients With Sperm Agglutination

If your semen report says:

Sperm Agglutination Positive

do not panic.

Ask:

Is this true sperm-to-sperm agglutination or aggregation?

What grade is it?

Is it head-to-head, tail-to-tail or mixed?

How many free sperm remain?

What is my sperm concentration?

What is my progressive motility?

What is my morphology?

Is semen viscosity abnormal?

Are pus cells increased?

Do I have symptoms of infection?

Did I have a vasectomy or reversal?

Have I had testicular surgery or trauma?

Should anti-sperm antibodies be tested?

How is my wife's fertility?

Can we continue trying naturally?

Would IUI be useful?

Would ICSI be more appropriate?

Can individualized Unani treatment support my general semen and reproductive health?

These questions produce a rational treatment plan.

Conclusion

Sperm agglutination is a semen-analysis finding in which:

motile spermatozoa stick directly to one another.

The current WHO sixth-edition laboratory manual clearly distinguishes true sperm agglutination from:

sperm aggregation

where sperm adhere nonspecifically to:

- mucus,
- cells,
- debris,
- or immotile sperm group together.

True sperm agglutination may occur as:

- head-to-head,

- tail-to-tail,
- tail-tip,
- mixed,
- tangled patterns.

WHO describes severity from:

- isolated,
- moderate,
- large,
- gross agglutination.

Agglutination can interfere with fertility by reducing:

- effective progressive motility,
- free motile sperm,
- cervical-mucus penetration,
- and in immune-mediated cases, sperm-egg interaction.

Potential causes or associations include:

- anti-sperm antibodies,
- vasectomy/reversal,
- genital inflammation,
- infection,
- testicular trauma,
- reproductive surgery,
- obstruction,
- selected other male reproductive conditions.

However:

sperm agglutination alone does not prove anti-sperm antibodies.

Current evidence specifically confirms that ASA may:

- produce agglutination,
- occur without agglutination,

so the finding must be interpreted clinically.

Modern treatment begins by:

confirming true agglutination,

determining severity,

reviewing the entire semen analysis,

identifying infection where present,

considering ASA testing selectively,

treating reversible reproductive problems,

optimizing lifestyle and general fertility health.

Natural pregnancy remains possible in many mild cases.

Selected couples may benefit from:

IUI.

For severe immunological infertility:

ICSI

is particularly effective at bypassing the functional barrier created by extensive sperm-bound antibodies.

The **Unani system of medicine** can make a useful supportive contribution through:

- Mizaj-based individualization,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised Ilaj-bid-Dawa,
- nutrition,
- lifestyle correction,
- broader semen and reproductive-health support.

Official Ministry of AYUSH sources recognize:

- dietotherapy,
- regimenal therapy,
- pharmacotherapy,

- surgery

as major Unani therapeutic modalities.

At **Saira Health Care**, Dr. Qasmi's formulations such as:

- **Spermogenic**
- **Nuskha No. 129 – Vitasem Max**

may be incorporated into selected individualized male-fertility treatment plans according to the complete semen and health profile.

However:

current scientific evidence does not establish these formulations as universal direct cures for sperm agglutination or anti-sperm antibodies.

At Saira Health Care, our approach can therefore be summarized as:

Confirm whether it is true agglutination.

Distinguish agglutination from aggregation.

Determine the grade and pattern.

Evaluate sperm count and progressive motility.

Look for infection and inflammation where appropriate.

Consider anti-sperm-antibody testing selectively.

Treat reversible causes.

Improve diet, lifestyle and reproductive health.

Use individualized Unani support appropriately.

Repeat semen analysis to document improvement.

Evaluate the female partner simultaneously.

Use IUI, IVF or ICSI when medically appropriate.

And never promise a guaranteed cure from one medicine or one medical system.

For every patient who asks me:

“Doctor, my sperm are sticking together. Can this problem be treated?”

my answer is:

Yes, many cases of sperm agglutination can be treated, improved or successfully managed once we identify the underlying cause. Even when agglutination persists, modern fertility

techniques such as IUI or ICSI may provide effective routes to pregnancy. The key is accurate diagnosis and individualized treatment—not simply treating the word 'agglutination' on a laboratory report.

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About the Author

Dr. Nizamuddin Qasmi

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

Professional Education & 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 current published physician profile specifically includes:

- **Positive Agglutination**
- oligospermia,
- azoospermia,
- asthenospermia,
- teratospermia,
- necrospermia,
- varicocele

among the reproductive-health conditions addressed within Dr. Nizamuddin Qasmi's focused infertility practice.

The clinic describes its overall approach as patient-centered and based on:

- individualized assessment,
- traditional Unani principles,
- contemporary diagnostic understanding,
- lifestyle guidance,
- appropriate referral where needed.

Medical Disclaimer

This article is intended for:

- patient education,

- fertility awareness,
- general reproductive-health information.

It is not a substitute for:

- individual medical consultation,
- standardized semen analysis,
- MAR testing,
- immunobead testing,
- infection testing,
- physical examination,
- reproductive-urology assessment,
- female infertility evaluation,
- ART consultation.

Do not assume that:

- semen clumping means true sperm agglutination,
- sperm agglutination means infection,
- sperm agglutination proves anti-sperm antibodies,
- agglutinated sperm are dead,
- positive agglutination means pregnancy is impossible.

Do not independently start:

- antibiotics,
- corticosteroids,
- immunosuppressants,
- fertility hormones,
- herbal medicines,
- Unani medicines,
- antioxidant combinations,
- supplements

simply because a semen report says:

“Agglutination Positive.”

Dr. Qasmi's Spermogenic, Nuskha No. 129 or other fertility formulations should not be interpreted as guaranteed cures for:

- sperm agglutination,
- anti-sperm antibodies,
- male infertility.

At Saira Health Care, positive sperm agglutination can be **evaluated and treated as part of an individualized male-infertility programme**, but the possibility and degree of improvement depend on:

- the underlying cause,
- agglutination severity,
- sperm count,
- motility,
- antibody status,
- female-partner fertility.

Where:

- IUI,
- IVF,
- or ICSI

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

No modern medicine, Unani formulation, procedure or ART technique can ethically guarantee:

- normalization of semen,
- fertilization,
- pregnancy,
- or live birth.

Saira Health Care
www.sairahealthcare.com

Medical literature reviewed and updated: September 2026